London Ambulance Service NHS Trust

Emergency operations centre (EOC)

Inspection report

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Date of inspection visit: 6 December 2021
Date of publication: 04/03/2022

Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services effective?	**Inspected but not rated**
Are services caring?	**Inspected but not rated**
Are services responsive to people's needs?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Emergency operations centre (EOC)

Inspected but not rated

We carried out this unannounced focused inspection as part of our review of north east London's urgent and emergency care services.

We inspected the Emergency Operations Centre (EOC) against our NHS Ambulance Services - system resilience focussed inspection framework.

The London Ambulance Service NHS Trust (LAS) is the only NHS provider trust to serve the whole of London and its population. They cover an area of 620 square miles, answer around two million 999 calls a year and crews attend more than 3000 emergencies a day. They are the busiest ambulance service in the country and one of the busiest in the world.

We carried out this unannounced inspection in December 2021. As this was a focussed inspection, and we did not look at every question in our key lines of enquiry, we did not re-rate the service this time. The previous rating for the EOC of 'Requires Improvement' remains.

A summary of CQC findings on urgent and emergency care services in Northeast London.

Urgent and emergency care services across England have been and continue to be under sustained pressure. In response, CQC is undertaking a series of coordinated inspections, monitoring calls and analysis of data to identify how services in a local area work together to ensure patients receive safe, effective and timely care. We have summarised our findings for Northeast London below:

Northeast London

Provision of urgent and emergency care in north east London was supported by services, stakeholders, commissioners and the local authority. The health and care system in this area is complex, made up of a large number of health and social care providers. We did not inspect all providers within the system and did not inspect any GP services.

We undertook these inspections during the COVID-19 pandemic; the pandemic had put significant pressure on health and social care services and the staff working within them. Despite the challenging circumstances, we found examples of staff working in partnership. For example, there was good engagement between service leaders to understand the impact of demand on different services and to discuss opportunities to signpost patients to services under less pressure.

However, system wide collaboration was needed to alleviate the pressure and risks to patient safety identified in the emergency department we inspected.

We were told there were capacity issues, especially in primary care, resulting in delays for patients trying to access urgent care or patients being signposted from 111 to acute services. We were told appointments for out of hours GPs were often unavailable. We observed patients queuing to access both the urgent treatment centre and emergency department and were told patients attended these services due to an inability to access their own GP. This put additional demand on the hospital and caused further delays in patients accessing treatment.

Our findings

In addition, there had been an increase in the number of 111 calls from patients requiring dental treatment and patients reported a local reduction in dental providers accepting new patients.

We identified an opportunity for more effective integration between the 999 and the integrated urgent care (IUC)111 service; the call system for the 999 service was unable to electronically send information to the 111 service if it was decided the caller did not meet the criteria for an ambulance. The caller was asked to redial 111. In contrast, 111 were able to communicate directly with 999 if they felt their caller required an ambulance.

We inspected one emergency department in NE London and found that local services did not always work together to reduce attendances or the length of stay in the emergency department. This resulted in situations of overcrowding, compromised infection control and extended waits for treatment, which impacted on outcomes for patients. The ambulance service had commenced daily calls with system partners to try and reduce ambulance handover delays and to monitor demand across NE London.

We identified a lack of collaborative working and poor communication between an emergency department and the co-located urgent treatment centre resulting in delays for people accessing services. Different digital operating systems within these services did not promote effective communication or integration between services and were a limiting factor in how services could work collaboratively to deliver safe, effective and timely patient care. These issues resulted in people being sent from the urgent treatment centre to the emergency department without an effective referral mechanism and meant they experiences further delays whilst in another queue to be assessed.

We found examples of delays in discharge from acute medical care impacting on patient flow across urgent and emergency care pathways. This also resulted in delays in handovers from ambulance crews and prolonged waits in the Emergency Department due to the lack of bed capacity. We also found patients in the emergency department for whom a decision to admit had been made; however, they were still waiting in excess of 24 hours before being transferred to a bed on the ward. These delays exposed people to a risk of harm.

We identified a significant number of patients unable to leave hospital to return to their own home or move into community care. This was due to a number of complex reasons including delays in the provision of care packages due to lack of availability, a lack of residential and/or nursing care beds and because of a shortage of social care staff and the impact of vaccination as a condition of deployment. We were told that Local Authorities were working to increase capacity in social care and that they regularly met with system partners to discuss the provision of urgent and emergency care in London; however, the impact on patient flow through urgent and emergency care pathways remained a significant challenge across NE London. Increased collaboration and support from system partners was required to manage the risk being held in the emergency department we inspected.

How we carried out the inspection

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

For our emergency operations centre inspection, we talked with 10 call handlers, four dispatchers, two CHUB clinicians, a paramedic member of the HEMS team, two advanced paramedics specialising in critical and urgent care respectively and two student paramedics. We interviewed three of the trust's senior operational managers and executives. After the inspection we requested further information and documents from the trust.

Summary of this service

Our findings

The service was under immense and sustained pressure from call demand, with increased numbers of ambulances being held at Emergency Departments (ED), resulted in less capacity to respond to calls. The service was staffed and resourced safely to meet people's needs in most areas for commissioned and planned levels of demand. However, the recent significant rise in numbers of callers to 999, and the inability to release ambulances from emergency departments meant the service was unable to reach all patients who needed an ambulance safely and effectively much of the time. Incidents of exceptional demand was occurring on most days, and staff told us that this was becoming unsustainable for the service. Staffing levels had been increased to deal with some of the anticipated rise in demand, however this was not able to keep in line with the increased demand on the service. Additional recruitment was underway to mitigate this.

Some of the EOC staff described feeling exhausted, demoralised and stressed at times by the job with the current pressures. This was recognised and acknowledged by the senior management and the executive team at the trust. Staff remained as positive as they could and we saw and heard how this helped in their response to callers.

The service had not fully implemented and enforced national guidelines relating to COVID-19 screening and social distancing within the workplace.

However:

Despite the pressure faced we heard EOC staff treat patients with compassion and kindness. They respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.

Is the service safe?

Inspected but not rated

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to all staff and made sure everyone completed it.

EOC staff received and kept up to date with their mandatory training. Staff we spoke with confirmed they were able to keep up to date during the COVID-19 pandemic as most of the training could be accessed via e-learning modules.

The mandatory training was given during induction and was detailed and varied to enable staff to meet the needs of patients and staff.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

Managers monitored refresher mandatory training and alerted staff when they needed to update their training. Figures supplied by the trust showed overall mandatory training at 82% against a target of 85%.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. EOC staff had training on how to recognise and report abuse and they knew how to apply it.

Our findings

All new staff received safeguarding training to the level required for their role on induction. The percentage of staff who had received safeguarding refresher training had fallen during the pandemic and in November 2021. Figures produced in December 2021 show 83% of the EOC staff had received level 2 refresher training, the figure was just under 55% for clinical staff at level 3. Staff we spoke with were able to demonstrate their knowledge of safeguarding and how to make referrals if required.

During our inspection we witnessed a safeguarding referral made by an EOC call handler as a result of a call they had taken. The call handler was required to call another LAS unit called the electronic bed service (EBS). Although EBS had access to the Computer Aided dispatch (CAD) system used by the call handlers and dispatchers the service felt the specialist support and advice offered was worth taking staff away from their front line duty for a short time. The average time for an EOC safeguarding referral was 8-10 minutes and at the time of our inspection such referrals amounted to approximately 7% of the referrals made by the trust. Safeguarding referrals could be complex and were often not always about the subject of the 999 call. For example; if a carer was to be taken to hospital leaving the cared for person alone.

Cleanliness, infection control and hygiene

The service generally controlled infection risk well. Staff used equipment and control measures to protect themselves and others from infection. They kept equipment and the premises visibly clean.

Following COVID-19 infection prevention and control (IPC) guidelines the headquarters building had sanitiser gel and masks available at reception. Throughout the building there were wall mounted sanitiser gel pumps at strategic locations such as doorways and within EOC areas.

The EOC staff all wore LAS uniforms which were visibly clean and well maintained. Staff wore masks when moving around the building but not at their desks.

In the main call handling area each position was separated from the next by a clear plastic screen. However, in the dispatch and other areas that was not the case. We asked senior managers why this was and we were told the dispatch and other staff needed to speak with each other and their seating was suitably socially distanced. An IPC COVID compliance audit completed and provided to us on 17/12/2021, agreed the dispatch seating area was suitably distanced but the tactical operations centre (TOC) had no screens, staff were not wearing masks and were not socially distanced.

When we spoke with a member of London's Air ambulance, the helicopter emergency medical service (HEMS) who shared their area with two other paramedics, that area also had no screening and they were not able to socially distance.

We were told EOC staff were supplied with COVID-19 rapid lateral flow test kits with which they were expected to test themselves twice weekly. Staff were also expected to report any symptoms and to self-isolate appropriately. Just over a third of the EOC staff had registered on the system to report the results of their tests and just under that number actually did so (data supplied by LAS for 13/12/2021). LAS conducted regular audits of the lateral flow test results and staff vaccine levels from the staff who had reported their results.

EOC staff did not have access to polymerase chain reaction (PCR) COVID-19 tests via LAS. Staff are referred to the UK Health Security Agency guidance (UKHSA) and the trust's well-being hub to obtain PCR tests when appropriate.

Staff we spoke with told us they felt protected from COVID-19 within the workplace.

Our findings

There was another EOC based in Bow, east London, which we did not inspect, which mirrored the headquarters EOC and was able to access the same 999 calls. This alternate location provided some resilience should equipment fail at either EOC. However, we were not assured consideration had been given to staffing requirements should there be a COVID-19 outbreak at either EOC.

We were told the trust continued to promote and encourage staff to participate in the vaccination programme for Covid-19 and Seasonal Flu.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. However, there were some issues around COVID-19 protection.

The trust had two EOCs, one based in Bow, east London and the other at their London headquarters in Waterloo. All 999 calls asking for an ambulance could be answered by either EOC as their systems were linked and the computers updated vehicle availability in real time.

The various areas of the EOC were only accessible by electronic swipe cards given to authorised staff. We were told, and saw, staff had been dispersed over two floors to allow for Covid-19 social distancing. The electronic systems in place provided continuity of cover and staff were able to talk and share content with each other as if they were together.

We saw multiple large video screens in the various EOC rooms which displayed ambulance attendance wait times, number of calls waiting to be answered etc and had the ability via access to the traffic control network of cameras to display incidents in real time.

There was a separate tactical operation centre (TOC) from which major incidents could be co-ordinated. We noted this area was not provided with COVID-19 screens between workstations.

The EOC Business continuity Plan we requested was dated October 2019, and was due to be reviewed in March 2020. This had not been done and in its current format did not mention COVID-19. However, we were given a copy of the EOC sustainability and surge plans, dated January 2021, version 32. In this document the trust set out how they would respond to provide both surge protection and short term loss of service of their EOC via a 'buddy sites' link with another ambulance provider. After a set period of time British Telecom (BT) would automatically look for pre-agreed 'buddy sites' to take the calls. Other measures were set out in the document, but they had not been updated to reflect the risk of a COVID-19 outbreak within EOC.

Assessing and responding to patient risk

Staff completed risk assessments for each patient swiftly. Staff identified and quickly acted upon patients at risk of deterioration or who were known to be deteriorating. However, there was a known risk associated with the lack of ambulances available to attend and the potential risk to patients deteriorating.

The EOC was staffed 24 hours every day of the year. Staff used a nationally recognised tool to identify risk and deteriorating patients and escalated them appropriately. Calls received into the EOC were categorised with a priority level through the medical priority dispatch system (MPDS). MPDS was used by call handlers to make decisions and dispatch appropriate aid to medical emergencies. The system provided standard questions relating to a patient's condition and provided pre-arrival and care instructions to the patient. The system listed calls in order and colour coded them to show their priority level. Calls could be re-prioritised if felt necessary by staff depending on clinical symptoms.

Our findings

We observed calls which had been triaged by a call handler and sent to the dispatch team for assigning to an ambulance. These calls were held in the dispatch area due to lack of available vehicles, as they were already assigned calls or delayed at hospital ED's.

We noted the 999 call handler system was unable to electronically send information to the 111 service if it was decided the call did not meet the criteria for an ambulance. The caller was asked to redial and speak with 111. In contrast, 111 were able to send messages to 999 dispatch if they felt their caller required an ambulance. We were told it was a national issue and new CAD software scheduled for introduction later in 2022, is likely to include this facility. EOC staff reported on occasion the same caller would be transferred back to 999 dispatch by 111. It was believed by the EOC staff this was sometimes because the patient had deteriorated further or had amended their symptoms to ensure an ambulance was sent.

The EOC staff carried out 'welfare check' calls. They were carried out, usually by specific members of the team, to callers who may require additional support or to check if circumstances had changed with the patient if the ambulance was delayed. We noted a dispatcher had identified a call that needed a call back due to a clinical risk and the time the patient had waited. The call was not identified to a clinician for this to be done by the dispatcher. Instead the call was made by a member of the dispatch team.

Clinical staff were available within the EOC in an area known as the clinical hub (CHUB). The responsibilities of CHUB were to 'hear and treat' patients and provide clinical oversight of all calls awaiting an ambulance response. The CHUB was also available to offer clinical support to call handlers who may have medical queries whilst triaging a patient.

Ambulance response times were available to the call handlers and they were able to provide patients with a realistic response time to manage their expectations and reduce follow-up calls coming back into the system.

There was an area of the EOC dedicated to specialist and advanced clinicians which consisted of a London's Air Ambulance (HEMS) paramedic, Advanced Paramedic Practitioner in critical care (APP-CC) and Advanced Paramedic Practitioner in urgent care (APP-UC). Collectively those staff undertook clinically led dispatch of specialist clinical resources including HEMS and APP responders as well as providing advice to operational ambulance crews, EOC staff and 999 callers and patients.

HEMS provided emergency trauma cover to patients who had been triaged to require advanced treatment at a scene and/or swift transport to hospital. The HEMS helicopter was not allowed to fly after sundown. The HEMS crew then transferred to a dedicated fast response car to continue to provide the service.

The EOC was also able to dispatch hazardous area response team (HART) members to calls where hazardous environments were notified.

Staffing

Due to the pressure and rapid growth in 999 calls, the service did not have enough staff to provide a safe service at all times.

In October 2021, NHS England requested all ambulance trusts recruit additional call handlers to meet a forecasted demand of 2019 staffing levels plus 25%. LAS were actively recruiting and had planned extra training courses for early in 2022. EOC staff recruitment levels was on the risk register.

Our findings

The rising demand for call handling meant staff resources were being continuously stretched. The delay in sending ambulances meant people were calling to the service a number of times to ask for updates or to provide new information if the patient's condition changed.

The trust told us that the difficult and stressful nature of the role, and competition from other employers had also presented a challenge to recruitment.

Some staff we spoke with acknowledged the mental and physical stress caused by the current pressures.

On the day of our inspection staff levels within the EOC were below planned levels. The number of call handling staff over the 24 hour period ranged between 57% and 91% of planned staff. The planned numbers for the lowest and highest fill percentages were 87 and 70, but the actual numbers were 50 and 64. In dispatch the percentages were 46% and 74%. The planned numbers should have been 30 at all times, but the lowest actual numbers were 17 and the highest 26. For clinicians within the CHUB the low and high percentages were 46% and 74%. The planned numbers were 24 and 27, but the actual numbers were 11 and 20. Over the previous weeks there had been particular hours of the day when all three areas had been fully or slightly overstaffed but the majority of time the staff numbers were less than planned in all areas.

Some members of the dispatch staff were reassigned as call handlers. Some of those described dissatisfaction as they felt their expertise was with dispatch which was also under staffed. Others saw it was a way to keep their skills up to date.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

The trust recorded all calls within EOC for safety and performance monitoring. The EOC handled 999 calls only. We observed call handlers and clinicians updating patient records during and after calls, ensuring information was as accurate and up to date as possible. All non-conveyance of patients by ambulance was recorded in their record with a reason for the non-conveyance.

Special patient notes were flagged to call handling staff with information relating to the patient. Information such as 'do not attempt cardiopulmonary resuscitation' (DNACPR) orders, anticipatory care plans and fragility notes were available for staff to view.

Is the service effective?

Inspected but not rated

Call answering times

The service monitored but did not always meet agreed response times.

The London Ambulance Service (LAS) provided ambulance services to the whole of London which has a resident population of almost nine million. This number could increase significantly when commuting workers and tourism were taken into account.

Our findings

Since June 2021, as at other times during the COVID-19 pandemic, LAS had been at Resource Escalation Action Plan (REAP) level 4, which meant the service was under 'extreme pressure'.

Despite the pressure the service was under it was able to meet the national average standard response time for Cat one calls until September 2021, and continued to meet it 90% of the time according to the latest figures we had available at the time of our inspection.

Between November 2020 and October 2021, LAS received 1,592,728 999 calls out of the total for England of 9,691,271. This meant LAS received almost 16.5% of all the 999 calls made throughout England. 999 calls continued to increase throughout the year from around 4,500 a day in March 2021 to an average of 6,500 a day during September 2021. The above figures did not include calls to the 111 service.

In October 2021, LAS averaged 25 seconds to answer 999 calls. That was the second quickest of the 11 NHS ambulance providers and 31 seconds faster than the average for England. In the same month the median time to answer calls, was zero seconds from the time the call was connected to the emergency switchboard. That meant the service answered half of the 999 calls immediately.

On the day of our inspection we saw on the large screens in the EOC areas there were often over eighty 999 calls held in the queue. The service told us the mean average call answering time on the day of our inspection was 54 seconds. LAS then prioritised response to the category one calls.

Calls to LAS via the 999 system are prioritised into one of four categories:

- Category one: for life-threatening injuries and illnesses, specifically cardiac arrest.
- Category two: for emergency calls, such as stroke patients.
- Category three: for urgent calls such as abdominal pains, and which will include patients to be treated in their own home.
- Category four: less urgent calls such as diarrhoea and vomiting and back pain.

There were a total of 861 breaches of the 60 minute ambulance handover target in the week leading up to our inspection. A record is made if an ambulance crew is held at a hospital for over 60 minutes before they can handover their patient to hospital care and be available for another call. During the Covid-19 pandemic it was not unusual for a number of ambulances to be held at hospitals and therefore not be available to take new calls.

During the inspection we heard callers, classified as Category three calls and below, being advised that there could be a five or six hour wait for an ambulance and in some instances advised, if possible, to make their own way to hospital.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The trust carried out regular audits to monitor how they were performing. In relation to the EOC audits included: call handling quality assurance; auditing a sample of triaged calls each month, and a CHUB audit to check a sample for the quality of each clinicians calls each month.

Our findings

The trust had achieved a significant marked rise in the rate of 'hear and treat' for patients. These were incidents resolved by staff over the telephone. This was a nationally measured standard for which the trust was benchmarked against other NHS ambulance services in England. The trust had an internal target for hear and treat of 8.39% of calls. In September 2021, the trust achieved a score of 16.2% and was ranked the second highest scoring ambulance service in England. The national average for September 2021 was around 11.5%.

Multidisciplinary working

All those responsible for delivering care worked together as a team as much as possible to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.

The trust worked closely with the Metropolitan Police Service (MPS) to co-ordinate responses to emergencies which required both services to attend.

Staff told us they worked with other providers in the wider health and social care setting, such as: social services, hospitals, primary care services and other emergency services. When required, there was good communication between EOC staff and external health and social care services.

The trust complied with the National Ambulance Resilience Unit (NARU) memorandum of understanding on the deployment of 'mutual aid'. The process of requesting or providing mutual aid was an aspect of this memorandum. The trust had good working relationships with other ambulance trusts and often sent and received 'out of area' calls from patients which required transfer to another ambulance service.

We observed all of the various specialists within the EOC working together to deliver the best and safest patient care they could deliver. Call handlers liaised with dispatch staff and raised safeguarding referrals when required. They also passed calls through to the clinicians in the CHUB for further advice and possibly a hear and treat service. The HEMS team were able to access any call they thought might fall within their remit. The dispatch teams worked well with the ambulance crews as well as maintaining liaison with the hospital ambulance liaison officers (HALO) at the ambulance receiving centres (ARC) at the busy hospitals. The role of the HALO is to help maintain a safe and effective handover, ensure the deteriorating or at-risk patient is identified in the 'queue' and liaise between the hospital and LAS.

Is the service caring?

Inspected but not rated

Compassionate care

Staff treated patients with compassion and kindness.

Staff were professional and demonstrated empathy and reassurance whilst speaking to members of the public during 999 calls.

The MPDS system had standardised advice staff were able to give callers on actions they should take whilst waiting for an ambulance. We observed this advice being given clearly and timely enough for the caller to understand.

A call handler diffused a difficult situation involving a member of the public, who was distressed at the wait time experienced for an ambulance. We heard their sensitive and caring approach while dealing with this.

Our findings

Staff showed understanding of the impact of their advice, highlighting their interest in further development. They told us of their particular interest in receiving further training to support members of the public experiencing mental health episodes. They demonstrated a keen interest to support the personal and cultural needs of the public.

Staff talked to patients in a way they could understand and made sure patients and those close to them understood their care and treatment.

Healthcare professionals demonstrated the ability to triage patients using effective communication whilst involving patients, relatives and carers in their interactions.

Is the service responsive?

Inspected but not rated

Service delivery to meet the needs of local people

Since the NHS Ambulance Response Programme standards were introduced in 2017, the service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

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.

Dispatchers were assigned a dedicated geographical area which was split into different sectors throughout London. This gave staff an understanding of the local areas such as; roads, hospitals, traffic information and liaison points.

The trust had planned for a further recruitment of EOC staff anticipating a rise in the number of calls due to the pandemic and moving into the 2021/2022 winter season. On the Friday before our inspection the EOC received over 7,600 999 calls. Despite the extra staff the trust found it difficult to maintain full staff coverage in the EOC areas.

Dispatch staff were rostered to perform call handling duties for 30 minutes during each of their shifts. While this enabled the EOC to maintain its category one call handling ability, dispatch staff reported it left them short staffed and affected their ability to allocate ambulances to the calls. The service told us EOC watch managers redeployed staff according to risk depending on the number of calls waiting and those waiting for an ambulance response in line with the clinical safety plan.

The trust reported a sickness rate for November 2022 of 11% within the EOC.

The trust was working closely with the hospitals in its catchment area to try and reduce the length of time their ambulance crews were delayed after arrival at the emergency departments (ED). They had trained additional HALO's and set up and staffed ARC's at certain hospital ED's.

Our findings

Access and flow

People could not always access the service when they needed it which was not always in line with national standards. Pressure from excessive demand meant many patients were now waiting too long for their call to be taken or to get a timely response after assessment.

Calls into the EOC were monitored at all times. Staff could see performance metrics displayed on large television screens positioned throughout the EOC. Given the level of calls the EOC frequently struggled to match resources to call volume.

The service was aware of the category and status of calls received from patients, members of the public and healthcare professionals to make sure the right response was arranged. The managerial teams and coordinators in the EOC made operational decisions about how to respond to excess demand.

We heard dispatchers make decisions about where to send or redirect resources related to patient risk. This was a dynamic risk assessment - balancing resources and the clinical needs of patients who had been waiting a long time.

Is the service well-led?

Inspected but not rated

Leadership

Leaders had the skills and abilities to run the service. However, staff did not always feel they understood and managed the priorities and issues the service faced. Leaders were not always visible and approachable in the service for staff.

The service was under intense pressure. Senior management told us they were meeting every day to assess the pressure on the system and find ways to ease it.

LAS senior management had engaged with hospital trusts and other care providers to attempt to smooth the flow of patients transported to hospital, and lower handover delays. Less busy hospital ED's had been identified and patients from certain postcodes could be diverted to these to help them get treatment as soon as possible and ease the pressure on the busiest hospital ED's. The trust had introduced innovative ways to ease the need for some patients to be transported to hospital such as the physician response unit and the end of life car, used to support patients around difficult decisions as they approach the end of their life.

Call handling staff told us their team leaders and management in the EOC were supportive and encouraging. However, they also told us they would find it beneficial for morale to see more senior management on the floor, outside of their normal call handling managers.

Culture

Most staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Our findings

The continued high pressure was recognised by senior management as having a detrimental effect on staff mental and physical wellbeing. We listened in to call handlers taking distressing 999 calls from the public and talking to the caller with empathy and understanding, yet having to explain in the case of non-life threatening concerns it might be a number of hours before help arrived.

Staff we spoke with understood the role of the Freedom to Speak-up Guardians and had found them useful.

Senior management were working hard to recruit more staff and had been successful but the numbers were still not sufficient to deal with the unprecedented demand on the service. In October 2021, LAS reported they had increased their overall percentage of newly recruited black, Asian and minority ethnic (BAME) staff to 37% which was above their internal target of 30%.

In October 2021, LAS held a special memorial event at the Waterloo headquarters for the families of 22 of their staff from all areas of the service who had died during the pandemic.

We were told about Project Wingman and later witnessed it in action. This was a volunteer scheme provided by COVID-19 furloughed British Airways (BA) staff. They had a seating area set aside at the Waterloo headquarters where they provided tea, coffee and magazines available free of charge. The BA staff used their training on how to communicate and deal with sensitive situations to offer LAS employees the chance to talk with someone external to their own organisation. Some staff we spoke with had found this useful.

In November 2021, the Chief Executive launched 'Our LAS' described as a significant and innovative programme to help improve the culture across the service. It was too early to report on any changes implemented by the programme.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events, although were struggling with how to manage the significant increase in demand in urgent and emergency care.

The Trust had put in place a strategic and tactical response for winter, which was focussed on three key areas: to manage demand, increase capacity, and work with system partners to reduce delays at hospital handover. The service had been at REAP level 4 (extreme pressure) since June 2021.

With the exceptional pressure on the system, the risk to a safe and effective performance of the ambulance emergency operations centres was high. The service was set up to cope with unexpected events but staff at all levels were becoming more concerned about the ability to manage performance with the increasing demand on urgent and emergency care capacity. However, foreseeable risk such as changes in demand generally (known as surge), adverse weather conditions and loss of service were well embedded and planned for. All events were escalated through clear structures and processes which had always been part of the emergency response.

The service generally followed the government COVID-19 guidance on safety for ambulance trusts. Staff we spoke with told us they felt COVID-19 safe within the EOC. However, as previously mentioned in this report the trust was not implementing and enforcing COVID safe practice guidelines everywhere within the EOC. In addition there appeared to be little planning for a COVID-19 outbreak within either or both EOC's.

Our findings

Areas for improvement

Action the trust SHOULD take to improve:

- Ensure the EOC and staff are following current government COVID-19 guidelines around screening, social distancing and mask wearing in all areas of the EOC;
- Ensure it produces a standard operating procedure (SOP), protocol or contingency plan for mitigating and managing a COVID-19 outbreak within either or both EOC's. It should be regularly reviewed in line with current national guidelines;
- Increase visibility for senior staff to improve approachability and support morale.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one other CQC inspector and a specialist advisor. The inspection team was overseen by Nicola Wise, Head of Hospital Inspection.