Care Quality Commission

London Ambulance Service NHS Trust

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

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

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

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

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

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

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

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

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

Overall, we rated this trust as requires improvement.

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

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

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

Our key findings were as follows:

Safety:

Summary of findings

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

Effective:

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

However,

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

Summary of findings

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

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

Caring:

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

Responsive:

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

However,

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

Well-led:

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

Summary of findings

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

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

We saw several areas of outstanding practice including:

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

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

Importantly, the trust must:

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

In addition the trust should:

Summary of findings

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

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

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Background to London Ambulance Service NHS Trust

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

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

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

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

Our inspection team

Our inspection team was led by:

Chair: Shelagh O'Leary

Head of Hospital Inspections: Nick Mulholland, Care Quality Commission

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

How we carried out this inspection

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

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

The inspection team inspected the following:

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

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

Summary of findings

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

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

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

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

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

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

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

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

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

Facts and data about this trust

Demographics:

The area is made up of:

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

Activity:

Between August 2016 and March 2017 the trust:

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

Resources and teams include:

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

Summary of findings

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

Frontline staffing

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