London Ambulance Service NHS Trust

Quality Report

22 Waterloo Road
London
SE1 8SD
Tel: 020 778302000
Website: www.londonambulance.nhs.uk

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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	Not sufficient evidence to rate
Are services at this trust safe?	**Not sufficient evidence to rate**
Are services at this trust well-led?	**Not sufficient evidence to rate**

Summary of findings

Letter from the Chief Inspector of Hospitals

We undertook a follow up inspection of London Ambulance Services NHS Trust (LAS) on 2 and 3 August 2016, in relation to the warning notice issued under section 29A of The Health and Social Care Act 2008 on 1 October 2015.

This inspection focused on issues raised in the warning notice, those being:

- Insufficient numbers of appropriately trained frontline paramedic staff.
- Shortage of paramedic and technician staff for the Hazardous Area Response Team (HART)
- Medicine management was not in line with Human Medicines Regulations 2012 and recommended guidelines.
- Lack of effective governance in mitigating staff and patient risks.

We visited the trusts headquarters in Waterloo, London, stations in Fulham, Newham and Waterloo, and the Hazardous Area Response Team (HART) in Cody Road, East London. We also visited the central stores in Deptford.

Our key findings were as follows:

- The trust had made significant progress with recruitment of frontline staff, with over 700 new staff recruited within the last year.
- Staffing figures provided to us indicated significant improvement compared to our findings on the previous inspection. Staffing levels had increased, with 3,050 whole time equivalent (WTE) staff, with frontline accounting for 2,856 and central operations 193.
- The National Ambulance Resilience Unit's (NARU) HART interoperability standard number 12 was being met at the time of this return visit, with six staff able to respond to a HART call at any one time.
- LAS had 85 HART staff, 42 on each site, plus one additional staff member to cover training, holiday, and absence.
- In instances where two HART teams were not available, notification was made to the London Fire Brigade and Metropolitan Police Service, and systems were established to comply with NARU protocols.
- The organisation was working with a workforce optimisation company to review HART rosters as a means of maximising cover.
- As part of the trusts five year strategic plan, recruitment plans included annual recruitment campaigns to attract paramedics from inside and outside the European Union, and from other ambulance services. Apprenticeship schemes for London were also being discussed.
- A new electronic reporting system had been set up but, had yet to be fully embedded within the organisation. However, the trust had seen an increase of both patient and staff incidents being reported onto the system in June 2016, compared to the previous two months.
- Staff were not always being encouraged to report incidents by their managers and this had an effect on local risks registers, and the extent to which problems were being monitored and assessed. For example, not all staff reported shortages of drug packs through the incident reporting system. Therefore, information that would help escalate issues to the appropriate places was not always captured.
- Staff we spoke with knew how to report incidents but they reported that they sometimes did not have sufficient time to do so. Staff did not want to report incidents at the end of a full shift in their own time.
- We were told that governance was not yet 'living and breathing' in the organisation. Although senior staff were said to be more open to listening and considering ideas, and were more understanding, they were not always able to respond proactively to these.
- There was a variation in the way stations were managed, in terms of organisation and maintenance and attention to communications.
- Although there had been acknowledgment of issues identified around medicine management, limited action had been taken, which had undermined the improvement process. Staff told us the paper based system was seen as open to failure and if more detailed thought had been placed at the start of the process, a better outcome may have been achieved.
- The Quality Improvement Programme (QIP) showed there were plans to roster administrative time during staff shifts to assist them with reporting incidents.

Summary of findings

- The London Ambulance Service special measures stocktake in May 2016 recognised their system of tracing and tracking medicines given to patients was ineffective and risky.
- Checks were not made to see if medicines were given to patients, after they were removed from paramedic drug packs. These included oral morphine solution and diazepam injections.
- Staff reported to us they often had shortages of drug packs due to the lack of tracking where drug packs were.
- Every drug pack had a unique number that could be tracked, but no audits had been done to check the location and number of packs actually in circulation.
- Distribution of drug packs was a concern at Whipps Cross and Walthamstow, as they were last on the distribution list and packs had often run out by then.
- Staff we spoke with told us the management of medicines had improved. We observed Morphine was now locked in secure storage units and the passcode was now changed every three months.
- Ambulance staff we spoke with informed us the team leaders checked controlled medicines and it was the staff on shifts responsibility to sign medicines in and out. The signing out of non-controlled drugs took time, and often drug packs were being taken without a sign out. The trust informed us staff were required to document the individual drug pack number on the dispatch summary/roadworthy check sheet (LA1) for each shift. Furthermore, the drug pack number would then be expected to be recorded on the patient report form, if the pack had been opened and drugs administered.
- Stocks of medicine drug packs were expected to be checked weekly but, there was a reliance on staff honesty and this sometimes led to gaps in the system, where checks had not been undertaken.
- There had been improved management of medical gases, yet there was no effective system of tracking cylinders. They could identify if a cylinder had gone missing via a unique pin number at corporate level, but not the location it was lost or stolen from.
- There was a one-year medicine management improvement plan, which involved the development of a clinical strategy. This would incorporate the medicine management strategy. The quality improvement plan update for medicines management in July 2016, indicated phase one of improvements were completed with phase two in progress.
- The trust was advertising for a full time pharmacist. One of their first objectives would then be to finalise the strategy.
- A Quality Improvement Programme (QIP) was launched in January 2016 in response to concerns raised by the CQC. Issues being addressed included, staffing levels, medicines management, and governance.
- Staff we spoke with of all grades, told us they had a lot of respect for the chief executive, and they were visible. We were told each executive had an area they were responsible for, which in turn made them more visible to staff. For example, the director of operations was responsible for delivering patient facing services, EOC, 111, HART and tactical response.
- We were told by a senior staff member that engagement with staff was much improved but there were still areas which required attention with respect to the physical environment especially the two call centres.
- The trust had focused on bullying and harassment, with workshops, and holding conversations instead of resorting to formal processes. Senior staff, including station managers and team leaders had attended the courses, and frontline staff were aware of the workshops. Ambulance staff reported feeling able to report a matter if necessary, and they would be taken seriously, and have their confidentiality respected.
- The bullying and harassment workshops had been attended by 490 staff.
- A lead director was in post, with a specific remit for overseeing the commitment to reducing bullying and harassment within the organisation. Incident response officers were available to respond to issues raised by individuals.
- However, the NHS staff survey 2015, found the trust's worst performing areas, included staff experience of bullying and harassment and not knowing who the senior managers were. These two areas were highlighted as concerns during our last inspection.
- Local risk registers were not always updated to reflect current issues, for example, the lack of drug packs at stations. However, the trust risk register acknowledged this was a high risk.

Summary of findings

- Staff told us they had a greater awareness of risk registers, including having these at departmental, divisional, and corporate levels.
- The Emergency Operations Centre (EOC) had clearer defined programmes for the improvement of operations. More work was needed to achieve this, and the trust recognised this was a long term plan with goals set for March 2017.
- Surgeries were held in June 2016 for staff to engage in discussion for improvement. Issues raised included, concerns on roster reviews and lack of facilities.

There remained areas of poor practice where the trust needs to make further improvements.

Importantly, the trust must:

- Implement an effective system that checks or monitors medicines removed from paramedic or general drug packs in order to assess if these were given to patients or otherwise used. These medicines include oral morphine solution and diazepam injections.
- Ensure a robust system of checks and audits are set up to trace, and track transactions of medicines removed from paramedic drug packs, which have been administered to patients.

In addition the trust should:

- Assess and monitor staffs adherence with procedures for reporting the shortage of drug packs through their incident reporting process.
- Develop local risk registers so these reflect the shortages, and thereby enable management to monitor and assess the extent of the problem.
- Have effective management systems and processes at their Deptford stores to monitor and control drug pack provision and availability. Establish a robust medical gas cylinders tracking system.

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 formed in 1965 from the nine existing services at that time. It became an NHS Trust on 1 April 1996 and covers London, the capital city of the United Kingdom. London Ambulance Service provides a range of services including: emergency response to 999 calls; an NHS 111 service for when medical help is needed but it is not a 999 emergency. They also provide a patient transport service (PTS), for non-emergency patients between community provider locations or their home address. Additionally, they have emergency operation centres (EOC), where 999 calls are received, and clinical advice is provided. Emergency vehicles are then dispatched if needed. There is also a Resilience and Hazardous Area Response Team (HART).

Our inspection team

A CQC Inspection Manager, a CQC Inspector, CQC Pharmacist Inspector and a specialist advisor with consultancy in emergency planning, health, ambulance, fire, and rescue disciplines, and paramedic experience, led our inspection team.

How we carried out this inspection

This was a short announcement follow up inspection to determine if the trust had taken action to address the concerns outlined in a warning notice issued under section 29A of The Health and Social Care Act 2008 on 1 October 2015. The need for significant improvements were identified as a result of the inspection, which took place in June 2015. Our concerns following that inspection related to three areas as follows:

There were insufficient numbers of frontline paramedics in the Emergency and Urgent Care and Resilience Planning services to provide a safe service to the population you serve.

There were poor systems and checks for ensuring medicines were managed in accordance with the Human Medicines Regulations 2012 and professional guidance.

The governance arrangements were inadequate and not effective in identifying and mitigating significant risks to staff and patients.

The trust provided a response, which detailed the activities that would be taken to address our concerns, and during the subsequent months, we had been kept informed of progress.

We visited the headquarters based at Waterloo, where we spoke with the medical director, director of operations for Hazardous Area Response Team (HART) and EOC, the NHS improvement director and director of transformation, strategy, and workforce (SRO) for Quality Improvement Plan.

Inspectors met with staff based at the HART located in East London, and visited ambulance stations located in Fulham, Waterloo and Newham and central stores in Deptford

We talked to station managers, the assistant director of operations, team leaders, paramedics, and made observations of the arrangements for storage and management of medicines and gases. In addition, we reviewed documentation provided to us.

As this was a focused inspection to follow-up on the action taken by the trust since we issued the 29A warning

Summary of findings

notice, we have not considered all of the key lines of enquiry. We have not awarded any ratings for this service. We will be conducting a more comprehensive, announced inspection of the trust in February 2017, where we will consider all existing ratings.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe?	**Not sufficient evidence to rate**

Overall we found:

- The checking and monitoring of drugs removed from drug packs was not formally managed. As a result it was not always known if these medicines, which included oral morphine solution and diazepam injections had been administered to patients.
- Missing gas cylinders, including oxygen and entonox (used for pain relief) could be identified at a corporate level. However, there was no effective system for the trust to check at a local level whether medical gas cylinders were lost or stolen.
- Staff were not always reporting shortages of drug packs through the incident reporting system.

However:

- Staff levels had significantly increased over the past year for frontline paramedics and the HART team.
- The service stations we visited in Fulham and Newham had a full complement of staff, and they were able to tell us how additional new staff had improved working conditions.
- The new electronic reporting system meant more incidents were being reported, although more time was required for the system to be embedded throughout the organisation.
- Staff we spoke with were happy with the new system and the ease of reporting incidents.
- The management of medicines had improved, and controlled drugs were now kept locked in secure passcode cupboards. Oversight of the management of controlled drugs was meeting safe practices.

Incidents

- There was a system for reporting incidents, which included issues related to lack of equipment or medicines. Staff were aware of the new incident system, which had come into use. A medicine management lead told us how they would report anything related to medicines, including for example, a broken medicine vial.
- There were variations in the extent to which staff were being encouraged to report incidents or adverse situations. The Newham station manager told us they had been encouraging staff to report issues, including lack of medicine packs. Despite

this, staff were not always following the correct procedures of reporting the shortage of drug packs through the correct channels. There was a lack of awareness and understanding of the benefits of reporting such matters as a means of assessing the extent of the problem.

- We asked a member of staff at Newham what they did if medicine packs were not available. They told us they let control know about the problem. They told us the ambulance may not be able to respond to a call for two hours if no medicine pack was provided. However, the trust informed us, staff without a drug pack at the commencement of their shift were assisted by the out of service desk to collect a drug pack from an alternative location during which time they are fully able to be dispatched to any priority of call. If after two hours the crew had been unable to collect a pack they were made unavailable for calls, unless they were required to render aid or provide basic life support. The staff member told us if they had to respond to a call without a medicine pack, they would report this as an incident. However, other staff told us they did not always have time to complete incident reports. Therefore the reporting of incidents was yet to be embedded in all staffs practice.
- Staff we spoke with at Fulham station said they were happy with the new electronic reporting system. There were two computers based at the station and staff we spoke with at this location told us they found it simple to use and easy to access. However, staff admitted time was a factor in the lack of reporting of what they considered to be 'minor incidents'. Staff said they did not want to report incidents after a full shift in their own time, as they wanted to go home. They did not feel reporting drug pack shortages would actually make a difference in increasing their supply.
- Feedback to incidents was communicated on a one to one basis between the duty station manager and the staff member. Incident learning and sharing was fed back in team meetings.
- The medicine minutes of 1 June 2016 showed an increase in reporting of incidents through the new online electronic reporting system.
- The Quality Improvement Programme (QIP), related to achieving good governance had proposed actions. These actions showed there were plans to review staff rosters, to include administrative time for staff to report incidents. This was due to be achieved by the end of September 2016, and will be followed up at future inspection.
- The LAS stocktake report of 4 May 2016, stated the measures taken to address under reporting of incidents included a 24

hour incident reporting telephone line, and the implementation of the new electronic system. Staff feedback had shown more confidence in getting a management response following reporting.

- We were told one hundred percent of serious incidents had been consistently reported under the 'serious incidents requiring investigation '(STEIS) guidelines, within 48 hours of declaration over the period April 2016 to June 2106. However we did not on this occasion review the process for investigating these, as it was not part of the follow up inspection.
- The QIP, key performance indicator (KPI) report of July 2016, indicated that as the electronic incident reporting system continued to be embedded within the organisation, there was a clear increase of both patient and staff incidents being reported into the system in June compared to the previous two months.
- The trust acknowledged they had a backlog of incidents to investigate, and the capacity of the investigators and executive directors to resolve investigations in a timely manner had been heavily impacted. The issue was regularly raised at the executive leadership team meetings to ensure there was a clear timetable to resolve overdue investigations.
- In June 2016, 92% of frontline staff had received training in relation to duty of candour.

Medicines

- The London Ambulance Service Special Measures Stocktake in May 2016 recognised a system of checks and audits must be set up to ensure medicines removed from a paramedic drug packs had been administered to patients. They acknowledged the system for tracking transactions of medicines was inefficient and potentially risky.
- Checks were not undertaken to monitor medicines removed from paramedic or general drug packs, and whether these had been given to patients. These medicines included oral morphine solution and diazepam injections.
- Medicines management update (dated 14 June 2016) stated over a six week period an additional 400 paramedic drug packs and 400 general drug packs were being introduced to add to the existing packs. This was to ensure availability of 1100 drug packs of each type rotating through the system. Stock levels at each station were being revised to ensure availability. Staff had been reminded in a clinical update (issue 41) in December 2015 and again in medical directorates medicines management update in June 2106, to return used and unused packs at the end of each shift.

Summary of findings

- The logistics manager confirmed 1100 paramedic drug packs were in circulation. They stated the peak vehicle requirement was approximately 420 (300 ambulance, and 120 cars), if all vehicles were in use, with one pack per vehicle. The June 2016 clinical review (dated 18 July 2016), focus area fleet, logistics and stores section, highlighted several areas of concern around the management of medicines at the Deptford stores. This included drug packs where it stated 'Drug packs are tracked bags', 'go missing', 'no steps to push for return'. The logistics manager explained there was an ongoing problem with staff not returning packs to lockers at end of each shift. Further, packs were said to disappear, sometimes turning up months or even years later. They mentioned one pack had been returned two years out of date the previous week.
- Staff told us paramedic drug packs often went missing, and there were no steps taken to push for their return. We were told by staff these packs were often left in paramedic's bags at the end of shifts and not returned to the station store as required, which could lead to shortages occurring and medicines diversion. Drug packs were numbered and were signed out but nobody was checking they were returned at the end of each shift.
- We observed the paramedic drug packs were uniquely numbered. We checked if there ever been an audit to check the location and number of packs actually in circulation and were told no.
- Staff at Newham ambulance station told us medicine pack provision was still an issue. Although packs were numbered and signed out, there were no checks on their return at the end of the day. Staff told us crews could not reliably obtain packs, so they "squirrelled" them away, rather than exchanging like for like.
- Distribution of medicine replacement packs was a concern to the Newham station manager, who told us the two of the stations under their remit (Whipps Cross and Walthamstow) were last on the distribution route, often the supply of packs had run out by then.
- Staff at both ambulance stations visited told us there were improved arrangements around the management of medicines. We observed Morphine was stored in a lockable cabinet, which also had a secure code for accessibility. Staff confirmed this code for the cabinet was changed every three months.
- We found schedule 2 controlled drugs were managed appropriately, with daily stock checks by team leader which were documented. We observed these checks had been

documented and the record was kept in the CD cupboards. It was also the crews' responsibility to sign medicines in and out. However, staff we spoke with reported the signing out of other non-controlled drugs took time, which resulted in packs being taken without a sign out. Although stocks were said to be checked weekly, staff said there was a gap in the system, with a reliance on staff honesty.The trust informed us staff were required to document the individual drug pack number on the dispatch summary/roadworthy check sheet (LA1) for each shift. Furthermore, the drug pack number would then be expected to be recorded on the patient report form, if the pack had been opened and drugs administered.

- We found that although the trust had improved the management of storage of medical gases since the last inspection, by placing them in lockable containers, there was no effective system to track cylinders and identify where gas cylinders may have been lost or stolen from. The staff could identify if a cylinder had gone missing via unique pin number at corporate level but not the location it was lost or stolen from.
- We were told and observed improvements had been made regarding the storage of gases, including oxygen and entonox. For example, there was a lockable container for storage of gas cylinders, which had a standard code for accessing. Staff reported the system wasn't particularly good with respect to traceability of gases, and there was no policy to support best practice. Although they tried to segregate full and empty cylinders, it was not always achieved.
- The medicines lead for the HART location we visited spoke with us and explained how they were the primary contact for medicines. They also ensured audits were carried out daily, and stock levels were checked. They described how they had tried to find a system to make life simple for staff. They had segregated boxes with sign out documents, which made it more streamlined.
- Medicine management leads attended quarterly meetings. We viewed minutes from the meetings of 24 February and 1 June 2016. The meetings covered topics such as incidents, near misses, and the serious incident policy. We saw discussion around medicines, supply chain/logistics and audit/risks, and governance issues.
- Discussions during the meeting mentioned sealed drug packs and highlighted the need for operations to manage and ensure ongoing governance of the system.

- The trust had a one year improvement plan for management of medicines and were in the process of developing a clinical strategy, which would incorporate the medicine management strategy.
- The trust were currently advertising for a full time pharmacist who would help finalise the strategy as one of their first objectives.
- The medicine management plan of August 2016, gave details of the progress of action plans started in 2015. For example, an action to review and reinforce the current process to capture batch numbers and to follow reporting, monitoring, and assurance of compliance was ongoing until 2017. Other examples included the auditing of PRF forms to ensure staff were recording CD administration and quarterly audits of drug locker codes.

Staffing

- At the time of our previous inspection, we found insufficient numbers of frontline paramedics in the emergency and urgent care and resilience planning services.
- There had been a substantial increase in staff, with an additional 700 ambulance crew recruited in the past year.
- Figures provided showed between July 2015 and July 2016, the paramedic total of staff for band 5 and 6 had risen from 1504 to 1768. The emergency ambulance crew figures had seen a rise from 675 staff in July 2015 to 771 for July 2016.
- Thirty five of the new staff were recruited to the special operations, as they could not be part of HART until they had been in the service for two years and completed additional training. The training for HART took up to six months to complete.
- Documents supplied to us demonstrated training had been signed off for the required competencies as part of the international paramedic end of placement. There was record of placement hours and the student had to pass several behavioural elements. The records gave detailed action plans and input from mentors and managers before they were signed off as fully competent. If the student did not pass one of the elements, they had to show evidence of their updated action plans and actions they took in order to demonstrate the necessary skills and knowledge before they were passed.
- We spoke with the group station manager (GSM) during our visit to the Fulham ambulance station. Their management

responsibilities included Chiswick and North Kensington. We were told staffing was at full complement at Chiswick and Fulham but there were vacancies at Trainee Emergency Ambulance Crew (TEAC) staff.

- We were told there were concerns about the skill level of some of the staff under the remit of the Fulham GSM. There were 36 staff who did not have the required driving license. Of these 15 were able to work as relief staff but others were awaiting courses. Similar concerns about inexperienced frontline staff were expressed by the Newham GSM. However, it was acknowledged all new starters would take time to complete required induction and competency assessments prior to working unsupervised.
- Staffing figures provided to us indicated there were 3,050 whole time equivalent (WTE) staff, with frontline staff accounting for 2,856, and central operations 193. The documentary information provided to us showed across the two Hazardous Area Response Team (HART) locations there were 85 HART staff. There were, 42 on each site, plus one additional staff member to cover training, holiday, and absence. We were told staffing would be increasing by a further 14.
- We were told by GSM the National Ambulance Resilience Unit's (NARU) HART Interoperability standard number 12 was now being met, with six staff able to respond to a HART call. We reviewed information to confirm this.
- Staff told us there were eight emergency medical technicians (EMT) in the HART, four on each site. A number of EMT were undergoing additional training via differing routes, leading to a paramedic qualification. They were not being used as paramedics.
- In June 2016, LAS achieved 93.5% compliance on filling HART shifts against a target of 100%. In line with national specification; the key performance indicator (KPI) is required to achieve 100%.
- HART rosters were reviewed on a daily basis to maximise capacity as far as possible, and overtime incentives were offered to fill gaps in the rosters. The gaps experienced in June were due to staff being unavailable because of annual leave and training.
- HART capacity update information of 26 July 2016 from the director of operations who reported this information to the trust board, explained the trust was working with a workforce optimisation company) to address the issue. They were reviewing HART rosters as a means of maximising cover. They

had identified the impact on day absences could only be mitigated through increasing the number of HART officers. Discussions were underway to determine the number of staff required.

- In those instances when two HART teams were not available LAS complied with the notification protocols required by NARU, and systems to notify the London Fire Brigade and the Metropolitan Police Service were in place.
- The trust had a formal agreement with South East Coast Ambulance Service (SECAMB) to provide coverage at Heathrow when staffing was incomplete.
- While 6.5% of their HART shift were incomplete in June 2016, they did not have to move their HART assets on any of these occasions because the two HART teams always had more than 10 officers on duty.
- We saw information to indicate staff training and competency sign off within the HART, which included extended duration breathing apparatus, electronic personal dosimeter, intra-osseous cannula, and dynamic risk assessment.
- Disruption payment incentives were now offered to HART staff, which helped to encourage to filling of vacant shifts.
- Paramedics we spoke with told us the recruitment of new trainee frontline staff had alleviated some of the operational pressure they faced. They were pleased with the motivation of the new trainees.
- To date 328 experienced paramedics had been offered continued professional bursary scheme (CPB), which had enabled the trust to retain experienced staff for the duration of their programme of study, plus a one year tie in.
- As part of the trusts five year strategy 2014/15-2019/20 they mentioned they would be proactive in their recruitment and have an annual recruitment campaign to attract paramedics from inside and outside the European Union and from other ambulance services. They were aiming to attract student paramedics, ex-military staff, and experienced staff from other health professionals, as well as new entrants to the ambulance service. They were looking to London as one of the markets for future talent with plans such as apprenticeships schemes being discussed.
- The strategy also mentioned ways in which they would improve the career and talent management structure to retain staff. The next stage of their clinical career structure involved a range of career choices for staff, and working with the local education and training boards, so that funded development packages were in place to support the retention of staff.

Summary of findings

- Staff sickness rates were below the target of 5.5% since December 2015.

Are services at this trust well-led?

Not sufficient evidence to rate

Overall we found improvements were made to the following:

- Staff were more aware and clearer on the vision and strategy of the organisation since our previous inspection.
- The Quality Improvement Programme was launched in direct response to issues raised in the previous CQC report. The programme managed a series of projects and programmes for specific areas within LAS.
- The bullying and harassment policy was revised and re-launched and was now called 'dignity at work'.
- Over 490 staff had attended the bullying and harassment workshops. In June 2016, 39 staff had received specialist training for bullying and harassment investigators, with further sessions planned.
- Staff told us they had a greater awareness of risk registers, including having these at departmental, divisional, and corporate levels.
- The emergency operations centre (EOC) were working towards more clearly defined programmes to improve operations, but more work was needed to achieve this, and the trust recognised this was a long term plan with goals set for March 2017.

Vision and strategy

- At our previous inspection, we found most of the frontline staff were not clear about the vision and strategy, and had not been engaged in the development of it.
- Staff we spoke with, of all grades, told us staff groups had been involved in discussing the vision and strategy. Information had been supplied with a payslip and there was a video accessible on the intranet. We observed the trusts vision, purpose, and values were visibly displayed, and we also reviewed the information provided to staff.
- Managers had attended 'having the conversation as managers' training, which provided tools to assist in supporting the delivery of the vision to staff.
- There was a programme, which included an agreed overall long term strategy to improve current initiatives and practices, such as reviewing all roster patterns, reviewing evaluation of all functions within EOC. Other areas included staff resource; monitoring staff enhanced effectiveness and staff development.

Summary of findings

Governance, risk management and quality measurement

- We were told by senior staff the executive team met weekly, reported to the board and the commissioners on a monthly basis. We saw minutes of board meetings, in which integrated board performance reports were reviewed, along with the quality improvement programme and quality governance committee assurance reports.
- We were told governance was not yet "living and breathing" in the organisation. Although senior staff were said to be more open to listening and considering ideas, and were more understanding, they were not yet sufficiently driven.
- A Quality Improvement Programme (QIP) was launched in January 2016. This set out the actions to be taken in order to address the concerns identified by CQC. The QIP had built upon the action plan submitted in response to the warning notice. This included staffing, medicines management, and governance.
- We observed from the QIP information provided to us various themes had been identified. For example, and with respect to the warning notice actions, achieving good governance (theme two). This was broken down to separate elements covering; risk management, capacity and capability, improving incident reporting, and operational planning. Individual directors had been appointed to oversee the deliverable actions, and target dates had been set. Progress on this was RAG rated, and we saw a number of actions had been completed between the period of January and May 2016.
- Theme four on the QIP covered the improvement of the environment and resources. However, whilst this included information about defining and agreeing responsibilities between operations, fleet and logistics, as well as vehicle preparation and equipment, we did not see any reference to drug packs or medicines.
- We were provided with a copy of the QIP progress update dated 26 July 2016. Whilst the report acknowledged the clinical review undertaken in June 2016 had identified improved medicines management at stations, it had suggested the end to end process from drug packing to destruction needed to be considered.
- The LAS June clinical review (dated 18th July 2016) focus area fleet, logistics, and stores section highlighted several areas of concern around the management of medicines at the Deptford stores. This included drug packs. It stated, "Drug packs are tracked but bags "go missing", no steps to push for return (bag amnesty etc.)"

Summary of findings

- During the inspection we were told by staff of all grades and levels that in the last year there had been acknowledgement of the issues identified around medicines provision for ambulances. However, they reported limited action had been taken, which had undermined the improvement process. Further, although staff were said to be better at medicines management, there was a feeling the process did not match with the policy for checking ambulances.
- Staff also told us Fleet and Logistics were inaccessible and were hard to engage with. This was said to be as a result of the areas being managed by finance and performance as part of an external provider.
- When we spoke with staff, there was greater awareness of risk registers, including having these at departmental, divisional, and corporate levels.
- The HART manager we spoke with told us the risk register was not discussed formally within team meetings. Staff we spoke with at the HART location told us in general, staff had not known what the risk register was but were now more aware, although there were variable levels of interest.
- The HART location told us there were 10 risks on their local register, which included for example, staffing, vehicle, and estates.
- The trust risk register identified a risk to patients not receiving the correct treatment because of on-going issues regarding the delivery of drug packs and general medicines to ambulance stations. This was rated as a red (major) risk in June 2016, with a target rating of green.
- A separate red risk, identified logistics were not delivering the required level of station based medicines, and were sticking to the maximum levels they had, which did not take into account the restructuring of the services.
- We were told by staff there were shortages of paramedic drug packs at stations at times.
- The station manager at Fulham told us there were two risks on their local register, one related to shortage of team leaders and the other to lack of administrative support. They added the staff had been encouraged to identify and report risks, such as cover for the two local stadiums. However, they had not identified any risks around medicines supply or availability.
- Local risk registers did not always identify shortage of drug packs although station managers and staff saw this as a high risk.
- Not all staff were aware of the risk register, although they had heard the term mentioned they told us they were “not entirely sure” what it was.

- We saw draft minutes from the west governance meeting held 21 June 2016. This referenced the risk register review, requesting staff to document the date of the last review, the number of risks and if there had been movement up or down. The information indicated there were seven risks on the register, as updated on 26 May 2016. Actions were identified separately and included adding drug pack shortages to the risk register, and the risk register was to be updated and circulated to staff.
- The emergency operations centre (EOC) main action was to deliver a long term strategy to be in place by March 2017. Information we reviewed showed actions had been taken to achieve this aim, but work was still in progress.
- The LAS had been tasked with a commissioning for quality and innovation goal (CQUIN) which involved identifying and scoping areas for improvements within the EOC.
- The CQUIN indicators were to develop an agreed plan to improve initiatives and practices and establish refined framework methods and processes that would help staff effectiveness and development.
- Surgeries were held in June 2016 for staff to engage in discussion for improvement. Issues raised included, concerns on roster reviews and lack of facilities.
- Staff we spoke with highlighted key concerns, which included poor ergonomics in the control room with comments such as it was “dark and cramped”.
- Information we reviewed showed that a great deal of work still needed to be done, but there were detailed actions with time frames, and clear direction, with more staff engagement.

Leadership of the trust

- The previous inspection findings indicated a lack of operational management, particularly with respect to day to day management issues affecting staff who operated the services. Staff had reported a lack of recognition of the problems they experienced, and lack of consultation in changes taken at the time. Further, there were concerns about the management of staff training and development, and appraisals.
- A new chair had been appointed in April 2016, and we were told by a member of the senior staff they had recognised some of the issues and behaviours of some staff, resulting in a capability review with the board.
- We were told there was a “massive amount of respect” for the chief executive, and they were visible. In addition we were told each executive had an area of responsibility and were reported as being more visible and accessible to staff.

Summary of findings

- The director of operations was responsible for delivering patient facing services, EOC, 111, HART and tactical response.
- During our follow up inspection, we were told by staff we spoke with, there had been good engagement at middle management level; however, they needed to be more focused on the opportunities to address everyday frustrations. For example, vehicle preparation, mobile technology, and proactively managing new staff joining existing teams.
- An example of leadership taking a reactive approach to problem solving rather than recognising the value of reflection related to the medicines management. The paper based system was seen as being open to failure and staff we spoke with told us if more detailed thought has been placed on the process from start to finish, a better outcome may have been achieved.
- We found a variation in the way stations were managed, in terms of the organisation and maintenance of location environments and attention to communications. The Fulham ambulance station was untidy and requested information was found to lack sufficient detail to make it fully accessible and informative to staff wishing to read and update their awareness. Further, the monitoring of safety checks was not sufficiently complete. For example, where failures were identified on the medicine management daily checks, the action taken was not specified. We did not know if staff were taking appropriate action and were not assured the station manager would know this too.
- The Fulham location held a 'death and doughnuts' meeting monthly, which any staff could attend, with a view to discussing issues and developments. These were informal and therefore not minuted. As a result, staff who did not attend were not fully aware of topics discussed.
- Frontline staff at Newham ambulance station reported feeling "very confident" in the GSM and other team leaders, telling us they were all "approachable." We were told local line managers had good oversight but those in higher positions may not "understand our pressures and the day to day aspects of the role." There was an acknowledgement by a member of frontline staff that some of the problems had arisen because staff did not find time to report matters or had given up reporting, as nothing was done to resolve issues.
- We were told by staff during the inspection, that at a GSM level, decisions could not be made and there was a lack of autonomy.

One comment made was the trust processes made it "impossible to improve and make efficiencies." GSM did not have their own budgets for training and development or miscellaneous costs.

- The GSM at Newham met with the team leaders approximately every six weeks. This provided an opportunity to discuss training and development, as well as other matters but also to instil confidence in them.
- Group station managers said they attended area meetings on a weekly basis, either in person or via telephone link. Monthly governance meetings were said to include risks, and we reviewed the monthly governance report for June 21, which confirmed this.
- Staff appraisals were not happening in practice. For example, we were told only three out of 129 staff at the Fulham ambulance station had received an appraisal. Although 15 staff appraisals had been planned for the month, there was a reliance on staff booking the review 10 days in advance. The appraisal process included receiving and preparing formal documentation, where previously it had been an informal process.

Culture within the trust

- During the previous inspection, we identified cultural concerns related to bullying and harassment.
- At our follow up inspection, we were told of the actions taken to address the concerns. This had included several bullying and harassment workshops, with a focus on holding conversations, rather than immediate formal processes. Senior staff including station managers and team leaders had attended the courses, and frontline staff were aware of the workshops. Junior staff reported feeling able to report a matter if necessary, and they would be taken seriously, and have their confidentiality respected.
- Staff told us dignity and respect was very much the focus of staff behaviours. Issues of bullying and harassment could be reported via 'pulse', an internal website staff could access, and there was a telephone line between 8am and 8pm to report any incidents of this nature.
- A lead director was in post, covering responsibilities for bullying and harassment. There were also incident response officers who could be notified of any issues.
- The bullying and harassment policy had been revised and re-launched and is now called 'dignity at work'. The policy included a new focus on mediation and facilitated

conversations to encourage an early and informal resolution of issues. The dignity at work policy set out the standards of behaviour expected of everyone in the workplace and the processes to follow when bullying and harassment was reported.

- A 'keep calm and mediate' conference was held which involved 60 members of staff from a wide range of teams across the trust. They explored the benefits of mediation and resolving conflicts at local level.
- External facilitators have been commissioned to train staff in mediation skills and to improve communication. The training is scheduled to start September 2016.
- The bullying and harassment workshops have been attended by 490 staff.
- Frontline staff we spoke with told us there had been a drive to highlight bullying, and harassment. They had received a good amount of communication from the trust and local managers on who to contact and where to go if they had concerns. Staff said they felt more confident to report bullying and harassment issues.

Staff engagement

- The previous inspection highlighted concerns with regard to staff satisfaction, high levels of stress and work overload. The NHS staff survey 2015 showed positive changes. The response rate increased by 4% and there were improvements in eight of the 22 findings.
- The best performing areas which showed an increase in staff satisfaction, included 'not able to do my job to a standard I am pleased with', 'would not recommend organisation as place to work', 'organisation does not act on concerns raised by patients/cares' and 'never/rarely look forward to going to work'.
- However, the trust's worst performing areas, included staff experience of bullying and harassment and not knowing who the senior managers were. These two areas were highlighted as concerns during our last inspection.
- The NHS Improvement Director told us there had been an underestimation of staffs appetite and willingness for change, as well as the positive responsiveness of staff. They added, although staff were now getting information, there was no feedback loop.
- We were told the executive team undertook one or two visits per month to locations and the non-executive director (NED) also did night time visits. This provided an opportunity for the NEDs to speak with or challenge staff.

Summary of findings

- The director of operations explained how they had spent a lot of time with the HART staff in order to understand and address their concerns. We were also told engagement with staff was much improved but improvements were still required with respect to the physical environment, particularly the two call centres.
- Band 7 staff and above were said by staff who spoke with us, to be involved in discussions and goal setting. Staff had specific responsibilities, for example, the deputy director had a responsibility for resilience, and a deputy was needed for EPRR.
- Additional clinical team leaders were said by staff to provide supervision, debriefings, and hands-on training, with half their time set aside for ride outs and other elements of the role. They also went through key performance indicators, medicines, and response times with staff.
- The NHS Improvement Director told us they were reasonably confident clinical teams had more ongoing dialogue and supervision, although appraisals were significantly behind. They added there had been less focus on EOC's, and as a result, they felt less connected. The role of EOCs was said to be stressful but staff did not always know the outcome of situations.
- We saw information, which demonstrated staff had access to counselling services.
- We were told morale had improved with the increase of staffing levels, as well as because staff were being listened to and felt able to discuss things more fully.

Outstanding practice and areas for improvement

Areas for improvement

Action the trust MUST take to improve

- Implement an effective system that checks or monitors medicines removed from paramedic or general drug packs given to patients. These medicines include oral morphine solution and diazepam injection.
- Ensure a robust system of checks and audits are set up, to trace, and track transactions of medicines removed from paramedic drug packs, which have been administered to patients. The trust acknowledges their current system is inefficient and potentially risky.

This section is primarily information for the provider

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 Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services Regulation 17 HSCA (RA) Good Governance (2)(b) • You do not currently have an effective system that checks or monitors medicines removed from paramedic or general drug packs given to patients. These medicines include oral morphine solution and diazepam injection. • The trust risk register identified there were sometimes shortages of paramedic drug packs. We saw the paramedic drug packs were numbered but often appeared to go missing, with no steps taken to push for their return. We were told these packs were often left in paramedics bags at the end of shifts and not returned to the station store as required, which could lead to shortages occurring and medicines diversion. The problem was compounded by the fact not all local risk registers were identifying the shortages. Staff were not following the correct procedures of reporting the shortage through the correct channels and were not always being encouraged to do so by their managers. There was lack of awareness and understanding of the benefits of reporting as a means of assessing the extent of the problem. • Medicines management update of 14 June 2016 stated over a period of six weeks an additional 400 paramedic drug packs and 400 general packs were being introduced to ensure the availability of 1000 drug packs of each type rotating through the system. Stock levels at each station were being revised to ensure availability. Staff had been reminded to return used and unused packs at the end of each shift. Each drug pack had a unique number so could be tracked. No audits had been undertaken to check the location and number of packs actually in circulation. The logistics manager stated packs often disappeared, sometimes turning up months or even years later.

This section is primarily information for the provider

Requirement notices

- The clinical review of 18 July 2106, focus area fleet logistics and store section, highlighted several areas of concern around the management of medicines at the Deptford stores, which stated drug packs go missing, but no action is taken to push for their return.
- There was no effective system to track medical gas cylinders and identify where gas cylinders may have been lost or stolen from. It is possible to identify if a cylinder has gone missing via a unique pin number at corporate level, but not the location it has gone missing from.