London Ambulance Service Headquarters

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.

Summary of findings

Letter from the Chief Inspector of Hospitals

The inspection of London Ambulance Service headquarters commenced on 20 November, and was unannounced.

The inspection was prompted in part by notification of an incident, which is subject to a criminal investigation. As a result, this inspection did not examine the circumstances of the incident.

However, the information shared with CQC about the incident indicated potential concerns about the management of risks around the security of ambulance stations, vehicles, and equipment. This inspection examined those risks.

We did not re-rate this service following the inspection.

We found:

- The safeguarding of vulnerable children had not been fully considered. As a result, external safeguarding agencies had not been notified of potential safeguarding matters.
- The timeframe for contacting individuals as part of the investigation was limited, which made the communication with persons affected less likely to be achieved.
- The trust had not notified the disclosure and barring service (DBS) of the individual involved in the incident.
- At the time of our inspection a security alert had not been sent to independent ambulance services to notify them of the incident.
- Immediate changes to the processes and systems within the Emergency Operations Centre had been made to help reduce the risk of the incident happening again; however, these changes had not been fully communicated and they had not been embedded in practice.
- Operational pressures often meant staff did not always make the relevant checks within the central support unit, when booking call signs onto the system.
- Security of ambulances, vehicle keys and some areas within ambulance stations was not sufficient.
- There was no firm guidance as to how long an ambulance vehicle could be left unattended before being collected.
- The checking of staffs' compliance with current and new practices was not sufficiently strong.

However:

- Stakeholders and key partners were notified as soon as the incident was identified. The trust worked collaboratively with other agencies, and kept them informed of progress on actions arising from the incident review.
- The investigative process was conducted in accordance with professional guidance, and within the boundaries of limitations made by a separate police matter.
- The duty of candour had been considered and acted upon in accordance with the trusts policy and regulation.
- Immediate actions had been taken to mitigate future risks, and the trust had developed a detailed action plan to improve the security of vehicles. This was continuously reviewed and monitored for progress.

Summary of findings

Background to London Ambulance Service Headquarters

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 main role of the LAS is to respond to emergency 999 calls, 24 hours a day,365 days a year. 999 calls are received by the emergency operations centre (EOC), where clinical advice is provided and emergency vehicles are dispatched if required. The LAS also provides resilience and hazardous area response teams (HART). Services are managed from the trust's main headquarters in Waterloo, Bow and Pocock Street. LAS is overseen by the Department of Health and its services are commissioned by the 32 London Clinical Commissioning Groups (CCG), with NHS Brent CCG acting as lead on behalf of the rest of the London CCG.

London Ambulance Service NHS Trust covers the capital city of the United Kingdom, over an area of approximately 620 square miles. The LAS is the busiest ambulance service in the country and one of the busiest in the world.

Our inspection team

Our inspection team was led by an inspection manager and was overseen by head of hospital inspections, Helen Rawlings.

The team included three CQC inspectors, an inspection manager and a specialist advisor with a background in organisational compliance and clinical effectiveness in the ambulance service.

How we carried out this inspection

We carried out this unannounced focused inspection over two days, 20 & 21 November 2018. The purpose of the inspection was to review systems and processes, which the trust had in place prior to a serious incident. Additionally, we reviewed the incident review process, and progress made on the actions initially implemented, and as a result of the completion of the review.

The planning of the inspection included a review of information sent to the commission following the declaration of the incident, immediate actions and mitigations taken, and the draft incident review report, which contained many other actions. We reviewed information held in our electronic database, including notifications.

During the inspection we visited the Emergency Operations Centres, (EOC) at Bow and the trust headquarters, Waterloo. We visited three ambulance stations, and spoke with staff at a NHS emergency and urgent care department.

We spoke with members of the senior team, which included:

- The head of public and patient involvement
- Head of quality governance and assurance
- Clinical advisor to legal and governance
- Director of people and culture.
- Deputy director of quality, governance and assurance
- Human resources director
- Medical director
- Director of operations
- Head of safeguarding
- Deputy director of clinical education and standards
- Deputy director of strategic assets and property

We spoke with other staff including:

- Incident response officers
- Allocators and dispatchers within EOC
- Watch managers and lead managers within EOC
- Group station managers
- Emergency ambulance crew
- Trainee emergency ambulance crew
- Paramedics
- Clinical tutor and educational lead

Summary of findings

We requested a range of documents to be available before the end of the second day.

Following the inspection, we spoke with several clinical commissioners.

Facts and data about this trust

London Ambulance Service NHS Trust covers the capital city of the United Kingdom, covering an area of approximately 620 miles. In 2016/17, they responded to over 1.8million 999 calls, attending to over 1.1 million incidents, including a number of major events. The services are provided to a population of around 8.9 million people, with over 30 million annual visitors.

The trust has a total of 70 ambulance station across London and two hazardous area response teams (HART). There are two EOC located at Waterloo and Bow.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? **Duty of Candour** • At our previous inspection we found the trust had developed a positive culture of being open and honest and of learning from adverse situations. The trust had applied duty of candour appropriately, and in accordance with their own duty of candour and being open policy. • The principles of openness and honesty are outlined in the NHS Being Open guidance and the NHS contractual Duty of Candour. The Department of Health introduced regulations for the duty of candour, namely; Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20. Part of this is a requirement of providers to notify anyone who has been subject (or someone lawfully acting on their behalf, such as families and carers) to a 'notifiable incident'. This includes incidents involving moderate or severe harm or death. This notification must include an appropriate apology and information relating to the incident. • Where the degree of harm is not yet clear but may fall into the above categories in future, the relevant person must be informed of the notifiable safety incident in line with the requirements of the regulation. • Providers are not required by the regulation to inform a person using the service when a 'near- miss' has occurred, and the incident has resulted in no harm to that person. We were told in our discussion with staff, the incident review process had not identified anyone with severe or moderate harm. • The lead investigator was asked how the duty of candour was applied within the investigative process. The response was it was applied to those who could be contacted. This reflected section 7.3 of the trusts policy we reviewed. This stated, 'all reasonable attempts must be made to trace and contact the relevant person and, where this does not prove possible, then the reasons must be documented on Datix'. • A clinical safety review was undertaken for all individuals, including those who were seen in the presence of a qualified practitioner. Of those who were seen without a qualified practitioner, an attempt was made to contact all patients	

irrespective of risk level, which was in line with the principles of the duty of candour regulation. No harm was identified for all patients contacted and/or the outcomes identified via the clinical review.

- The quality and business risk partner told us the patients who had been contacted had been offered a copy of the serious incident report. They said the trust had been open because of the potential for harm.
- A copy of the trusts investigation summary had a section related to duty of candour. This indicated the patient/next of kin had been contacted and apologised to on the 13 August 2018; were followed up in writing, and the duty of candour had been complied with.
- We commented on the lack of visible detail in the incident report to the lead investigator, and were advised there were two spreadsheets sitting behind the process. These were said to detail each stage of the process, the communications made, patient details and contact points.
- During the inspection we were shown information, including data which related to the patients and records detailing ambulance journey activities, and the calls made to patients as part of the investigative process. We were concerned to see from the information the calls to individuals were limited to three attempts and these were conducted on the same day, rather than over a period of days or weeks, which did not reflect the section of the policy described above. Most calls were made in day-time working hours, which limited the response rate.
- We asked to see copies of letters sent to people and were told it was a standard letter. Our review of this found the letter was open and provided some generalised detail of the matter, with an apology.
- The initial letter that was sent to patients was to alert them to the incident. Patients were made aware the trust would be making contact with them to have a more detailed conversation with regards their assessment and outcome with contact details of a LAS member of staff. The trust did not have Patient Report Forms (PRFs) for these patients and could therefore not put any further details in the letter.
- The investigation process identified 46 patients who were attended to by the individual of concern, when they worked alone, without any supervision. The investigation team were unable to contact 12 of the 46. These patients were followed up by contacting the attended care facility (hospital/urgent care centre) to ascertain that patient's outcome.
- Of the 46 patients 16 were contacted by the investigation team and informed of the investigation. This included the parents of

five children, who were written to, and three of whom were spoken with too. The patients were offered an enhanced clinical assessment, the outcome of which was documented within the related call log. The notes of the calls were entered directly into the computer aided dispatch (CAD) system.

- We asked for clarification around the consideration of patients who were attended to in the presence of a trained crew member. We were advised this matter had been discussed with commissioners in a private session of the LAS Clinical Quality Review Group meeting, and the independent medical reviewer. The view was that as those patients had been attended to by a suitably qualified member of staff on scene, the risk of harm was minimal. The trust identified the greatest risk for potential harm was to those patients for whom no other qualified clinician attended the scene, of which there were 46. However, the trust still conducted a clinical review of all cases where the call sign responder was dispatched either alone or with other trained staff. We were provided with evidence to support this during the inspection.

Safeguarding

- At our previous inspection we found the arrangements for safeguarding vulnerable people were well established and acted upon. Staff had access to a safeguarding lead and procedural guidance to support them in bringing matters of concern to the right people.
- Part of the focused inspection included a review of policies and procedures. In addition to the duty of candour and being open policy, we reviewed the safeguarding children and young people policy, the safeguarding adults in need of care policy, and the policy and procedure on the management of safeguarding allegations against staff. Policies provided clear instructions on responsibilities and actions required of staff.
- We noted the trusts duty of candour and being open policy indicated the head of safeguarding would liaise with the nominated contact when a notifiable safety incident was identified. This was in accordance with the procedures set out in the policy and procedure on the management of safeguarding allegations.
- We asked the investigating lead if there had been any consideration of potential safeguarding concerns and of informing the safeguarding authority. In response, we were told the investigating team had checked to see if the person involved in the incident had submitted any safeguarding directly. Further, they told us; ‘we considered information and liaised with safeguarding internally.’

Summary of findings

- The chief quality officer was the lead for safeguarding within the trust, and as such was fully involved in the consideration of possible safeguarding matters. Further, safeguarding and nursing commissioning leads were involved in all discussions at regular meetings throughout the process.
- We spoke with the head of safeguarding, who was a member of the serious incident group. This was the committee who met to hear declarations of incidents. As such they were aware of the matter as a subject for investigation. They told us at the initial meeting held after the incident came to light, they had advised of the need to identify any vulnerable patients, which would include children. However, they told us they were not involved in any discussion with the lead investigators. Further, they had not been approached for any advice or consideration of potential safeguarding concerns during the investigative process.
- The final serious incident report had only become available four days prior to our inspection. From the review of the report the head of safeguarding identified the investigation team had looked at each case and determined no harm or safeguarding concerns.
- Whilst the head of safeguarding was not aware until we informed them there were several children who were included in the incident review, they indicated to us by way of response, a safeguarding should possibly have been raised for each of the children. At the very least, discussion ought to have been held with other agencies to consider this.
- We were informed that the investigation team was not provided with any information (during the patient contact) which suggested a safeguarding concern. However, we noted in the serious incident (SI) report, section 11.2, it stated; No patient raised a safeguarding concern during the investigation. We were concerned these individuals may not have known what a safeguarding concern might be, and therefore, may not have thought to raise one.
- The quality and risk business partner was asked about safeguarding notices and responded that they imagined they would have been completed, but would need to check. They were also unsure regarding the status of safeguarding training of the person involved in the incident, although they believed they would have been trained in a previous role.
- We explored the area of notifying the disclosure and barring service, (DBS) with the safeguarding lead. They told us they understood a new DBS check would be carried out for a new starter, and for an internal role change. They believed a DBS notification would be sent on dismissal of an employee too.

- The medical director was asked about consideration around notifying the DBS. They told us as a non-registered member of staff, undergoing training, the notification was made to healthcare and professionals council (HCPC). The HCPC registers different professionals, including paramedics. Trainee emergency ambulance crew would not be registered through the HCPC. However, if a person was acting outside of their responsibility, including possibly impersonating a qualified practitioner, the HCPC would be notified. They added external organisation were notified via an NHS alert, and they would then have a responsibility to notify other ambulance providers.
- The investigating lead was asked if they knew if the DBS had been informed and they told us they were not aware. The quality and risk business partner did not know about this either. Further, there was no reference to DBS in the incident report. It was clear from discussion with staff, including the human resources executive lead they were unaware of the guidance available for making decisions to notify the DBS or not.
- We fed back our concern about this at the end of the inspection and it was confirmed with us on 29 November, the DBS had been notified. The trust provided email confirmation of notification having been made on 21 November 2018.

Risk assessment related to patient safety

- At the previous inspection we found there were a range of patient risk assessments in use by staff. During the focussed inspection we considered if the investigative process carried out by the trust had included a review of patient safety risks. We spoke with the medical director (MD) who was the Caldicott Guardian for the trust. They were responsible for protecting the confidentiality of people who used the service of LAS health and care details, and making sure the information was used properly.
- The MD told us they felt they had done all they could to consider patient safety. They told us a clinical safety review was undertaken, which included a review of all call logs, and available patient report forms. A risk matrix was followed to identify any safety concerns or patient deterioration. This was 'blind' assessed by the clinical commissioning group (CCG) reviewer, which resulted in the assessment of harm level.
- Information we requested identified 22 people who were contacted and received an enhanced clinical assessment. From this, 15 patients were identified in the moderate risk category. Most of these individuals were contacted, and hospitals were contacted in some cases to ascertain additional information.

Summary of findings

- We had found at our previous inspection the security arrangements for medicines had been improved. However, the incident review had identified a small number of patients had been given medicines by a non-qualified crew member. We were told the individual, who was a first aider, had not administered anything, which would not be an over the counter item, apart from one product, (Entonox gas, which is used for pain relief). The use of these medicines had been fully considered in the clinical safety review.
- We discussed and observed the processes for logging crew members to ambulance vehicles and any potential risks around this. We were told the trust had implemented several actions to mitigate the risk of an unauthorised member of staff from being able to log onto the trust computer aided dispatch system (CAD). This was addressed as soon as the incident was known about. Actions taken included; removing all non-essential call signs from the CAD system and mandating Vehicle Resource Centre (VRC) staff to make cross checks of the trust rostering system, known as GRS when asked to log-on a non-rostered vehicle. This process had been tested on several occasions in recent weeks and was said to have been effective.
- When starting their shift, staff selected their skill level, such as trainee emergency ambulance crew (TEAC) or paramedic on their mobile data terminal. This added the highest clinical skill to the rostered call in CommandPoint™. If a crew member failed to select their skill level, the system provided them with an audible and visible prompt.
- We were informed that in the interest of system stability and security, the CAD was isolated from all other trust systems. As a result, GRS did not directly interface with the trusts dispatch system. There were additional actions currently being looked at to strengthen the control in relation to only having authorised staff on board LAS vehicles. These had been referenced in the trusts action plan.
- Our observations in the emergency operations centre demonstrated crew members could still be logged on to the system, even after their shift finished. Crews were informed to switch to channel 33, based at the Bow emergency operations centre (EOC). They could speak to someone about booking on if they were not showing on the system. We were told however, if EOC staff recognise a call sign they just booked it on, rather than checking with the person.
- Further clarification was sought following the inspection on the above point. We were told emergency crews would remain logged onto the system until they handed the vehicle over to the next crew, or it returned to its base station. The call sign

then reverted from a capital prefix to a lower case to indicate that the vehicle was off shift and would not be dispatched to further emergency calls. For example, J201 to j201. This allowed for additional crew safety and the tracking of vehicles. Additionally, should the crew encounter a call on their way back to their base station, EOC were then able to create a call and dispatch this to the vehicle.

- In relation to the access to and use of radios, we were told all ambulance vehicles had a radio onboard, and crews also carried two handheld radios.
- Call signs were allocated to crews depending on shift times and base station. LAS had pre-set available call signs, outlined in the operational radio procedure and radio call signs document, a copy of which was provided to us. We viewed this and saw there were call sign ranges, consisting of pre-set words then a range of 01-99. The EOC staff would need to learn these or be able to check them as part of their activities. We found by way of example in the events team there were four groups of these, which meant there were 400 available call signs to choose from.
- We were told about and provided with a copy of the updated operational radio procedure and radio call signs policy. This had been recently approved for release. This demonstrated the call signs used in this incident had been removed. All call signs were reviewed as part of the learning from the incident, and only those essential to the safe operation of the trust remained.
- When we visited the Emergency Operations Centres, we spoke with staff and viewed the various screens to check how the systems worked. We checked to see if the expected improvements which had been started immediately on identification of the incident were being followed.
- At the Waterloo EOC we observed the recording of start and finish times for a call out by crew and the individual skill set. We could see such things as the location of the vehicle and the speed of travel. Information provided to us demonstrated clear tracking and traceability for vehicles.
- We visited the EOC at Bow and spoke with an area controller, dispatchers and allocators within the North-East region. We asked staff to take us through the process of how crew could book onto the system so they could be allocated patient visits. When crew members called into the control room they provided a call sign, which allowed them to be entered onto the system. The trust had a system called global resourcing system (GSR). The EOC watch manager and clinical hub managers had access to the system. The allocators and dispatchers we spoke with did not refer to the mangers for these checks. Subsequently, checks that should have been made of the staff

members qualifications and who they were, were not being completed. Staff at the BOW EOC told us booking onto the system should be done through the central support unit (CSU) and not the control room but this was not happening consistently. Staff we spoke with within the control room told us they had not received any instructions from senior management to stop booking crew onto the system. This was still happening at the time of our inspection.

- Staff within the Bow control room told us, they took call signs on face value and rarely made checks. There were unfamiliar call signs still being used, particularly by managers, and staff said they would not question or challenge managers who called in to be booked onto the system. Staff within the control room could confirm that when they booked a call sign onto the system they did not know the individual or their skill set. Staff at Bow EOC confirmed they were not aware of any new practices having been put in place since the time the incident came to light. Further, staff confirmed that due to the lack of systems to check staff credentials they were unable to tell crews who they were working with. Staff within the control room said the incident could happen again as everything was taken on face value. The control room and CSU used to have joint team meetings and regular watch meetings within the department, but they had both stopped due to operational pressures.
- We visited the central support unit and spoke with an allocator and the department lead. Since the incident staff told us they now cross referenced everything that went through their department. Extra levels of checks were now completed for community first responders and these were embedded at the time of our inspection. CSU staff acted and responded to the incident and ensured the checks they should have been making were now taking place.
- Lead managers were now making extra checks to ensure staff were following the correct processes. Staff could explain that when a staff member called them with a call sign, they were able to access the GRS system and made checks against the staff members personal data, such as qualifications and skill set. They asked staff, their personal number, shift start time, fleet number. If they could not find the staff member on the system then they did not book them onto the system. However, due to operational pressures, checks were not always fully completed. The lead told us there was more awareness to complete such checks since the incident. Some staff told us they had received a bulletin regarding the incident, but no further information or any instructions to change processes.

Summary of findings

- We reviewed the clinical safety review information provided to us. This included listed cases of patients attended to by the individual involved in the incident. We noted from the information the individual worked rolling days, with hours throughout the day and night one after the other. For example, cases were attended to between the hours of 11:10am until 11:47pm on the 27 July, and between 3am and 11:39pm on 30 July.
- We asked about staffs' ability to work excessive hours and the monitoring of this, as we noted the individual of concern had worked beyond the accepted work pattern, even that of a qualified practitioner. The response was there was a process to follow with respect to booking shifts, including overtime. The GRS would highlight where excessive hours have been worked, and overtime was monitored. If staff wanted to do overtime they had to request this, identifying where they were from, a call sign and shift allocation. The vehicle resourcing centre was then notified to ensure a vehicle was made available. Vehicle allocation screens indicated the number of the vehicle and call sign in use.
- We discussed the risks around staff not declaring secondary jobs outside of the trust, and were told this was an area which the trust was strengthening. Whilst it was a requirement of staff to declare secondary jobs, and seek permission, this had not always happened.
- Staff signed into their station via a sign in sheet. The system was not robust as most staff told us they did not use the sign in sheets.
- There was a reliance on crews to "book in" at the start of their shift, by calling the allocators at the emergency control centre (EOC). This was done on an informal basis by one crew member. This meant one crew member could book all crew onto the system. Although the staff member with the highest skill set was meant to book onto the system, this did not always happen and all crew we spoke with said they had neither been challenged or questioned when they had done so. We saw one paramedic had not signed into the station sign in sheet, however the electronic dashboard had the staff member listed as out on J203 call sign with a trainee emergency ambulance crew member. The lack of robust checks meant there was no strong oversight as to who was at the station and on duty. Most allocators and dispatchers we spoke with at EOC, said for most of the time crews did not call to book onto the system and they had to chase staff.

Summary of findings

Incidents

- At our previous inspection we found the trust had a formalised process for incident reporting, investigating and following up, including learning from these. The trust had been working hard to develop a culture which encouraged staff to speak up, and there was evidence reporting incidents had improved. The incident on which we were focussed came to light when a staff member felt confident to challenge the individual and then to speak up about their concerns.
- As soon as the trust became aware of the incident stakeholders and key partners were notified. The investigation process followed the NHS Serious Incident Framework. The Serious Incident framework sets out the processes and procedures to help ensure serious incidents are identified correctly, investigated thoroughly and, most importantly, learned from to prevent the likelihood of similar incidents happening again. A single timeframe of 60 working days has been agreed for the completion of investigation reports. The aim of this is to allow providers and commissioners to monitor progress in a more consistent way. Further, this gives clarification to patients and families in relation to completion dates for investigations. This timeframe was met by the trust.
- Serious Incidents include acts or omissions in care, which result in; unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm - including those where the injury required treatment to prevent death or serious harm, abuse, never events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services, and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services.
- The NHS Serious Incident Framework requires the declaration of the incident internally as soon as possible, and immediate action must be taken to establish the facts, ensure the safety of the patient(s), other services users and staff, and to secure all relevant evidence to support further investigation. Serious Incidents should be disclosed as soon as possible to the patient, their family (including victims' families where applicable) or carers. This recognises that the needs of those affected should be the primary concern of those involved in the investigation process, and its outcomes.
- The trust reported the serious incident on the Strategic Executive Information System (StEIS). This system enables the reporting and monitoring of investigations between NHS providers and commissioners. In addition, the trust provided the commission with a 72-hour report, and told us this had

been shared with regulators and commissioners. This was confirmed in our discussion with members of the clinical commissioning group. The 72-hour report detailed the immediate actions taken by the trust to remove the risk and mitigate possible future risks.

- The lead investigator confirmed with us they had followed the standard framework but did revise the serious incident process, recognising information within it would be sensitive. This meant the report in its entirety would not be sent out to patients/relatives.
- Terms of reference for this process were developed and shared with NHSI, NHSE and the commission. They were also signed off by the Clinical Quality Review Group (CQRG). Following which it was agreed a joint investigation would take place.
- The NHS Serious Incident Framework outlines responsibilities of NHS providers, and includes the premise that investigations are undertaken by appropriately trained and resourced staff, and/or investigation teams who are sufficiently removed from the incident to be able to provide an objective view.
- We asked about the training and competence of the lead investigators for the trust. Both the lead investigator and the quality and risk business manager told us they had been trained in enhanced clinical assessments. The lead investigator was said to have experience in root-cause analysis (RCA) and governance, and the quality and risk business manager told us they had been trained in serious incidents (SI), and had a basic understanding of RCA. The latter individual told us they were involved as an advisor, with overall responsibility for patient safety.
- As soon as the trust became aware of the incident they held an initial multidisciplinary meeting. The purpose of this was to identify immediate risks and address the mitigations; to make requests for information, and to escalate to the chief quality officer. It was confirmed in discussion with staff that a serious incident group meeting was held with a declaration by exception. At this meeting it was discussed and agreed the review process met the level two, comprehensive review threshold, and therefore would not be an independent one. (Comprehensive investigations, which are suited to complex issues, should be managed by a multidisciplinary team involving experts and/or specialist investigators. This is set out in NHS England's serious incident framework).
- The lead investigators for the trust were confirmed, and assurance to the board made about the process.

- We were provided with a copy of the SI summary, which identified 20 initial actions taken by the trust within the first 72 hours.
- It was confirmed by the quality and risk business manager that there had been feedback from the CCGs regarding the draft and a response was made via the serious incident group. We were provided with information which detailed the CCG feedback and the trusts response to the points raised. Members of the CCG confirmed the extent of their involvement in the review and monitoring process, and the positive and responsive nature of the trusts engagement.
- From our own observations, we noted there were some time delays in gathering information, such as gaining access to emails. This was not thought of initially by the team, although once recognised, access was provided within 24-hours.
- We questioned staff around the clinical review and were told the level of harm was determined through discussion with patients, the doctors review, and number of re-contact presentations. Onward referral details to another health care facility were available to the team. This enabled the investigators to contact the facility and obtain the clinical outcomes for the patients.
- The RCA for this incident determined there were seven underpinning factors. An action plan was developed, which considered the post investigation risk score. The action plan detailed seven actions, with recommendations, actions, due dates and responsible individuals. Of these three had been completed at the time of our inspection. A revised action plan had also been developed following the emergence of information from the investigative process. The updated plan was provided to us. This showed there were a total of 12 actions. In addition to this, six further actions were identified following the inspection visit, considering new information from an external agency.

Communication and lessons learned

- At the previous inspection we found a serious incident group had been set up, and staff were self-reporting. Scrutiny and assurance had improved because of having more time to evaluate, audit and research improvements in practice. Learning and updates to practice was cascaded to staff.
- The focused inspection identified the nature of this incident had meant the communication of information to staff in general had to be restricted. This was because external investigations

were being carried out. However, we found there was a missed opportunity to provide a considered communication to staff, without providing all the detail. This may have helped with the implementation of actions and adherence to them.

- We were told the communication to staff in general had been limited to the importance of call signs. This was said to be because there was potential for the incident report to change up until its sign off. The investigation lead told us actions would affect staff but not in a way which would change process, 'Just making things tighter.' We found whilst there was some awareness of an 'incident', staff in general were not aware of any changes to the systems or processes. The communications had been limited to one bulletin, sent out on 3 July 2018, which related to the Emergency Operations Centres (EOC). However, the message therein had not been reinforced subsequently.
- The timeframe from the investigation and conclusion of the report was four days prior to our inspection. Due to the sensitive nature of the report the findings had been restricted to key individuals. Therefore, and as expected, some of the detail was not fully known by some of the staff we spoke with.
- There was awareness of some immediate actions taken, and these had been discussed on a need to know basis. We were told the terms of reference for the investigation were agreed by the executive committee, and stakeholders and commissioners were informed. In addition, the board were briefed and discussion was shared at the provider oversight meeting. The director of operations told us they were aware of actions arising from the incident and the processes for monitoring the delivery of these. They added there were policies and procedures for staff to follow at the time of the incident, but these had not been carried out properly.
- There had been a generic communication about security and we were told the trust would be doing more, because of the sign off the report.
- Speaking about the actions, the lead investigator said there had been a number related to weak governance processes. Respective individuals and areas would need to put forward a business case to resolve the issues. Required actions would be put into Datix and relevant staff would be alerted this way. We had this latter point confirmed by a member of the events staff who said they had received a message via Datix detailing actions required.
- We asked how assurance of the completion of actions would be measured, and were told this would be via the quality

assurance meetings. Outstanding actions would be reported to the board, and bigger projects, such as asset tracking, had been drafted but not put out, as they were waiting for sign off by the CCG.

- During our discussion with deputy director of clinical education and standards it was stated the incident report had not been shared with them until prior to our interview. (This was because the report was restricted until signed off.) Further, they had not been communicated with regarding the outcome of the investigative process, although they had some awareness. No specific communications had been received in relation to training, but there was awareness of information having been shared around vehicle security.
- Having seen the recently signed off incident report just prior to our discussion with them, two staff indicated to us they would have liked to have been involved, and one said they were surprised about some of the actions and wording. They were not aware of the actions required of themselves. In response to our question; could your team have done things differently? we were told; 'I do think there is not always a joined-up approach. We don't get consistent advice or support.' The actions had not been discussed, although by default, 'they got to the right place.' This had included strengthening processes, such as discussion of internal staff moves.
- We were advised the three senior executives approved the report before it was sent to the CCGs, and the report would be shared with the board at the next meeting. Communications arising from the incident review sign off were then likely to start. We were told by the quality and risk business partner new actions would include the establishment of serious incident action group. This would review audit processes arising from serious incidents.
- We asked about the process for informing other agencies and were told by the lead investigator there had been some 'talk about putting a message out to independent ambulance.' However, they were unsure exactly which private providers had been informed. The quality and risk business partner understood the alert had gone everywhere in the NHS and they believed to all independent and voluntary sectors.
- The trust provided us with assurance around the notification to other NHS trusts, in the form of a security alert. This contained relevant information, including the persons identification.

- During a meeting with the trust on the 29 November, we were informed an external provider of first aid services had been alerted of the matter of concern. We were provided with email confirmation of notification to the Independent Ambulance Association, which was sent out on 22 November 2018.

Equipment/Environment

- The director of strategy, assets and property spoke with us and confirmed their responsibilities for overseeing vehicles, their movement, kit, medicines and buildings. They told us the system for requesting vehicles via the vehicle response centre (VRC) was robust, but added level of rigour had been introduced since the adverse incident. Two people were now responsible for auditing the start and finish times, and for the recording of information on 'manning' sheets.
- We visited the VRC in Bow. We spoke with the VRC lead who told us they had been made aware of the incident but had little involvement. Since the incident they told us there was more awareness amongst the team regarding the tracking of vehicles. Staff now completed daily checks, but were sometimes hindered by the old system they used. The system did not self refresh, so staff had to remember to do this to get the most up to date information. Staff could explain that if a vehicle was off road they would lose the location of the vehicle and it became untraceable. This also applied if the engine was turned off or the vehicle was experiencing mobile data terminal (MDT) issues. If there was no call sign to the vehicle the vehicle was not moved for at least 24 hours. There was no set guidance on how long a vehicle with no allocation should be left before being collected by VRC. We were told people were still taking vehicles without VRC knowing.
- The purpose of the VRC was to put vehicles in place at the start of the shift. Technically the VRC department was at the end of the chain and the relevant checks on crew would have been made beforehand by other departments. Therefore, VRC would not necessarily check staff who were allocated to vehicles. There was no overnight staff cover within VRC and therefore no tracking of vehicles during the night. The serious incident highlighted that most vehicle movements happened during the night.
- With respect to building the assistant director of operations (ADO) had check-lists and they were required to make sure areas were secure. If they were found not to be, then they were to escalate this upwards. We noted the codes to secure doors were written on door frames at one of the ambulance stations,

and whilst these locked rooms came under the responsibility of another provider, they were of concern. The trust advised us on the second day of our inspection they had alerted to the relevant organisation.

- We were told a buildings survey had been undertaken and a formal report was expected in January 2019. This was expected to identify the level of security, what each facility was being used for, and if appropriate.
- During our discussion we asked about the security of vehicle keys and were told that at the time of the incident, key management was casual and the use of key boxes was not really enforced. An immediate process was set up so key usage could be tracked and traced. To develop this a group of staff had met mid-August and they set up a new system. In addition, it was expected that new key safes would be installed, with a roll out from the 3 December. Finish time was expected to be the second week of January 2019. We were told this information had not yet been communicated and therefore crews would not be aware.
- Further work was expected to be taking place with respect to the development of an asset management tool. It was confirmed with us the information management team owned the assets related to ambulance telephones, radios, and the radios carried by crew.
- We visited three ambulance stations and found security issues at two. The restriction of access into the stations was good. However, we found one staff member had the pin codes written on a piece of paper. Once inside the stations, access to keys for vehicles and equipment was not secure, which made it possible for unauthorised people, including trainees to be able to gain access to a vehicle. At one station the key safe which held vehicle keys did not lock and there was no combination code. We spoke with the station support manager and they were unaware of the key safe location at the station. At another station the key safe was unlocked and not secure to the wall, which meant the key safe could have easily been lost or removed from the station. At a third station we found the key safe to be locked and secure.
- We spoke with an incident response officer and group station manager, who informed us that all key codes were immediately changed across all stations after the incident. However, most ambulance crew said staff would share codes to other crew they did not necessarily know, if they required access. We spoke with one trainee emergency crew member. They told us if they wanted to they could easily gain access to a vehicle and remove it from a station, as the system was not secure.

Summary of findings

- Seven crew members we spoke with said they would not challenge anyone in a 'green uniform'. Therefore, most crew activity within a station, of collecting equipment and moving vehicles was taken at face value.
- We found four of the six vehicles parked in the stations forecourt of one station, unlocked. These vehicles were vehicle call signs, 7959,8156,7995,7691. Our inspector was able to access and check all vehicles unchallenged, even though we were visible to some staff who were working there.
- In a station staff rest room, we found an unattended hand set whose airwave radio was on loud speaker. Staff were unable to identify who the handset belonged to, as the handset was meant to remain with the member of staff at all times. We handed the handset to the station support manager to take the appropriate action.
- Medical equipment and grab bags containing essential equipment to help treat patients were kept in the new controlled drugs room. This room was accessed via a swipe card, making it suitably secure.

Are services at this trust well-led?
Governance, risk management and quality measurement

- At our last inspection we found the local governance arrangements had been improved and there was a higher level of awareness and understanding of the value and importance of reporting, reviewing and learning from incidents, for managing risks and performance outcomes.
- The trust held a Serious Incident Group (SIG) meeting every Wednesday. Potential serious incidents (SIs) were reviewed by a multidisciplinary team of senior leaders from across the organisation. The meeting provided an opportunity to monitor actions from previous SI's. The Quality, Governance & Assurance team monitored actions on a weekly basis and liaised with the responsible manager, providing support to ensure their timely completion.
- During the focussed inspection we explored the measures taken to provide assurance to the board. We were told the board had an initial brief to make them aware of the incident. We saw minutes of the private board meeting held on 31 July 2018, which confirmed this.
- The Board Assurance Framework and Corporate Register were reviewed during the public board meeting on 31 July. There were five top level risks, none of which related to the incident under investigation.

Summary of findings

- We found at our previous inspection the trust had a risk compliance and assurance group (RCAG). The purpose of which was to manage and monitor all risk management processes and activities within the trust, and to ensure the objectives of the risk management policy were met. This included the regular review of the corporate risk register and movement on key risks, and holding risk owners to account.
- The previous inspection found there were good arrangements for identifying, recording and managing risks, issues and mitigating actions. The trust board had sight of the most significant risks and mitigating actions were clear. Risks were reviewed at a range of governance meetings and further by the board.
- The medical director confirmed that prior to this incident, such a risk had not been considered or identified. However, the risk of an ambulance vehicle being obtained without authority, was on the risk register. We were provided with a copy of the risk register as it stood at the time of the incident. This identified risks around theft, criminal damage and vandalism due to the lack of robust and inadequate security arrangements at LAS properties/sites. The director of operations told us that prior to the incident, station and vehicle security was always a concern of theirs. Mainly this was to do with assurance around access, and the possibility of taking vehicles. We observed this was on the risk register.
- We asked if the risk register had been revised following the incident. We were provided with information which indicated the register was updated following the incident on 4 July 2018. A gap in control was added to the risk, and the risk was further updated 13 November 2018. This stated a review of the security of vehicles at stations had been undertaken, and a new procedure for key management had been introduced.
- With respect to the policies and procedures which were in place at the time of the incident, it was felt by the staff we spoke with, the risks would have been minimised, but only if these documents had been followed fully.
- The director of operations was asked where they thought the risks were at the time of our inspection. They replied that they were assured the immediate actions taken had reduced the risk of something similar happening again. They acknowledged some actions had not been delivered yet, and they could not say for certain there were no risks.
- We asked about the incident approval process and were told; the report had now been signed off, and would go through various governance committees and the clinical quality and risk group (CQRG). The private board would then receive the

information. Ongoing actions arising from the review process were expected to be monitored and assurance would be provided via the various committees. The medical director expected the monitoring of compliance would probably include spot checks and 'deep dives'.

- We viewed a copy of the action plan arising from the investigative findings and noted amongst other actions, some of which had been closed, two required separate business cases to be developed due to the complexity and size of the change required. One related to vehicle security, with a target date for presentation to the executive team in quarter three. The other was in respect to station security, for presentation in quarter four. An updated action plan showed the matter related to station security had an aaccelerated solution under review, with a new timeline to ensure completion by January 2019. For vehicle security, a first draft of the required actions had been completed and went out for comment in August, and was expected to be presented at the executive committee in December.
- The trust provided us with a copy of the draft business case for telematics and driver safe technology. This was expected to address unauthorised vehicle use by enabling the identification, audit, tracking, tracing and monitoring of vehicles in use.
- The completed investigation report was signed off by executives on 27 September, and was on time. The report underwent a review process by all 32 CCGs, followed by feedback to the trust. This was responded to, and an updated report was submitted to the lead CCG on 15th October 2018. Since then, the report was reviewed by the CCG Serious Incident Review Group and was closed.
- The executive committee meeting provided an opportunity to consider a range of information, including progress on serious incidents, and actions arising from the findings.
- More recently, a decision had been taken to form a separate Serious Incident Action & Learning Group. This would provide focussed oversight of actions and report progress directly to the Quality Oversight Group and up to the Board via the monthly Quality Report and SI reporting mechanisms.
- The trust informed us they had initiated a separate weekly oversight meeting. This would provide an update to the executive committee prior to sharing this with external partners.

Summary of findings

Events-public engagement

- During our discussion with the head of engagement and patient involvement we were assured the arrangements for managing volunteers and covering events at the time the incident was identified followed the previous inspection. Once they became aware of the incident, via two of their colleagues who had been part of the initial multidisciplinary team meeting, they had been asked to take some actions, which they did.
- Although this staff member had not seen the incident report, they had become aware of the matter or 'worked it out.' They decided to be proactive and put in place some measures until the incident outcome was shared. We were shown email confirmation of summarised actions being taken. One of the measures they had put in place, subject to approval by the information governance team, was to send out the policy and code of conduct to volunteers each time they did an event. Risk assessments had also been revised, to include management authorisation, and the procedure had been tightened up for vehicles going to events. For example, volunteers recorded which vehicle they used, vehicle sign and the registration number. Email confirmation of attendances were now sent to the volunteer line manager for sign off and approval.
- We were told the outcome of the incident had not been shared or the additional actions via a formal discussion route. However, an action appeared via the Datix system the previous week. We noted there were actions for this area on the SI report, but the relevant manager was not aware of these.
- We posed the question as to whether a person could request a vehicle for an event, and be using this outside of the event, with no shift time or call sign. The response was this was not likely, as there was a policy to follow. We asked how it was known if staff were complying with this. The response was that monitoring was done through the Datix system, although there was no formal auditing of these. Spot checks were expected to be carried out. Further clarification from the trust showed that action 18778/2 arising from the SI investigation stated a formal assurance processes should be developed to address this point.

Training

- At our previous inspection we established there were good educational programmes to support the progression of internal staff, and to facilitate the development of required skills for new staff joining the ambulance service.
- We explored the area of staff training during our focussed inspection as this had been part of the investigative process.

Summary of findings

- It was confirmed through our discussion at the focussed inspection the training of emergency ambulance crew required candidates to complete a written application, assessment, a skills test and interview. Trainees were then assigned to one of the six education centres which offered the training programme. Support was provided through education managers based at each location, and a team of tutors who were qualified paramedics, as well as link tutors. The training programme extended over a period of six months and included a comprehensive induction, which covered aspects of safety. In addition, the course covered such matters as medicines, medical conditions, trauma and vehicle driving. The latter took place later in the programme, and this included driving under blue light situations. The programme followed a national framework, which was professionally recognised. This required candidates to complete a series of assessments, and a portfolio, as set out in the trusts examinations and assessment procedure.
- Candidates who did not make the required progress were supported to address areas, with a view to having the opportunity for re-assessment. This had been set out in the department of clinical education and standards re-assessment policy, a copy of which we reviewed. Where the required standard was not achieved, individuals were managed in accordance with standard operating practices and the trusts policies, such as that related to capability or disciplinary. The former would enable a trainee to be 'stood down,' but required to attend each day or they remained at home with self-directed learning, and regular contact with their point of contact.
- We asked if there was a system for a trainee emergency ambulance crew member to be on GRS during this time. We were told they could not be assigned to a shift, and if they were stood down for any reason, the scheduling sector were notified.
- Since the incident the training centre at Ilford have made small changes to practices as a way of mitigating risks. If a trainee staff member was stood down they were now unable to work as a volunteer until they were re-assessed. Staff we spoke with at Ilford, said they had received very limited information regarding the incident and no support or guidance from any senior manager.

Outstanding practice and areas for improvement

Areas for improvement

Action the trust MUST take to improve

The provider must ensure potential safeguarding matters are fully considered and reported to the relevant local authority, and the commission.

The provider must ensure the disclosure and barring service and other relevant external organisations are informed where a member of staff is dismissed as a result of safety concerns.

The provider must ensure the local policies and procedures are fully acted upon, and sufficient monitoring of staff's adherence with required practices takes place.

Action the trust SHOULD take

The provider should consider how it communicates required changes in practices, so that staff are fully aware.

The provider should consider increasing the time frame in which it tries to establish contact with those people who may be affected by an adverse incident.

The provider should ensure the arrangements to secure vehicles and equipment are improved.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 (1) Safe Care and treatment** **Care and treatment must be provided in a safe way for service users.** **Regulation 12(2)(c) ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to so safely.** A member of staff who had not completed the required training was able to provide treatment and care to members of the public, without any supervision.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Regulation 13 – Safeguarding (1)(3) Service users must be protected from abuse and improper treatment in accordance with this regulation** (3) Systems and processes must be established and operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse. Information was not fully considered in accordance with safeguarding practices. Communication with external agencies was not made with respect to possible safeguarding concerns.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulation 17 (1)(2)(b) Good Governance

Regulation 17(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements.

Regulation 17(2)(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.

Policies and procedures were not always followed. The arrangements to communicate changes in practice were not effective. The checking and monitoring of staffs' adherence to required practices were not sufficiently strong.