London Ambulance Service Headquarters

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

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

Overall summary

This provider was rated as Good overall but Requires Improvement for providing effective services at the previous inspection on 2 September 2019 and 6 September 2019)

The key questions are rated as:

Are providers safe? – Good

Are providers effective? – Requires Improvement

Are providers caring? – Good

Are providers responsive? – Good

Are providers well-led? – Good

We carried out an unannounced unrated inspection of the NHS 111 London Ambulance Service on 6 December 2021. The inspection formed part of a review of urgent and emergency care within the wider healthcare system.

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

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

North East London

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

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

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

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

Overall summary

There are opportunities for more effective integration between 999 and 111 services. Due to the way 111 and 999 services integrate nationally, the call system for the 999 service was unable to electronically send information to the 111 service if it was decided the caller did not meet the criteria for an ambulance. The caller was asked to redial 111. In contrast, 111 were able to communicate directly with 999 if they felt their caller required an ambulance. Ambulance service leaders in London were fully sighted on a national pilot to improve this issue and hoped this would improve people's experience of urgent and emergency care, wherever they live.

We inspected one emergency department in North East London and found that local services did not always work together to reduce attendances or the length of stay in the emergency department. This resulted in situations of overcrowding, compromised infection control and extended waits for treatment which impacted on outcomes for patients. The ambulance service had commenced daily calls with system partners to try and reduce ambulance handover delays and to monitor demand across North East London. Leaders from services in North East London acknowledged their responsibility to support the emergency department and are working to implement improvement plans with colleagues from primary care and community services.

We identified an opportunity for more effective collaborative working and communication between an emergency department and the co-located urgent treatment centre resulting to improve people's experience of accessing urgent and emergency care. Different digital operating systems within these services did not promote effective communication or integration between services and impacted on how services could work collaboratively to deliver safe, effective and timely patient care. These issues resulted in some people being sent from the urgent treatment centre to the emergency department without an effective referral mechanism and meant they experienced further delays whilst in another queue to be assessed. Leaders from a range of services were looking to further integrate services in the area and, in response to our findings, were collaborating to implement new and innovative ways of assessing patients safely and in a timely way.

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

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

This report covers the inspection of the London Ambulance Service's (LAS) 111 Integrated Urgent Care, Clinical Assessment Service in North East London.

You can find the reports of our previous inspections by selecting the 'all reports' link for London Ambulance Service Headquarters on our website at www.cqc.org.uk.

This report comprises information from a combination of:

Overall summary

- What we found when we inspected the provider
- Information from our ongoing monitoring of data about the provider and information from the provider, patients, staff, the public and other organisations.

At this inspection we found:

- The provider had systems to manage risk so that safety incidents were less likely to happen. When they did happen, the provider learned from them and improved their processes. However, some staff reported that they were not always able to routinely read information disseminated so may be unaware of incidents that occurred.
- The provider routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence- based guidelines.

The provider had an overarching governance framework in place, including policies and

- protocols which had been developed at a provider level and had been adapted to meet the needs of the providers locally.
- Call audits were in place to monitor the performance of staff.
- Staff involved and treated people with compassion, kindness, dignity and respect.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.

The areas where the provider **should** make improvements are:

- Continue to review call performance data to ensure national targets are being consistently achieved.
- Continue to proactively monitor call demand to ensure staffing levels are appropriate.
- Liaise with the clinical commissioning group to discuss ways to improve the Directory of Services.
- Take steps to improve methods of communication with staff to ensure disseminated information has been reviewed and understood.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Providers and Integrated Care

Our inspection team

Our inspection team was led by a CQC lead inspector who was accompanied by a second CQC inspector, a GP specialist adviser and an operational manager specialist advisor.

Background to London Ambulance Service Headquarters

The London Ambulance Service NHS Trust (LAS) was established in 1965 from nine previously existing providers 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. LAS has delivered a 111 service in South East London (SEL) since 2013 when it became the step-in provider; SEL 111 covers the boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark. Its offices are based in Southern House, Croydon (5 minutes' walk from East Croydon station).

The 111 service transitioned to an integrated urgent care (IUC) service through phased mobilisation from 26th February to 8th May 2019. LAS was awarded, through open tender, the contract to deliver the Integrated Urgent Care (IUC) Clinical Assessment Service (CAS) for the boroughs of Barking & Dagenham, City & Hackney, Havering, Newham, Redbridge, Tower Hamlets and Waltham Forest, which commenced in 1 August 2018. This North East London (NEL) provider is based at Maritime House, Barking (five minutes' walk from Barking station). Only the NEL site was inspected on 6 December 2021.

In line with the national specification, the new LAS IUC CAS has a multidisciplinary team of GPs, Advanced Practitioners, Pharmacists, Nurses, Paramedics, Health & Provider Advisors providing expert advice over the phone and working closely with other urgent care providers in the area as part of the overall integrated urgent care system. The model for an IUC CAS requires access to urgent care via NHS 111, either on a free-to-call telephone number or online. The provider provides:

- Triage by a Health Advisor;
- Consultation with a clinician using a clinical decision support system or an agreed clinical protocol to complete the episode on the telephone where possible;
- Direct Appointment Booking post clinical assessment into a face-to-face provider where necessary;
- Self-help information delivered to the patient.

Inspected but not rated

Are services safe?

Safety systems and processes

The provider had clear systems to keep people safe and safeguarded from abuse.

- The provider conducted safety risk assessments. It had safety policies, including Control of Substances Hazardous to Health and Health & Safety policies, which were regularly reviewed and communicated to staff. Staff received safety information from the provider as part of their induction and refresher training. The provider had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance.
- The provider worked with other agencies to support patients and protect them from neglect and abuse, such as the local safeguarding team. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The provider carried out staff checks at the time of recruitment and on an ongoing basis where appropriate. Disclosure and Barring Provider (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- Staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed. There was a system in place for dealing with surges in demand.
- The provider had an action plan in place and had systems for work force planning to ensure that shift rotas matched the demand of the providers. However, staff told us there was difficulty securing clinical staff, in particular GPs on weekends. We saw that between the week commencing 12 July and 26 July 2021, the provider had increased GP hours from 80.28% covered to 88.9% for the service's funded hours. The provider also took steps to address staffing by recruiting 18 staff members, including 16 clinical staff, and had developed two new training centres.
- There was an effective induction system for temporary staff tailored to their role.
- Systems were in place to manage people who experienced long waits.
- Staff told patients when to seek further help. They advised patients what to do if their condition got worse.
- When there were changes to providers or staff the provider assessed and monitored the impact on safety.
- Complex calls had a criterion and a caveat that if a health advisor felt out of their depth, they could request a clinician take over management of the call.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The provider had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.

Track record on safety

Inspected but not rated

Are services safe?

The provider had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.
- The provider monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.
- There was a system for receiving and acting on safety alerts.
- Joint reviews of incidents were carried out with partner organisations, including the local A&E department, GP out-of-hours, and urgent care providers.

Lessons learned and improvements made

The provider learned and made improvements when things went wrong. However, there were areas where improvements should be made.

- There were adequate systems for reviewing and investigating when things went wrong. The provider learned and shared lessons, identified themes and took action to improve safety in the provider. We reviewed the learning from serious incidents. The reviews outlined the context, staff factors, contributory factors, good practice and actions undertaken. For example, following a call triage error, the provider introduced an organisational change which required clinical navigators to oversee all calls scheduled for a two hour call back. Additionally, the NHS Pathways training was updated to include the use of individual interpretation, with examples. However, two staff members told us that most information, including the learning from incidents, was forwarded via email, and they often did not have time to read all materials.
- The provider took part in end-to-end reviews with other organisations. Learning was used to make improvements to the service.
- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses.
- The provider learned from external safety events and patient safety alerts. The provider had an effective mechanism in place to disseminate alerts to all members of the team including sessional and agency staff.

Inspected but not rated

Are services effective?

Effective needs assessment, care and treatment

The provider had systems to keep clinicians up to date with current evidence-based practice. We saw evidence that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Clinical staff had access to guidelines from the National Institute for Health and Care Excellence (NICE) and used this information to help ensure that people's needs were met. The provider monitored that these guidelines were followed. These were available on the intranet system and were emailed to staff.
- Telephone assessments were carried out using a defined operating model. Staff were aware of the operating model which included the transferring of calls from call handler to clinician, and the use of a structured assessment tool.
- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. Where patients needs could not be met by the provider, staff redirected them to the appropriate provider for their needs.
- Care and treatment was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- We saw no evidence of discrimination when making care and treatment decisions.
- Arrangements were in place to deal with repeat patients, including engaging with the local NHS acute trust to share information, to identify, monitor and support patients who frequently called the NHS 111 provider and those who also frequently attended the hospital emergency department.
- There was a system in place to identify frequent callers and patients with particular needs, for example palliative care patients, and care plans and protocols were in place to provide the appropriate support.
- When staff were not able to make a direct appointment on behalf of the patient clear processes were in place. These were agreed with senior staff and clear explanation was given to the patient or person calling on their behalf.

Monitoring care and treatment

The provider had a comprehensive programme of quality improvement activity and routinely received the effectiveness and appropriateness of the care provided.

Providers of NHS 111 services are required to submit call data every month to NHS England by way of the Minimum Data Set (MDS). The MDS is used to show the efficiency and effectiveness of NHS 111 providers. We saw the most recent results for the provider (September 2020 – July 2021) which showed the provider was meeting the following national performance indicators:

- The KPI for patients with a life-threatening condition having an ambulance dispatched within three minutes of the call was 100%. The provider achieved between 98% and 100%.
- During July 2021, 27% of calls were closed as self-care, the target for this is 33%.
- During the period the provider exceeded the KPI target of 95%, for a post event message to be sent to a patient's GP practice by 8am the following day.

There were areas where the service was outside of the target range for an indicator. For example:

- The provider was consistently below target for referral and management of patients within the Clinical Assessment Service. The provider had developed categories of patients to be managed within a specific timeframe depending on their needs, this ranged from P1 to P6. Patients within the P1 category should be called back within 15 mins from them making the call. We saw that the site's performance was between 42% and 78% (KPI 95%).

Inspected but not rated

Are services effective?

The provider was aware of these areas and we saw evidence that attempts were being made to address them. We discussed the areas where the where the services were below some of the performance indicators and were informed that it had been acknowledged that the service model assumptions required further work and evaluation.

The provider was also generally meeting its locally agreed targets as set by its commissioner. For example:

- Calls abandoned after at least 30 seconds was achieved in nine out of eight months against target of <5%.
- The average time to answer a call was 0.4 seconds. The national target is that 95% of calls should be answered within 60 seconds. The provider met this target in October 2020 and February 2021 scoring 95%". In the remaining months, the provider's performance was between 72% and 90%.

Prior to the inspection we spoke with one of the commissioners whom informed us that 'call abandonment rate' (for which the provider was performing well) was the most important metric to demonstrate accessibility for patients.

- Where the provider was not meeting the target, the provider had put actions in place to improve performance in this area. For example, the provider carried out regular end-to-end reviews of KPIs and documented learning and action points which were disseminated to the wider team.
- There was clear evidence of action to resolve concerns and improve quality through clinical auditing. For example, we saw that in November 2021, the provider audited 100% of Senior Clinical Advisor (SCA) calls; it was found that 10% failed for reasons such as, not giving a patient the correct information about another service. In response, the provider covered the audit with all SCAs and gave individual feedback where necessary. The information was also passed to the local Governance Team to see if the trend was apparent elsewhere. A second audit was not undertaken fully due to lack of auditor capacity. However, the line manager of each SCA where the issue occurred was required to speak with the specific clinician.

Effective staffing

In the main, staff had the skills, knowledge and experience to carry out their roles.

- Although, there were clear clinical pathways and protocols it was unclear whether the provider had ensured they were fully understood by all staff. For example, we found that a member of staff was unaware that calls could be transferred to home working clinicians.
- Although staff had access to clinical support, a member of staff told us that clinical leadership was not always visible within the provider and at times they found it difficult to direct clinical staff without senior clinical leaders' support. We raised this with the provider and was told that clinical staff will be trained in the differential environment of 111 services.
- The provider understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. That said, we were told that staff who are trained to coach were not required to periodically take a certain amount of calls to maintain their competency.
- The provider had processes in place to provide staff with ongoing support. This included one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. The provider could demonstrate how it ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing. Although most staff informed us that they felt supported by senior staff, we saw one-to-one meetings were occasionally cancelled due to operational pressures on the provider.
- The provider had an induction programme for all newly appointed staff. This covered topics such as NHS Pathways, safeguarding and whistleblowing.
- The provider ensured that all staff worked within their scope of practice and had access to policies and procedures relevant to their role.

Inspected but not rated

Are services effective?

- There was a clear approach through the provider's quality audit programme, for supporting and managing staff when their performance was poor or variable. Measures included direct staff feedback, mentoring and supervision.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

Staff worked together, and worked well with other organisations to deliver effective care and treatment.

- Staff told us of issues with the Directory of Services (DoS) which hindered their ability to refer patients to local providers. We spoke with senior leaders concerning this and were told that such concerns should be escalated through the incident reporting system, after which the concerns would be escalated to the Clinical Commissioning Group for action because they have overarching responsibility for maintaining the integrity of the DoS. This issue was also identified during the inspection in September 2019.
- There were clear arrangements for booking appointments, transfers to other providers, and dispatching ambulances for people that require them. However, staff told us these arrangements were not always effective due to the volume of patients requiring appointments, particularly for primary medical providers. For example, in December 2021, 9.6% of calls were booked at a GP out-of-hours base, this was a decline from the previous month when it was 11%. Although, the service can do direct bookings into GP practices, we were told, that GP out-of-hours slots get filled quickly, which results in, patients remaining within the service's Clinical Assessment Service (CAS) queue.
- The percentage of calls transferred to the CAS is targeted at over 50% in year one and the provider maintained this level throughout the period reviewed. At our last inspection in September 2019, there were over 20,000 calls each month being transferred to the CAS, then called back according to priority. During this inspection, we saw the number had increased to an average of over 33,000 calls.
- We saw records that showed that all appropriate staff, including those in different teams, providers and organisations, were involved in assessing, planning and delivering care and treatment.
- Staff worked together and worked well with other organisations to deliver effective care and treatment. For example, there was regular liaison with care homes and mental health providers.
- Patients received coordinated and person-centred care. This included when they moved between providers, when they were referred, or after they were discharged from hospital. Care and treatment for patients in vulnerable circumstances was coordinated with other providers. Staff communicated promptly with patients' registered GPs so that the GP was aware of the need for further action. There were established pathways for staff to follow to ensure callers were referred to other providers for support as required.
- Patient information was shared appropriately, and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way.

Helping patients to live healthier lives

Staff were consistent and proactive in empowering patients, and supporting them to manage their own health and maximise their independence.

- The provider identified patients who may be in need of extra support, for example, through alerts on the computer system.
- Where appropriate, staff gave people advice so they could self-care. Systems were available to facilitate this.
- Where patients needs could not be met by the provider, staff redirected them to the appropriate provider for their needs.

Consent to care and treatment

The provider obtained consent to care and treatment in line with legislation and guidance.

Inspected but not rated

Are services effective?

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The provider monitored the process for seeking consent appropriately.

Inspected but not rated

Are services caring?

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- The provider gave patients timely support and information. Call handlers gave people who phoned in clear information. There were arrangements and systems in place to support staff to respond to people with specific health care needs such as end of life care and those who had mental health needs including training, awareness seminars and Bulletins.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given):

- Interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas, including in languages other than English, informing patients this provider was available. Patients were also told about multi-lingual staff who might be able to support them. Information leaflets were available in easy read formats, to help patients be involved in decisions about their care.
- For patients with learning disabilities or complex social needs family, carers or social workers were appropriately involved.
- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy providers. They helped them ask questions about their care and treatment.

Results from the provider's last three-month patient survey showed that:

- 96% of patients said they would recommend the provider to friends and family.
- 66% of patients said they found the provider very helpful.
- 45% of patients confirmed that they felt better a week later after receiving care from the 111 Clinical Assessment Service. Thirty percent of patients confirmed they felt completely better after a week.

Privacy and dignity

The provider respected and promoted patients' privacy and dignity.

- Staff respected confidentiality at all times.
- Staff understood the requirements of legislation and guidance when considering consent and decision making.
- Staff supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.

Inspected but not rated

Are services responsive to people's needs?

The provider organised and delivered providers to meet patients' needs. It took account of patient needs and preferences.

- The provider understood the needs of its population and tailored providers in response to those needs by providing access to local and regional out of hours bases.The provider engaged with commissioners to secure improvements to providers where these were identified.
- The provider had weekly contract meetings with the commissioner to discuss performance issues and where improvements could be made.
- The provider had a system in place that alerted staff to any specific safety or clinical needs of a person using the provider. For example, there were alerts about people being on the end of life pathway and repeat callers. Care pathways were appropriate for patients with specific needs, for example those at the end of their life, babies, children and young people.
- The facilities and premises were appropriate for the providers delivered.
- The provider had regular end-to-end reviews with commissioners and other providers have increased the understanding of an IUC, wider system working and to improve patient care.
- In response to the COVID-19 pandemic, the provider changed it's working pattern to manage demand and arranged for some staff members to work from home with the required IT equipment.

Timely access to the provider

In the main, patients were able to access care and treatment from the provider within an appropriate timescale for their needs.

- Patients were able to access care and treatment at a time to suit them. The provider operated 24 hours for seven days a week.
- The abandoned call rate was between 0.1% and 8.5% (in January 2021), the national target and commissioner key performance indicator (KPI 5% or less).The January 2021 results were an improvement on our finding at the last inspection in September 2019, when it was between 0.9% and 6.1%,
- Patients could access care and treatment at a time to suit them. The NHS 111 providers operated 24 hours a day.
- The provider can be accessed by patients via the telephone and electronically.
- The provider was aware of the areas where the providers were not meeting targets and we saw evidence that attempts had been made to address them through close working with their commissioners. Measures included advanced monitoring and reporting of performance data, recruitment of staff and increased use of call handling networking capabilities across the provider's network. For example, transferring calls between different 111 providers if the other location had more capacity.
- Patients with the most urgent needs had their care and treatment prioritised.

Listening and learning from concerns and complaints

The provider took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. Eighty four complaints were received in the last year. We reviewed ten complaints and found that they were satisfactorily handled in a timely way.
- Issues were investigated across relevant providers, and staff were able to feedback to other parts of the patient pathway where relevant.

Inspected but not rated

Are services responsive to people's needs?

- The provider learned lessons from individual concerns and complaints and also from analysis of trends. They acted as a result to improve the quality of care. We saw learning

from complaints and other patient feedback being shared through the provider's internal bulletin, in developing staff training packages, and through management of staff performance. However, two members of staff told us information was mainly communicated via email and there was limited time to view it. In addition, due to staffing pressures and an increase in calls to the provider, there had been a reduction in staff meetings where learning could be shared.

Results from the provider's 2020 staff survey showed (the results are based on cross-directorate and wider London Ambulance Provider comparison):

- 'Team members often meet to discuss the team's effectiveness' 23% overall.
- 'Satisfied with recognition for good work' 37% overall.
- 'Able to make improvements happen in my area of work' 31% overall.
- 'My last experience of harassment/ bullying/ abuse was reported' 37% overall.

Additional staff survey findings (most improved scores versus 2019 results):

- 'I know how to report unsafe clinical practice' +30%.
- 'Enough staff at organisation to do my job properly' +20%.
- 'I have realistic time pressures' +15%.
- 'In last 3 months, have not come to work when not feeling well enough to perform duties' +15%.
- 'I am not planning on leaving this organisation' +15%.

Following the staff survey, the provider's Trust People & Culture team introduced workshops open to all staff to generate a culture that works for the whole organisation and people can share ideas.

Inspected but not rated

Are services well-led?

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders had the experience, capacity and skills to deliver the provider strategy and address risks to it.
- Since the last inspection in September 2019, the provider increased senior leaders' numbers to improve service resilience.
- They were knowledgeable about issues and priorities relating to the quality and future of providers. They understood the challenges and were addressing them with commissioners. For example, the provider was aware of the contradictory position of 111 services being able to transfer calls into a 999 service, but 999 services not being able to transfer to a 111 service. As a result, they were involved in initiatives around 999 and 111 services' telephone platforms to make it easier to move calls around the system.
- Senior management was accessible throughout the operational period, with an effective on-call system that staff were able to use.
- The provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the provider.

Vision and strategy

The provider had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- There was a clear vision and set of values. The provider had a realistic strategy and supporting business plans to achieve priorities.
- The strategy was in line with health and social priorities across the region. The provider planned the provider to meet the needs of the local population.
- The provider monitored progress against delivery of the strategy.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The provider ensured that staff who worked away from the main base felt engaged in the delivery of the provider's vision and values.

Culture

Although the provider had a culture of high-quality sustainable care it was impacted by low staffing levels.

- Most staff told us that they felt respected, supported and valued. One member of staff said they did not feel listened, another mentioned that senior leaders do not have time to invest in staff due to the increasing demand on the provider.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. However, additional work was needed to ensure staff read information related to learning from incidents.
- The provider focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so.
- Staff had received equality and diversity training. Staff felt they were treated equally. The provider introduced Equality and Diversity workshps for all staff.
- The service had a wellbeing advocate who met with staff on a monthly basis and welfare checks were carried out every seven days by the duty manager.
- There were positive relationships between staff and teams.

Governance arrangements

Inspected but not rated

Are services well-led?

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared providers promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.
- Leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

- There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The provider had processes to manage current and future performance of the provider. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Leaders had oversight of MHRA alerts, incidents, and complaints. Leaders also had a good understanding of provider performance against the national and local key performance indicators. Performance was regularly discussed at senior management and board level. Performance was shared with staff and the local CCG as part of contract monitoring arrangements.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to resolve concerns and improve quality.
- The providers had plans in place and had trained staff for major incidents.
- The provider implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care. For example, the provider introduced a low acuity queue to take pressure off clinicians when the Clinical Assessment Service queue was over-flowing.
- The provider had plans in place and had trained staff for major incidents.

Appropriate and accurate information

The provider acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The provider used performance information which was reported and monitored, and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The provider used information technology systems to monitor and improve the quality of care.
- The provider submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The provider involved patients, the public, staff and external partners to support high-quality sustainable providers.

Inspected but not rated

Are services well-led?

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape providers and culture. The provider in conjunction with the out-of-hours providers in the area met regularly with the CCGs for which it had responsibility and shared information with them as relevant.
- Staff were able to describe to us the systems in place to give feedback, such as through feedback forms, staff surveys and verbal feedback through internal meetings and service delivery managers.
- Staff who worked remotely were engaged and able to provide feedback. We were told that remote workers were contacted up to three times a day to check on their wellbeing and discuss work priorities.
- The provider was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- The provider made use of weekly reviews of incidents and complaints. Learning was shared and used to make improvements. Although, there were areas for improvement in relation to ensuring the information was viewed by all staff.
- Staff knew about improvement methods and had the skills to use them.
- The provider made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.
- There was a strong culture of innovation evidenced by the number of pilot schemes the provider was involved in. For example, the provider introduced a resilience partnership with two other 111 providers outside of London to support demand. There were systems to support improvement and innovation work.