London Ambulance Service NHS Trust

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

The London Ambulance Service NHS Trust (LAS) is one of 10 ambulance trusts in England providing emergency medical services to the whole of Greater London, which has a population of around 8.6 million people. The trust employs around 4,251 whole time equivalent (WTE) staff who are based at ambulance stations and support offices across London.

The main role of LAS is to respond to emergency 999 calls, 24 hours a day, 365 days a year. 999 calls are received by the emergency operation centres (EOC), where clinical advice is provided and emergency vehicles are dispatched if required. Other services provided by LAS include patient transport services (PTS) for non-emergency patients between community provider locations or their home address; NHS 111 non-emergency number for urgent medical help and/or advice which is not life-threatening; and resilience services which includes the Hazardous Area Response Team (HART).

Our announced inspection of LAS took place between 1 to 5 and 17 and 18 June 2015 with unannounced inspections on 12, 17 and 19 June 2015. We carried out this inspection as part of the CQC's comprehensive inspection programme.

We inspected four core services:

- Emergency Operations Centres
- Urgent and Emergency Care
- Patient Transport Services
- Resilience planning including the Hazardous Area Response Team:

We did not inspect the NHS 111 service provision during this inspection.

Overall, the trust was rated as Inadequate. Caring was rated as Good. Effective, and responsive were rated as Requires improvement. Safe and Well-led was rated as Inadequate.

Our key findings were as follows:

- The trust was making efforts to recover from a decline in performance which had worsened in late 2014. At the time of our inspection the interim chief executive was appointed substantively to the post. This was seen as a positive move by many front line staff to assist stability. There had been two previous chief executives in post or appointed since 2012.
- The trust was operating with a shortage of trained paramedics in the light of a national shortage and due to paramedics leaving its service for a number of reasons including better pay elsewhere. It had conducted recruitment of paramedics from as far afield as Australia and New Zealand to combat this.
- We had significant concerns about a reported culture of bullying and harassment in parts of the trust. The trust had commissioned an independent report into this which it had received in November 2014. However this was only presented to the trust board in June 2015.
- We had similar concerns about the trust's provision and use of HART paramedics and the trust's ability to meet the requirements of the National Ambulance Resilience Unit (NARU).
- The trust had been facing increased contractual competition for its patient transport services (PTS) leading to a diminishing workload. It was trialling a new non-emergency transport service (NET) which had begun in September 2014.
- During our inspection we found staff to be highly dedicated to and proud of the important work they were undertaking.At the same time they were open and honest about the challenges they were facing daily.They were largely supportive of their immediate managers but found some senior managers and executives and board members to be remote and lacking an understanding of the issues they were experiencing.

We saw several areas of good practice including:

- The trust's intelligence conveyancing system to help prevent overload of ambulances at any particular hospital emergency department.
- Good levels of clinical advice provided to frontline staff from the trust's clinical hub.
- We observed staff to be caring and compassionate often in very difficult and distressing circumstances.

Summary of findings

- The percentage of cardiac patients receiving primary angioplasty was 95.8% against an England average of 80.7%
- Good multi-disciplinary working with other providers at trust and frontline staff levels.

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

Importantly, the trust must:

- develop and implement a detailed and sustained action plan to tackle bullying and harassment and a perceived culture of fear in some parts.
- recruit sufficient frontline paramedic and other staff to meet patient safety and operational standards requirements.
- recruit to the required level of HART paramedics to meet its requirements under the National Ambulance Resilience Unit (NARU) specification.
- improve its medicines management including:
- formally appoint and name a board director responsible for overseeing medication errors and formally appoint a medication safety officer.
- review the system of code access arrangements for medicine packs to improve security.
- set up a system of checks and audit to ensure medicines removed from paramedic drug packs have been administered to patients.
- set up control systems for the issue and safekeeping of medical gas cylinders.
- improve the system of governance and risk management to ensure that all risks are reported, understood, updated and cleared regularly.
- address under reporting of incidents including the perceived pressure in some departments not to report incidents.

In addition the trust should:

- review and improve trust incident reporting data.
- ensure all staff understand and can explain what situations need to be reported as safeguarding.
- review the use of PGDs to support safe and consistent medicines use.
- improve equipment checks on vehicles and ensure all equipment checks are up to date on specific equipment such as oxygen cylinders.
- ensure sufficient time for vehicle crews to undertake their daily vehicle checks.
- ensure consistent standards of cleanliness of vehicles and instigate vehicle cleanliness audits.
- set up learning to ensure all staff understand Duty of Candour and their responsibilities under it.
- ensure adequate and ready provision of protective clothing for all ambulance crews.
- ensure equal provision of ambulance equipment across shifts.
- improve the blanket exchange system pan London to prevent re-use of blankets before cleaning.
- ensure full compliance with bare below the elbow requirements.
- review and improve ambulance station cleaning to ensure full infection, prevention and control in the buildings and in equipment used to daily clean ambulances.
- set up a system of regular clinical supervision for paramedic and other clinical staff.
- ensure all staff have sufficient opportunity to complete their mandatory training, including personal alerts and control record system.
- increase training to address gaps identified in the overall skill, training and competence of HART paramedics.
- review staff rotas to include time for meal breaks, and administrative time for example for incident reporting.
- review patient handover recording systems to be more time efficient.
- provide NICE cognitive assessment training for frontline ambulance staff.
- improve training for staff on Mental Capacity Act assessment.
- ensure all staff receive annual appraisals.
- review development opportunities for staff.
- improve access to computers at ambulance stations to facilitate e-learning and learning from incidents.
- review maintenance of ambulances to ensure all are fully operational including heating etc.
- review arrangements in the event of ambulances becoming faulty at weekends.
- review and improve patient waiting times for PTS patients.
- ensure PTS booking procedures account for the needs of palliative care patients.
- develop operational plans to respond to the growing bariatric population in London.

Summary of findings

- review operational guidelines for managing patients with mental health issues and communicate these to staff.
- ensure better public and staff communication on how to make a complaint including provision of information in emergency and non emergency ambulances.
- communicate clearly to all staff the trust's vision and strategy.
- develop a long term strategy for the (Emergency Operations Centres (EOCs).
- increase the visibility and day to day involvement of the trust executive team and board across all departments.
- review trust equality and diversity and equality of opportunity policies and practice to address perceptions of discrimination and lack of advancement made by trust ethnic minority staff and staff on family friendly rotas.
- review the capacity and capability of the trust risk and safety team to address the backlog of incidents and to improve incident reporting, investigation, learning and feedback the trust and to frontline staff.

The above list is not exhaustive and the trust should study our reports in full to identify and examine all other areas where it can make improvements.

On the basis of this inspection I have recommended that the trust be placed in special measures.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Background to London Ambulance Service NHS Trust

London Ambulance Service NHS Trust (LAS), was established in 1965 from nine previously existing services. It became an NHS Trust on 1 April 1996 and covers the capital city of the United Kingdom, which has a population of around 8.6 million people. The trust employs around 4,251 WTE staff.

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

The trust covers the most ethnically diverse population in the country. In the 2011 population census, the three main ethnic groups were: White (59.79%), Asian or Asian British (18.49%) and Black or Black British (13.32%).

Life expectancy at birth for both males and females in London is greater (better) than that for England. However, life expectancy at birth for males in London is lower (worse) than that for females. Life expectancy at birth for females in London is the highest in the country.

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

Our inspection team

Our inspection team was led by:

Chair: Dr Andrew Welch

Head of Hospital Inspections (Interim): Robert Throw, Care Quality Commission

London Ambulance Service was visited by a team of 54 people including CQC inspectors, inspection managers, national professional advisor, pharmacist inspector, inspection planners and a variety of specialists. The team of specialists comprised of paramedics, urgent care practitioners, operational managers and call handlers.

How we carried out this inspection

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

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

The inspection team inspected the following:

- Emergency Operations Centres
- Urgent and Emergency Care
- Patient Transport Services
- Resilience Team including the Hazardous Area Response Team

Prior to the announced inspection, we reviewed a range of information that we held and asked other organisations to share what they knew about the trust. These included the clinical commissioning groups (CCGs), the Trust Development Authority, NHS England, and the local Healthwatches.

Summary of findings

We held interviews, focus groups and drop-in sessions with a range of staff in the service and spoke with staff individually as requested. We talked with staff from acute hospitals who used the service provided by the trust. We spoke with patients and observed how they were being cared for. We also talked with carers and/or family members and reviewed patients' treatment records.

We carried out the announced inspection visit between 1 to 5 and 17 and 18 June 2015 with unannounced inspections on 12 and 19 June 2015.

What people who use the trust's services say

Hear and Treat survey

LAS performed similar to other ambulance trusts in all questions in the ambulance 'Hear and Treat' survey.

Patients' Forum

There is an independent patients' forum which works proactively to monitor all aspects of service provided by the trust. Amongst its focus are issues around equal access to services, clinical partnerships with other providers, access to training for paramedics, additional use of 111 services, services for people with mental health issues, services for people with dementia, standards of PTS services, emergency response times, Duty of Candour, category C call performance and dealing with patient falls.

Local Healthwatch

Several locations contacted us across London and the majority of responses were favourable about user experience although concerns were raised in relation to response and waiting times.

Patients' views during the inspection

During the inspection, we spoke with a number of patients across all services. Patients also contacted CQC by telephone and wrote to us before and during our inspection. The comments we received were mainly positive about their experiences of care. The main concerns raised with us were in relation to delays in transport for patients using PTS.

Facts and data about this trust

The London Ambulance Service (LAS) is one of 10 ambulance trusts in England providing emergency medical services to the whole of Greater London. It employs up to 4251 WTE staff who are based at ambulance stations and support offices across London.

Their main role is to respond to emergency 999 calls, 24 hours a day, 365 days a year. Other services they offer include providing pre-arranged patient transport and finding hospital beds.

LAS works closely with other emergency services including the police and the fire services to provide emergency services during major events and in response of any major incidents.

The trust serves entire population Greater London.

Activity:

- The emergency and urgent care service made over 1.4 million vehicle responses to incidents in 2014-15
- The EOC received around 1.9 million 999 calls which averages 5,193 calls per day, in 2014-15
- The PTS made around 115,468 journeys transporting patients across London, in 2014-15

Staff (WTE December 2014): 4251

– 2864 Qualified ambulance service staff

– 1287 Support to clinical staff

– 86 NHS infrastructure support

– 14 Qualified nursing, midwifery & health visiting staff

• **Locations:** 86

• **Financial Performance**

• Fiscal Year 2014/2015

Summary of findings

• Income **£301,874,000**

• Full Costs **£300,874,000**

• Surplus **£1,000,000**

Currently the LAS Operations Directorate is being transformed in a formal reorganisation.

Three geographical areas and the other elements in Operations have been made into four Operational Divisions, each managed by a Deputy Director of Operations.

North and South Divisions deliver the operational core response across the LAS operational area.

Central Operations is a pan London division responsible for Emergency Planning Resilience and Response Department, Cycle and Motor Cycle response units as well as operationally responding managers. Control Services Division also provides the Emergency Operations Centre across London and 111 Call Centre function at Beckenham.

The trust has a total of 70 ambulance stations across London which, for management purposes, currently sits within 26 local operational areas, known as complexes.

Overall performance indicators:

Safe:

95% of 557 incidents reported to NRLS between Jan 2013 and Feb 2015 are reported as 'Low' or 'No' harm.

• There were 26 incidents reported as 'Moderate' harm.

Effective:

LAS performed better than the England average with ROSC overall and Utstein Comparator Group although this has recently dropped below the England average.

• LAS performed best amongst ambulance trusts in England for the provision of Primary Angioplasty within 150 minutes.

• LAS performed similar to other ambulance trusts in all other Clinical Indicators.

Caring:

LAS performed similar to other ambulance trusts in all questions in the ambulance 'Hear and Treat' survey.

• The number of written complaints received by LAS has increased every year and has doubled over the last five years.

Responsive:

LAS performed much better than the England average and best amongst ambulance trusts in England for call abandonment.

• LAS had the best (lowest) re-contact rate with 24 hours for patients discharged from care by phone.

• LAS performed much better than the England average and best amongst ambulance trusts in England for emergency calls resolved by telephone advice

• LAS performed better than most trusts in the time taken to answer calls.

- LAS has a slightly higher frequent caller rate than the England average.

• LAS slightly worse than the England average for incidents managed without the need to transport to an A&E Dept.

• LAS performed similar or slightly worse than other trusts in time to treatment of Category A calls.

- LAS is the worst performing ambulance trust for getting to Category A calls within eight minutes and has failed to reach the 75% target since May 2014.

• LAS has also failed to reach the 95% target for Category A calls reached within 19 minutes since May 2014 and is worse than the England average.

• LAS had the worst (highest) re-contact rate with 24 hours for patients following treatment and discharge at the scene.

Well led:

- LAS staff sickness rate has risen above the England average since May 2014 and has continued to rise.

• The 2014 staff results show 29 negative findings with only one positive and one neutral.

- The trust has had more than two changes in chief executive in recent years. At the time of our inspection its interim chief executive was appointed to the post substantively.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? There were limited measures and monitoring of safety performance. A culture of under-reporting of incidents was evident. There was little evidence of learning from incidents or actions taken to improve safety. LAS was affected by a national shortage of paramedics which resulted in a high number of vacancies. Levels of staff participation in the mandatory training were inconsistent. Training was affected by operational pressures and scheduled training was at times cancelled to a due low number of attendees. Equipment and vehicle checks were not always regularly carried out. We saw no systems, checks or regular audits in place to ensure medicines removed from paramedic or general drug packs had been administered to patients. **Incidents** The reporting, investigation, learning and feedback of incidents across the trust were inconsistent. The trust did not have good quality incident data. Reporting of incidents by front line staff was paper based and there were often delays in the paper forms reaching the trust safety and risk management team. The safety and risk management team had a backlog of incidents to input into Datix. We found that there was an under reporting of incidents across the trust. The safety and risk management team could not be assured that there was consistent and accurate reporting by all members of staff. Several frontline staff told us they under reported incidents due to the lack of time to complete the forms during their shifts. Some staff were clear that incident reporting should also include near misses and non-harm related incidents; but this was not consistent. Staff did not identify with learning from incidents, such as changes to practice, equipment or policy, because they were not presented as being as a direct result of an incident. Most staff told us there was little learning from incidents. It mainly required staff to have access to a computer. However, there were few computers at ambulance stations. However PTS staff told us the learning from incidents and near misses was communicated during monthly “Team talk” meetings and via the “PTS directorate bulletin” which was circulated on an ad hoc basis.	**Inadequate** 

Summary of findings

We did find several examples where changes had been made as a result of repeat adverse events.

We found that when we questioned frontline staff about the principles of the 'Duty of Candour', this was not well understood by them.

There was a major incident plan to ensure that the trust was capable of responding to major incidents of any scale in a way that delivered optimum care and assistance to the victims. The plan was prepared in light of guidance from the Department of Health, Home Office and Civil Contingencies Act 2004.

Mandatory training

Staff completion of mandatory training was variable across the trust. In frontline emergency and urgent care we were told training had effectively stopped in recent years due to operational pressures. Many staff reported not having received mandatory training for a number of years.

Staff were paid for 24 hours (three days) per year to undertake mandatory training. This was paid at the beginning of the financial year. If staff did not complete the training, they were 'challenged' by their managers and either had the days deducted from their pay or worked extra days to cover the payment. In these circumstances the mandatory training was not completed.

Levels of mandatory training in PTS and in the emergency operation centres were higher though not reaching the trust target of 100%. Records provided by the trust indicated that 83% of EOC staff completed mandatory training in 2013/2014 and 41% in 2014/2015. We saw an internal PTS computerised spreadsheet which showed a wide range of training was provided. The recorded dates of staff training were largely within the past year.

Safeguarding

Front line emergency and urgent care staff had a good understanding of what safeguarding concerns might be and all were clear about the process for reporting concerns. However, most of the staff we spoke with had not undertaken any form of safeguarding training but felt they could benefit from undertaking such training

Awareness of safeguarding processes and procedures was variable among PTS staff; some were able to describe what would constitute a safeguarding concern and provide examples, whereas other staff were unfamiliar with the term and what they would do if they were worried about a patient they were transporting.

Summary of findings

Appropriate cases were referred to the safeguarding authorities in documents we looked at. Emergency Operations Centre staff did not routinely discuss safeguarding referrals to share learning and increase awareness and patients' safety.

Cleanliness, infection control and hygiene

We found variable standards of cleanliness, infection control and hygiene across the areas visited. Some frontline staff confirmed they had not been trained on infection control. In addition, LAS stipulated that staff should receive annual refresher training on infection control. However some staff had not attended this training for over four years.

Allowing for the fact that ambulances are in repeated use and out in all weathers there was inconsistency in the cleanliness of the ambulances we viewed. We found some were visibly clean, whilst others were not.

We saw most staff wearing gloves during patient contact. However we did not observe staff using disposable plastic aprons when appropriate when attending to patients.

Cleaning of vehicle equipment after use was variable; we observed some staff cleaning equipment thoroughly, whereas others returned equipment to the vehicle after using it with a patient without cleaning it.

We found most ambulance stations we inspected not to be clean. Some were contaminated with black dust. This dust covered boxes which contained medical supplies. In some stations the cupboards where sterile supplies were kept were not closed nor locked.

There was no infection control policy but information about infection control was available to staff via the trust's intranet 'The Pulse'. There was also an infection control handbook given to each member of staff. There were up to date protocols which advised staff on special measures and how to respond to certain high risk infectious diseases and there was a process in place for call handlers to alert ambulance crews to specific patient infection risks.

Environment and equipment

Provision of equipment on ambulances appeared not to be evenly spread in some cases. For example vehicles on early shift were fully stocked but late shift crews sometimes found themselves short of equipment. This sometimes delayed or prevented vehicles going out or crews had to make a decision to go out not fully stocked. LAS had a policy that a paediatric advanced life support (PALS) pack should be carried on all response vehicles. However, we found some ambulances did not have these in place.

Some staff reported a lack of blankets, pillows, finger probes for pulse oximeters (to measure oxygen in blood) and ECG leads (to measure heart rhythm). However, others told that there were enough supplies at the central store of each station and that the supply of consumables was said to have improved in recent months.

Defibrillators were available on all PTS vehicles. Emergency ambulance crews told us they would not start work without them.

The trust used a flexi-fleet system, where vehicles were used service wide, and no individual station had control of any vehicle. With flexi-fleet, there was no personal accountability for vehicles therefore it was difficult to ascertain how and when damage to a vehicle or equipment may have occurred.

Restocking of ambulances, other than the 24 hour ambulances, was carried out by external contractors; however staff told us the thoroughness of this was variable. We were told that if there was a problem with an ambulance at weekends, there was no one to report it to or to fix the vehicle.

Call handling staff working at the Waterloo EOC complained that the environment they worked in was very dark. They felt it was not suitable for long shifts. The room had very limited day light and was located on a lower ground floor. Both EOCs had suitable staff welfare facilities.

Medicines

The trust followed the NHS Protect guidance; security standards and guidance for the management and control of controlled drugs in the ambulance sector.

Paramedic staff were administering medicines under the legal group authority that entitles paramedics to administer some prescription only medicines without a prescription. However the authority to administer some medicines that were used was less clear. Subsequent to our inspection the trust undertook to review these arrangements and ascertain if a PGD (a written instruction for the administration of medicines to a group of patients who may not be individually identified before presentation for treatment) may be needed for some of these circumstances.

The trust had no systems, checks or regular audits in place to check that medicines removed from paramedic or general drugs pack had been given to patients, this included oral morphine solution and diazepam injection.

At the time of our inspection the trust did not have identified a board level director to have responsibility to oversee medication

error incident reporting. It also did not have a formally appointed Medication Safety Officer. The MSO role had been informally delegated to the chair of the medicines management committee, until a permanent arrangement was in place.

The trust was not following the NHS protect guidance on the requisition, distribution, security and storage of medical gas cylinders and medical gas stock.

Records

Completed patient record forms (PRFs) were transferred for safe storage at ambulance stations. However we did find some examples across the trust where patient record forms were in unsecured vehicles.

There was no effective system for auditing records and most staff we spoke with were not aware of any patient records audit being undertaken by the service.

Patient handover records at hospital A and E were paper based, time consuming and often involved some duplication. Although there were electronic systems available the trust viewed these as not economically viable.

The trust used 'special notes' about patients to share with ambulance crews. These detailed clinical information for patients with complex needs or risk information if there was a safety concern. We observed these were not easily accessible through the MPDS data system used. Staff told us ambulance crews on occasion complained as they could not access documents directly from their mobile data terminals and needed to be instructed over the telephone.

Assessing and responding to patient risk

The trust had a clear pathway for ambulance crews to follow when responding to life threatening conditions, emergency or responding to non-life threatening conditions. There were processes in place for transporting bariatric patients.

Ambulance crews were alerted by the control centre if a patient they were transporting had a Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR) order in place. Crews told us they would also confirm upon arriving to collect a patient whether or not the patient was for resuscitation.

The medical priority dispatch system (MPDS) was used by call handlers to make decisions related to dispatch appropriate aid to

medical emergencies, it allowed for systematised caller interrogation and pre-arrival instructions. The Manchester Triage System (MTS) supported decisions made by clinicians working in the 'clinical hub'.

The dynamic risk assessment framework (DRAM) required all PTS and NET staff to complete a visual assessment of mobility and frailty as well as other patient risks when arriving to collect a patient. This was a situational assessment prior to moving the patient which involved assessing the surroundings, such as property access difficulties, like the presence of clutter or the size of doorways.

Staffing

London Ambulance Service was affected by a national shortage of paramedics which resulted in a high number of vacancies. This led to the recruitment of paramedics from Australia and New Zealand over the past six months.

We were told by all the ambulance crew members we spoke with that there were insufficient numbers of appropriately trained staff with the necessary skills mix to ensure that patients were safe and received the right level of care. Typically during our inspection of 280 ambulances scheduled to be operational only 234 were operational due to staff shortages.

The trust had problems with staff retention due to pressure of work with increased responsibility and a lack of opportunity for career progression. Most of the paramedic staff we spoke with said they were still being paid on a band five (5), whereas some counterparts elsewhere in the country were being paid at band six (6) for an equivalent job.

Average staff turnover rates within the emergency operation centre department were high at 15% in 2014/ 2015. The highest turnover was reported among emergency medical dispatcher level 1 staff (EMD) at 28%, and nursing staff at 41%. The lowest turnover was among EMD allocators (5%), managers (7%), and sector controllers (6%).

Serious concerns were identified about how the trust had been fulfilling their responsibilities to deliver a HART capability to the NARU specification. Team members told us that they did not meet this specification. Managers also told us they struggled to meet this specification, but that HART staffing was "risk assessed" and always "capable". However, our examination and initial analysis of rotas for May 2015, led us to believe that the trust was not always able to fully provide this function.

Major incident awareness and training

Summary of findings

Major incident protocols, although following requirements of the Civil Contingencies Act, were not up to date. The document stated that it was to be reviewed at least annually by the department for emergency preparedness, resilience and response. However, it had not been amended since July 2012. There was a tiered structure of command to be implemented according to the severity of an incident.

Some staff we spoke with were aware of the LAS major incident procedures and how such incidents were escalated to the incident command centre. However, other staff we spoke with were unaware of the major incident procedures and most ambulance crews had not been trained in major incident procedures apart from rehearsals for the London Olympics in 2012.

Are services at this trust effective?

Requires improvement 

LAS performed better for EOC call abandonment than the England average and was best amongst ambulance trusts in England. The EOC performed better than all ambulance trusts in the time taken to answer calls.

The proportion of emergency calls resolved by telephone advice was much better than for any other ambulance trust in England.

There was good coordination with other providers allowing for better patient experience.

Clear patient eligibility criteria were in place and key performance indictors (KPI) were identified for each PTS contract. PTS achieved slightly below the KPI target of 95% throughout 2014/15.

PTS crews received regular teaching sessions delivered by work based trainers. However for emergency and urgent care ambulance staff this was inhibited by lack of time to undertake the training as there was no in-built training session during a shift. Staff had access to information via the personal digital assistant on each vehicle and could access trust policies and procedures via the trust internet.

The LAS followed both National Institute for Health and Care Excellence (NICE) and Joint Royal Colleges Ambulance Liaison Committee (JRCALC) clinical practice guidelines. The service had effective relationships with the emergency department and other wards at acute hospitals where they conveyed patients to and from those facilities.

However, London Ambulance response times for Red 1 and Red 2 category A calls was one of the worst in the country. Since May 2014 there had been a significant decline in the number of Category A calls attended within the target time of eight minutes.

Summary of findings

Evidence-based care and treatment

NICE guidelines were circulated to staff through electronic bulletins, clinical updates and directives and staff bulletins. Training rooms and e-learning facilities were available at some stations, where training aids were available and ready for use across the patch and to support the development of JRCALC and NICE guidance.

The trust had specific contracts in place with various organisations within London. Each agreement outlined certain eligibility criteria for using PTS, based on national guidelines for the non-emergency transportation of patients.

Procedures for the dispatch of resources by the EOCs were up to date and informed by relevant guidance.

Assessment and planning of care

The trust followed medical protocols in assessing patients and planning their care. It used a variety of care pathways, in line with what was agreed with different local clinical commissioning groups (CCGs).

Standards and expectations of the PTS service were stipulated in service level agreements.

All calls to the EOCs were categorised in line with the national guidance. For example Red1 calls which required response within eight minutes (classified as immediately life threatening).

Response times

The trust was consistently the best performing region in the country for category A calls until March 2014. However since then there had been a substantial decline in performance and the target time had not been met in the required percentage of calls. EOC staff were frequently unable to dispatch crews due to lack of availability of paramedics and general staff shortages.

The trust performed better than all ambulance trusts in the time taken for EOC to answer calls with 50% of all calls being answered in less than one second and 95% in less than two seconds. 99% of calls answered below 37 seconds which was slightly better than the England average of 48 seconds.

Patient outcomes

The trust achieved 31.6% for return of spontaneous circulation (ROSC) at the time of arrival at hospital following cardiac arrest (April 2013 to November 2014), which was better than the England average of 27.5%.

Summary of findings

The trust had the highest proportion of cardiac patients receiving primary angioplasty within 150 minutes (April 2013 to November 2014). They achieved 95.8%, which was better than the England average of 80.7% and was the best performing ambulance trust. However, in relation to the number of patients who achieved an appropriate care bundle for angioplasty, LAS achieved 72.6%, which was worse than the England average of 80.7%, and was the worst performing ambulance trust nationally.

The proportion of stroke patients receiving thrombolysis within 60 minutes by LAS (April 2013 to November 2014) was 60.1%. This was just below the England average of 60.6%.

The proportion of emergency calls resolved by telephone advice was much better than for any other ambulance trust from April 2014 to February 2015 (13.3%). The trust performed better than the England average (8%).

The trust had the lowest telephone re-contact rate of patients within 24 hours after discharge of care, at 2% (England average 7.8%).

Competent Staff

Most frontline staff we spoke with had not received an appraisal in the last three years. This was due to operational pressures and staff shortages which did not allow for staff to be taken off the road for their appraisals. There was a mixed view from staff on the effectiveness of appraisals.

All the ambulance crews we spoke with were registered with the Health Professional Council and therefore had received appropriate clinical supervision for their revalidation requirement. The trust used the clinical hub desk (CHUB) to train senior paramedics.

Many staff expressed a lack of confidence working within the Mental Capacity Act 2005 (MCA) and working with mental health patients.

Some of the staff we spoke with lacked understanding in relation to 'reasonable restraint' permitted by the MCA generally and Mental Health Act (MHA) during the conveyance of patients liable under the MHA.

Several gaps were identified in the overall skill, training and competence of HART paramedics. For example, low numbers of staff had undertaken training in 'confined space' and initial operational response (IOR); and there had been no physical competency assessment of staff in the past two years.

Coordination with other providers

The trust's command and control system was linked electronically with the equivalent system for London's Metropolitan Police.

Call handlers were provided with information on when to redirect callers to the 111 service (NHS non-emergency number) or transfer calls and how to respond when patients were handed over to LAS from 111.

We saw examples of how staff worked with other providers of health and social care such as; pre-alerting A&E departments or services who may request urgent ambulance transfers including for patients with mental health conditions or being detained under the Mental Health Act. We saw several handovers where information relevant to the patient, including any special notes, was explained in detail to the receiving emergency department staff

PTS staff liaised closely with staff at various centres that provide care, such as clinics and hospices.

Multidisciplinary working

The emergency departments, urgent care unit, maternity units, critical care units and other departments within the acute hospitals were positive about the coordination of care with the LAS staff. They were all positive about the service provided by the LAS and reported that the co-operation between frontline staff and emergency department staff was very cordial and professional.

EOC staff knew what type of calls should be allocated to the hazardous area response team (HART). We observed overall good multidisciplinary team working between the ECTs, clinical advisors and dispatch staff.

Access to information

General information for staff was through the "Pulse" intranet site and was accessible through the computers in ambulance stations. This contained updates to medical information. Some services on The Pulse could be accessed by staff from their home computers.

The medical priority dispatch system (MPDS) used by call handlers to make decisions on dispatching appropriate aid to medical emergencies, provided staff with patient specific information. It allowed for systematised caller interrogation and providing pre-arrival instructions.

The Manchester Triage System (MTS) provided staff with information and supported decisions made by clinicians working in the 'clinical hub'.

LAS emergency ambulances, response cars and other vehicles were fitted with mobile phones, two-way transceiver radios, global positioning systems (GPS) and an automatic vehicle location system (AVLS) through mobile data terminals on each vehicle. Ambulance

crews had access to special notes including advanced care plans/ directives and 'do not attempt cardiopulmonary resuscitation' (DNACPR) orders through the EOC and were always informed of this before they arrived on the scene.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Paramedics received training in the Mental Capacity Act (MCA) 2005 as part of their induction and mandatory training. LAS provided e-learning on the MCA. There was annual core service refresher training that included the MCA. When we spoke with staff we found variations, with some staff being more confident in using the MCA and completing MCA assessments than others.

There was an algorithm for dealing with mental health patients by ambulance crews. However, most of the ambulance staff we spoke with said they were not confident in dealing with mental health issues. There was guidance on conveying mental health patients, which all staff had to adhere to for their safety and security.

There were mental health nurses able to provide advice related to patients with a mental health problem, Mental Health Act, and Mental Capacity Act. However, this service was not routinely provided 24 hours a day with occasional shifts being left uncovered.

Are services at this trust caring?

Good

We observed staff talking to people in a compassionate manner and treating them with dignity and respect. Feedback from people who use the service, those who are close to them and stakeholders was positive about the way staff treat people.

The London Ambulance Service participated in the 'hear and treat' survey for 2013/ 2014. Overall the trust was performing similar to other trusts that took part in the survey.

Compassionate Care

EOC staff spoke to people in a compassionate manner and treated them with dignity and respect. They listened carefully to what was being said and rechecked information when necessary and were sensitive and supportive whilst on the phone.

The London Ambulance Service participated in the 'hear and treat' survey for 2013/2014. This survey looked at the experiences of over 2,900 people who called an ambulance service in December 2013 or January 2014. Responses were received from 321 patients for the London Ambulance Service NHS Trust.

PTS and NET staff maintained patient dignity at all times, ensuring patients were suitably dressed or covered during their journey.

Summary of findings

We observed patients being treated with respect by ambulance staff throughout our inspection. Ambulance crews consistently showed patience and sensitivity to the needs of patients. Ambulance crews asked how patients wanted to be addressed and introduced themselves.

Understanding and involvement of patients and those close to them

Patients and those close to them reported being involved in their care and treatment. Ambulance crews explained what they were doing and the care and treatment options available, such as being treated at the scene followed by discharge or being conveyed to a hospital if that was the assessed as the most appropriate option.

Patient forums were hosted by the trust, during which patients had the opportunity to provide feedback about the service and make suggestions for future improvements. Some patients we spoke with were aware of this forum; most of these patients were regular service users.

In the 'hear and treat' survey the trust scored 8.7 out of 10 for patients who felt that the call handlers understood what they were being told and the trust scored 8.8 out of 10 for patients who received understandable advice from a clinical advisor when an ambulance was not being sent.

Emotional support

All the patients we spoke with said ambulance crews consistently reassured them. The 'hear and treat' survey indicated that 7.8 out of 10 for patients who spoke to a second person who had any anxieties or fears, had the opportunity to discuss them with a clinical advisor.

We observed ambulance crews being very calm and supportive to distressed patients and their relatives. Ambulance crews told us how they supported families and people close to patients who died in their care and stayed with them until it was appropriate to leave.

The trust had a bereavement booklet the ambulance staff gave to relatives if they attended a call to someone who had died.

Are services at this trust responsive?

The emergency and urgent care ambulance service was dealing with an increasing number of emergency calls and action was being taken on long waiting times for ambulances. LAS had also introduced measures to ensure that people were monitored while waiting and high-priority calls took precedence over non-urgent calls.

Requires improvement

Summary of findings

The service had limited specialist vehicles for obese or bariatric patients. However, new vehicles were being introduced which were able to convey these patients.

The call handling system allowed alerts to be recorded for frequent callers, patients with complex needs, and learning disabilities as well as for patients from other vulnerable groups. However, it was not effective and did not allow to access important information promptly.

There were limited opportunities for learning from complaints. Patients' complaints were not routinely discussed to prevent future occurrences or improve the quality of the service in response.

There was a very active patients' forum which met regularly to discuss patient issues.Trust officials attended these meetings but more as observers than as active participants.

Service planning and delivery to meet the needs of local people

The trust had developed initiatives to respond to over 124,000 calls routed to them annually by the Metropolitan Police.

Each of the EOC call staff and emergency ambulance crews had a small geographical area allocated to them to improve local knowledge and call response efficiency.

There was a control services surge management plan to ensure that at times of sustained high pressure the EOC provided a consistent service to 999 callers.

The trust had introduced a more advanced triage system resulting in an increased use of the 'hear and treat' system. This improved responsiveness as patients were able to receive faster care and treatment through more appropriate pathways.

Meeting people's individual needs

We saw a number of care pathways used to redirect appropriate patients with minor ailments and minor injuries to health centres.

There was a flagging system for addresses for a number of issues, for example, where there were risks of violence to ambulance staff; where drugs were misused, or where specialist equipment had been used in the past.

We did not see evidence of operational plans to respond appropriately to the growing bariatric population in London or to train staff in the assessment of patients and the use of specialist

manual handling and clinical equipment during their care and treatment of this group of patients. The trust had limited specialist vehicles for obese or bariatric patients although new vehicles were being introduced which had this capacity.

The trust had commissioned focus groups with the Alzheimer's Society and Age Concern to hear about how the services could improve.

Access and flow

LAS had a low rate of abandoned calls, so most callers were able to make contact with the ambulance service. However, London also had a higher than average number of frequent callers.

Shortage of ambulance crews was a limiting factor in the responsiveness of the service. Significant financial incentives were offered to front line staff prepared to work overtime to increase the number of staff on the road. Staff were also encouraged to join the staff bank to work extra hours if and when they wanted to.

Eligibility criteria for PTS were determined by the organisations which had commissioned the service, based upon on national guidelines for the non-emergency transportation of patients.

There was an intelligence conveyance desk (ICD) at each of the emergency operation centres to support management of pressures at London emergency departments (ED). The aim was to proactively balance the arrival of ambulances across London trusts to reduce the surge of ambulance attendance at busy hospitals.

Learning from complaints and concerns

Most complaints related to delays in ambulance dispatches and long waits; others were from patients who were referred to NHS111 when they believed their condition was very serious.

There were limited learning opportunities from complaints for staff. Patient complaints and cases were not routinely shared with all staff although some staff did receive feedback. In some but not all cases there were examples of actions taken by the trust and learning from complaints.

There was no information on how to make a complaint in ambulances. Frontline staff did not have any information to give to patients or relatives about how to make complaints, but said that if asked, they would advise people to contact the headquarters or look at the LAS website.

Summary of findings

Are services at this trust well-led?

Inadequate

The LAS had a vision and strategy for the way in which they wanted to provide the service. However, most ambulance staff were not clear about what this was and were not engaged with the development of the service's vision and strategy. There was no long term strategy for the EOC. The restructure of the EOC had not been managed well.We were told that there had been no staff involvement and that it had been imposed from the top down.

The PTS management team had a thorough understanding of the diminishing workload PTS was facing and had presented a structured exit plan in early 2015.There was a limited approach to obtaining views from the patients.

There was a recognised issue with bullying and harassment and a perception of discrimination. Staff told us that the trust did not act proactively to address this. An external report into bullying and harassment produced in November 2014 was only presented to the board in June 2015.

There was a lack of operational grip from the board downwards on day to day management issues affecting how staff operated the overall service.There was demonstrable inconsistency of service oversight within emergency and urgent care and PTS management. In the EOCs there was insufficient operational overview, management of appraisals and overall performance of the function.

Risks were not managed well and the risk register was not kept up to date. Individual stations did not hold local risk registers to identify issues or concerns relating to the station and its sub/satellite stations. This meant the Duty Station officers (DSOs) and other staff had no way of monitoring their risks.

We saw the trust's risk register related to emergency preparedness. Insufficient HART staff was not listed on the register, but inadequate training of staff and managers in major incident procedures was.

There were low levels of staff satisfaction, high levels of stress and work overload. Staff did not feel respected, valued, supported or appreciated. The NHS staff survey 2014 showed that the trust rated worse than average in 29 of the 30 findings.

We wrote to the trust after the inspection to see what actions they were taking in relation to governance and in relation to the poor results in the latest staff survey. Their response included continued emphasis on recruitment and future actions to review the trust performance management policy, establish an effective appraisal system based on the next agreed business plan and to make improvements to team talk.

Summary of findings

There was a limited approach to obtaining views from patients. Public engagement activity took place in many forms including community liaison, school and local fayres and presentation to other stakeholders.

Vision and strategy

Most of the ambulance crews we spoke with demonstrated their passion and drive to provide of a high quality and safe service; however they were not aware that the trust's values included supporting and developing staff. PTS staff were aware of the trust values but told us these had been recently updated and this had failed to be communicated to the PTS part of the organisation until several weeks later. Some EOC staff advised us the trust's values had changed recently and it was communicated via the trust's staff intranet page:"Pulse". Others we spoke to in the EOC were not aware that the values had changed.

Information about the service vision and strategy were not displayed anywhere within the stations we visited.

Governance, risk management and quality measurement

Individual ambulance stations did not hold local risk registers to identify issues or concerns relating to the station and its sub/ satellite stations. This meant the duty station officer (DSO) and staff had no way of monitoring their risks. Ambulance crews and other office-based administrative staff we spoke with had no knowledge of what their risks were. However, we were told that operational managers monitored their risks through incident reporting and real-time data about demands on the service, but this information was not shared with the staff at local level. A PTS risk register was maintained and senior management staff met to discuss and review this on a quarterly basis.

The last risk identified on the EOC risk register was in April 2013 and this had not been regularly updated. We did not see that all risks were listed, for example the failure of the computer based Command Point system in the EOC. The system had failed in May 2015 which resulted in the EOC having to resort to paper based systems.

Performance was monitored and reported at ambulance station level. The Resourcing Escalator Action Plan (REAP) level was displayed in stations and managers received comparative performance data on stations.

EOC Call handlers told us 1% of all their calls should be monitored. However, there was no standardised system to ensure this was the

case and calls were selected at random. Staff working in the clinical hub advised us that they would undertake daily peer reviews, listening in to each other's calls. Check sheets were used and they would constructively feedback to colleagues.

There was insufficient operational overview and management of staff training development and appraisals. Some managers told us support received from human resource department was inadequate which made tackling poor performance and frequent staff absence difficult.

Leadership

Several members of staff told us the management style of the interim chief executive had helped improve the organisation performance targets and boost staff morale.

Some of the staff we spoke with thought local leadership was good. Operational staff said they rarely saw senior managers based at the headquarters. They were less favourable towards more senior managers and members of the executive team whom they saw less regularly and who they thought lacked understanding of the day to day reality of their working lives.

The trust informally announced in January 2014 the plan to restructure its management tier by September 2014. However,formal consultation began in October 2014 and the reorganisation of the workforce had not been completed at the time of our inspection in June 2015.

Staff turnover rate within the emergency operation centre department was 15% in 2014/2015. The highest turnover was reported among emergency medical dispatcher level1 staff (EMD), at 28%.

Culture within the service

Some staff reported a culture of fear amongst frontline emergency and urgent care ambulance staff. Some staff stated they felt unwilling to use their initiative when appropriate or raise concerns with their managers out of fear of repercussions.

Bullying and harassment was reported to us by several frontline staff, and a few black and minority ethnic staff stated that at times they felt 'humiliated' and 'ignored' by managers. Some claimed that they were overlooked for promotion.

During the inspection, we were made aware of the findings of an independent external review into bullying and harassment in LAS, which was undertaken in October and November 2014. The reason

for the review was the rise in reported incidents of bullying and harassment in the 2014 LAS results from the NHS Staff Survey. Despite the executive team having sight of this report since November 2014, it was only presented to the board in June 2015.

Following the inspection we wrote to the trust to ask the trust what action they were taking in relation to the issue of bullying and harassment as outlined to us and contained in the report that they had commissioned. In their reply they outlined actions which had been completed or part competed which included two group sessions for senior managers and the executive team with proposed follow up sessions for those unable to attend; one to one coaching sessions for those senior managers specifically named in the bullying and harassment report and the creation of a bullying and harassment helpline set up by an outside agency which the trust reported a few staff had contacted. Future actions planned but not yet completed included scoping of a dignity at work strategy, training in early intervention for managers, training for investigation officers, a review of the trust bullying and harassment policy and a survey of employees within a further 6 months.

Some ambulance staff told us there was an open and friendly culture at station level. They felt confident to raise concerns with their team leaders and DSOs. Many loved their jobs, however, they were frustrated with changes imposed by the top level management and did not feel valued by the organisation.

PTS staff told us they felt proud to represent the service and of their work in PTS.However they did not believe they were valued within the wider organisation, outside of the PTS management stream.

EOC staff felt that they had an important role. However they were unable to openly challenge each other and they felt the management of the service was not supportive. Others told us some of their colleagues had left the department as they did not feel they were valued by their managers and the trust.

Public and staff engagement

Outreach work by the LAS across London was proactive and extensive. For example, the ambulance service had recently taken part in fayres organised by local councils. Staff engagement took place through the 'Routine Information Bulletin' (RIB) and monthly 'Team Talk' newsletter. Management communicated with staff via emails and mobile phones in addition the RIB and Team Talk newsletters. Despite this, many of the staff said they felt disengaged from the management of the service.

There was an independent Patient Forum that monitored ambulance services performance which met monthly. It is made up

of members of the public. The Patient Forum held their meetings on the premises of LAS and was supported the organisation's leadership. Their monitoring information was made public on their website. Where they identified concerns about the care of the elderly and other vulnerable patients, they presented these to the LAS management team. Other concerns by the members of the forum included delays in ambulance handover to emergency department staff and inappropriate equipment for bariatric patients.

Quick question cards were instigated to obtain feedback from patients using PTS.

Innovation, improvement and sustainability

The trust was involved in research projects led by St Georges University of London (SGUL). A mobile phone app showing care pathways was a useful innovation enabling staff to have ready access to information.

A communications book for people with learning disabilities or speaking other languages was regularly used and a helpful aid to clarifying patients' needs.

A significant innovation within PTS was the implementation of the NET trial which began in September 2014. NET services facilitate the transportation of non-emergency category three and four patients who need to be taken to receive medical care.

There was an intelligence conveyance desk (ICD) at each of the emergency operation centres to support management of pressures at London emergency departments (ED). The aim was to proactively balance the arrival of ambulances across London trusts to reduce the surge of ambulance attendance at busy hospitals.

Overview of ratings

Our ratings for London Ambulance Service NHS Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	Inadequate	Inadequate	Good	Requires improvement	Inadequate	Inadequate
Patient transport services (PTS)	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Access to the service						
Emergency operations centre (EOC)	Requires improvement	Good	Good	Requires improvement	Inadequate	Requires improvement
Resilience	Inadequate	Requires improvement	Not rated	Not rated	Requires improvement	Inadequate
Overall	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate

Our ratings for London Ambulance Service NHS Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall trust	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate

Outstanding practice and areas for improvement

Areas for improvement

Action the trust MUST take to improve

Importantly, the trust must:

- develop and implement a detailed and sustained action plan to tackle bullying and harassment and a perceived culture of fear in some parts.
- recruit sufficient frontline paramedic and other staff to meet patient safety and operational standards requirements.
- recruit to the required level of HART paramedics to meet its requirements under the National Ambulance Resilience Unit (NARU) specification.
- improve its medicines management including:
- formally appoint and name a board director responsible for overseeing medication errors and formally appoint a medication safety officer.
- review the system of code access arrangements for medicine packs to improve security.
- set up a system of checks and audit to ensure medicines removed from paramedic drug packs have been administered to patients.
- set up control systems for the issue and safekeeping of medical gas cylinders.
- improve the system of governance and risk management to ensure that all risks are reported, understood, updated and cleared regularly.
- address under reporting of incidents including the perceived pressure in some departments not to report incidents.

In addition the trust should:

- review and improve trust incident reporting data.
- ensure all staff understand and can explain what situations need to be reported as safeguarding.
- review the use of PGDs to support safe and consistent medicines use.
- improve equipment checks on vehicles and ensure all equipment checks are up to date on specific equipment such as oxygen cylinders.
- ensure sufficient time for vehicle crews to undertake their daily vehicle checks.
- ensure consistent standards of cleanliness of vehicles and instigate vehicle cleanliness audits.
- set up learning to ensure all staff understand Duty of Candour and their responsibilities under it.
- ensure adequate and ready provision of protective clothing for all ambulance crews.
- ensure equal provision of ambulance equipment across shifts.
- improve the blanket exchange system pan London to prevent re-use of blankets before cleaning.
- ensure full compliance with bare below the elbow requirements.
- review and improve ambulance station cleaning to ensure full infection, prevention and control in the buildings and in equipment used to daily clean ambulances.
- set up a system of regular clinical supervision for paramedic and other clinical staff.
- ensure all staff have sufficient opportunity to complete their mandatory training, including personal alerts and control record system.
- increase training to address gaps identified in the overall skill, training and competence of HART paramedics.
- review staff rotas to include time for meal breaks, and administrative time for example for incident reporting.
- review patient handover recording systems to be more time efficient.
- provide NICE cognitive assessment training for frontline ambulance staff.
- improve training for staff on Mental Capacity Act assessment.
- ensure all staff receive annual appraisals.
- review development opportunities for staff.
- improve access to computers at ambulance stations to facilitate e-learning and learning from incidents.
- review maintenance of ambulances to ensure all are fully operational including heating etc.
- review arrangements in the event of ambulances becoming faulty at weekends.
- review and improve patient waiting times for PTS patients.
- ensure PTS booking procedures account for the needs of palliative care patients.
- develop operational plans to respond to the growing bariatric population in London.

Outstanding practice and areas for improvement

- review operational guidelines for managing patients with mental health issues and communicate these to staff.
- ensure better public and staff communication on how to make a complaint including provision of information in emergency and non emergency ambulances.
- communicate clearly to all staff the trust's vision and strategy.
- develop a long term strategy for the Emergency Operations Centres (EOCs).
- increase the visibility and day to day involvement of the trust executive team and board across all departments.
- review trust equality and diversity and equality of opportunity policies and practice to address claims of discrimination and lack of advancement made by trust ethnic minority staff and staff on family friendly rotas.
- review the capacity and capability of the trust risk and safety team to address the backlog of incidents and to improve incident reporting, investigation, learning and feedback the trust and to frontline staff.

The above list is not exhaustive and the trust should study our reports in full to identify and examine all other areas where it can make improvements.

We issued a Warning Notice to the trust on 1 October 2015, under Section 29A of the Health and Social Care Act 2008, requiring the trust to make significant improvements in the areas of medicines management, good governance and staffing by 30 November 2015.