CareQuality Commission

North East Ambulance Service NHS Foundation Trust

North East Ambulance Service NHS Foundation Trust

Quality Report

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Website: www.NEAS.nhs.uk

Date of inspection visit: 18-22 April, 4 May 2016
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This report describes our judgement of the quality of care at this provider. It is based on a combination of what we found when we inspected, other information know to CQC and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this ambulance location	Good	🟢
Emergency and urgent care services	Good	🟢
Patient transport services (PTS)	Good	🟢
Emergency operations centre	Requires improvement	🟠
Resilience planning	Good	🟢
Are acute services at this trust safe?	Good	🟢

Summary of findings

Are acute services at this trust effective?	**Good**	🟢
Are acute services at this trust caring?	**Good**	🟢
Are acute services at this trust responsive?	**Good**	🟢
Are acute services at this trust well-led?	**Good**	🟢

Letter from the Chief Inspector of Hospitals

North East Ambulance Service NHS Foundation Trust (NEAS) covers the areas of County Durham, Northumberland, and Tyne and Wear, along with the boroughs of Darlington, Hartlepool, Middlesbrough, Redcar and Cleveland and Stockton-On-Tees covering almost 3,230 square miles. The trust employs over 2,700 staff and provides 24-hour emergency and healthcare services to a population of 2.71 million people.

The trust provides an accident and emergency (A&E) service to respond to 999 calls, a 111 service for when medical help is needed fast but it is not a 999 emergency, patient transport services (PTS) and Emergency operation centres (EOC) where 999 and NHS 111 calls are received, clinical advice is provided and from where emergency vehicles are dispatched if needed. There is also a Resilience and Hazardous Area Response Team (HART).

The comprehensive inspection of the ambulance service took place from 18 to 22 April 2016 with an unannounced inspection on 4 May 2016. We carried out this inspection as part of the CQC's comprehensive inspection programme.

We inspected five core services:

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

Overall, we rated all of the five key domains as good which meant the overall rating for the trust was also good.

Our key findings were as follows:

- There was generally a culture of passion and enthusiasm with a focus on the patient. However, there were differences in culture across the different geographical patches. The trust had recently undertaken a cultural survey which had identified some concerns regarding management support. Actions had been identified and were being implemented to address this; an example was the management essentials programme.
- Most staff confirmed there had been a real shift in emphasis toward patient engagement and staff wellbeing. This was reinforced by the NHS Staff Survey 2015 where it was reported trust management had a real interest in staff health and wellbeing which was better than the England average.
- The relationship between the executive team and union representatives had improved and we were told by both sides that there was now a more open dialogue and discussion regarding meeting the needs of staff and the service.
- The emergency care clinical managers were front line leaders who supported staff and supervised operations. This recently established role was to ensure staff received appropriate clinical leadership, which was documented and evidenced via quarterly one to one meetings. However this had only been implemented in the urgent and emergency care service.
- Throughout the inspection and across services we found that patients received care in a clean, hygienic and suitably maintained environment.
- Patients on the whole told us they were happy with the care they received and the attitude of staff. We observed staff engaging with patients in a caring and respectful manner.

Summary of findings

- The trust was experiencing difficulties recruiting to paramedic vacancies and information provided by the trust before the inspection indicated there was a vacancy of 102.49 wte paramedic posts which equated to vacancy rate of 16%.
- There were concerns identified during the inspection regarding the emergency operations centre in relation to the management of clinical risks when the 'stack' of calls was increasing.
- Concerns were raised regarding the business continuity plans for the emergency operations centre in the event of a major disruption of services. There would be a delay in the setting up of the dispatch function of this service.
- Data showed that between April 2015 to March 2016 out of the eleven national ambulance trusts NEAS was the joint worst performing ambulance service in NHS with responses within the target for Red 1 performance. There was a downward trend in the proportion of Red 1 calls responded to within 8 minutes between June 2015 and March 2016.
- Patient Transport Services (PTS) provided resilience to support the emergency and urgent care service, both operationally and within the Emergency operations centre. The trust was in the process of implementing a project to integrate PTS with emergency care to create an integrated care and transport service. This meant additional capacity would be created to support the transportation of urgent care patients.
- The trust took into account local events which increased demands on the service. Information provided by the trust highlighted that staffing demands for local events were planned in advance and staffing rotas were adjusted as required.
- There was a lack of clarity in the line management and governance arrangements for the community first responders they told us that there had been many changes recently, which had left them unclear about who managed them.

We saw several areas of outstanding practice including:

- The trust had enrolled in the Mind blue light mental health programme and had encouraged staff to take on training to support colleagues with their mental health.
- The trust provided national support for a motorcycle application; this was a mobile phone application, that used smart phone technology to identify if a motorcyclist had had an accident, and sent location data to the NEAS EOC, allowing staff to contact the nearest appropriate ambulance service to arrange an emergency response. The trust had been recognised at a national level for this.
- The resilience service developed strong working relationships with the Sports Ground Safety Authority (SGSA) following innovative approaches to improving medical safety standards at stadia events such as premier league football matches and music concerts.
- The advanced paramedic programme was an area of work that would benefit patient care and improve treatment pathways for patients.
- The trust research and development team were involved in a number of trials which were underway at the time of the inspection. These included for example trailing a device that regulated intrathoracic pressure during resuscitation and the PASTA trial which was a multi-centre randomised controlled trial to determine whether a Paramedic Acute Stroke Treatment Assessment (PASTA) pathway could speed up access to stroke patients.
- The Trust had pioneered a Flight Deck methodology for the North East. This was a capacity management system intended to support improved whole system awareness of capacity, quicker and safer diverting of patients to appropriate receiving care locations, and enhanced whole system learning.
- The trust had been nominated for a national innovation award for the development and use of the electronic communication system.

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

Importantly, the trust must:

- The trust must review and ensure there are appropriate arrangements in place to provide dispatch in the event that Bernicia House was unavailable to operate as a dispatch centre.
- The trust must ensure at all times there are sufficient numbers of suitably skilled, qualified and experienced staff.
- The trust must ensure all staff have completed mandatory and role specific training relevant to their role.

Summary of findings

- The trust must ensure all staff receive an appraisal and are supported with their professional development. This must include support to maintain the skills and knowledge required for their job role.
- The trust must continue to address the complaint and incident backlog and ensure systems and processes are put in place to prevent a re-occurrence.
- The trust must ensure that clinical records are stored securely.

In addition the trust should:

- The trust should ensure all relevant staff have received appropriate major incident training.
- The trust should ensure staff within the emergency operations centres are involved in the development of the strategy and vision of the service.
- The trust should ensure staff are supported and encouraged to report incidents and feedback is provided to staff on the outcomes of the incident investigation.
- The trust should review the training requirements for operational staff for vulnerable groups such as patients living with dementia and patients experiencing mental health concerns.
- The trust should ensure there is a robust system in PTS to monitor the daily cleanliness of vehicles and ensure deep cleans are carried out to planned levels.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Emergency and urgent care services	Good 🟢	Overall we rated emergency and urgent care services as good because: • There was an open and transparent culture with regard to the management of risk. Staff reported incidents and lessons learnt were shared. Clear escalation procedures were in place and advice was always available. There was effective infection prevention procedures and we found ambulance stations and vehicles clean. Several strategies had been implemented to help recruitment and retention of staff. • Care and treatment was delivered based on National Institute of Health and Care (NICE) Guidance, Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines and the Resuscitation Council UK (RCUK) guidelines and there were a number of Care bundles in place, based on the ambulance quality indicators. The care and treatment of patients following a stroke and a heart attack was above the national average. • NEAS was part of a vanguard programme working collaboratively with North East Urgent Care Network (NEUCN) to deliver projects to facilitate a better service. There were alternative pathways in place to reduce avoidable admission. • Feedback from patients and their relatives regarding the care they received was consistently positive. Where people had cause to complain, there were processes in place for responding to their concerns. Staff were observed to engage with patients in a compassionate and caring manner. • There was a clear vision and strategy for the service and staff had been engaged

in the development of the mission, vision and values. Governance systems and process were in place and there was a clear process for escalation of risks. The ECCM's were front line leaders who supported staff and supervised operations. This new role had been well received by staff and positive changes had resulted from the development of this role

- Overall staff we spoke with was positive about the leadership of the organisation. Staff told us that the chief executive had had a positive impact, was visible, supportive and approachable

However,

- NEAS was failing the national targets for responding to Red 1, Red 2 and Cat A calls.

- Between August 2015 and March 2016 the trust breached the 95% standard forthe proportion of category A calls responded to within 19 minutes

- Staff raised concerns around late or missed meal breaks and late finishes, this was having an effect on staff morale, a pilot scheme was in place which included strategies to reduce this.

Patient transport services (PTS)

Good ●

Overall, we rated Patient Transport Services as good because:

- The service had a clear vision and strategy that was linked to the overarching corporate objectives. Managers monitored the risk register regularly and could explain what mitigating actions they were taking.
- Staff told us they felt proud to work for the trust. PTS crews felt their immediate operational managers supported them in their role.

Summary of findings

- **All operational staff knew how to keep patients safe through incident reporting, assessing risks and taking appropriate action, and the maintenance and cleanliness of vehicles.**
- **Staff were caring towards patients and we observed ambulance care assistants and call handlers from the control centre treat people with kindness, dignity and respect.**
- **The service took into account the needs of different people, such as bariatric patients or people living with dementia, and journeys were planned based upon their requirements. Patients could also book their own transport and some hospitals could book transport for their own patients attending the clinic.**
- **Managers monitored the performance of PTS on an ongoing basis and held meetings every month to discuss the outcomes. The latest performance figures showed the service had exceeded its target in relation to the time patients spent on a vehicle and local commissioners had extended the contract for the transportation of patients receiving renal dialysis.**

However:

- **Patients did not always arrive at hospital on time for their appointment. To address this, the service was looking at different ways to improve its performances. This included providing specific information to PTS crews about the patient's actual appointment time and an option to text patients when the vehicle was on its way to collect them.**
- **Managers only reviewed the performance of ambulance care assistants once a year. There were no arrangements for 1-1 or team meetings, or supervision.**

Summary of findings

Emergency operations centre

Requires improvement 🟠

Overall the emergency operations centre was rated as requires improvement. We rated safe and well led as requires improvement and we rated responsive, effective and caring as good. We found that:

- Concerns were raised regarding the business continuity plans for the emergency operations centre in the event of a major disruption of services. There would be a delay in the setting up of the dispatch function of this service. Management could describe what they would do if dispatch at Bernicia House was unable to operate, however there were no formal procedures in place for dispatch resilience.
- Clinical advisor staffing levels were highlighted as being a challenge, however management were addressing this by enhancing the number of clinical advisor roles.
- There was a backlog of open incidents which had exceeded the trust timescales for completion. However, staff knew how to report incidents and root cause analysis was undertaken as required.

- Display screen equipment assessments were not always completed.

- Staff we spoke with understood how to report safeguarding concerns.
- The trust used systems which were evidence based and we found staff to be competent in their areas. The emergency operations centre co-ordinated with other services as required. Hospital advice liaison officers were in place in some hospitals to assist in the communication between the ambulance service and hospitals.
- Mandatory training completion rates were not always achieving the trust targets.
- Appraisal rates were below the trust target.

- The trust participated in the ambulance quality indicators which allowed the trust to monitor performance. Response data varied in the service, call abandonment rates were within thresholds between September 2015

and March 2016, however the proportion of patients who re-contacted the service following discharge of care, by telephone within 24 hours was higher than the England average.

- Staff were caring and compassionate and took into account patient's needs. Staff provided emotional support where required to patients and supported patients during calls to 999. Hear and Treat rates were mostly in line with other trusts.
- The emergency operations centre had access to a language interpreter service and text relay service for patients with impaired hearing.
- There was limited access to training on dementia awareness, mental health or vulnerable adults, however the trust was progressing a piece of work to enhance mental health provision from the emergency operations centre.
- Governance processes were in place and there were clear governance structures. Risk registers were regularly reviewed and management were able to describe the current risks to the emergency operations centre.
- Staff were not always aware of the trusts vision or strategy. Staff views on the culture varied in the different areas of the emergency operations centre and staff told us that senior management were not always visible and they had limited interaction with senior management. However, most staff told us they received good support from their team leaders and duty managers.
- The trust had been involved in a number of innovative initiatives.

| Resilience planning | Good 🟢 | **Overall, we rated the resilience service as good because:**

- **Staff understood their responsibilities to report incidents and raise concerns. There were a low number of reportable incidents with none resulting in patient** |

Summary of findings

harm. There were clearly defined processes to keep people safe and these were underpinned by robust national guidance. Staff shared and learnt lessons from debriefings.

- Safety risks were assessed, planned and responded to accordingly. Resilience functions and business continuity plans were embedded and ensured service continuity.

- Staff within the service were trained and proficient in their role. This was supported by a sound evidence base, in line with national standards and competencies, informing practice and clinical skills. The service fully utilised the NARU Proclus database.

- There was evidence of outstanding co-operation and effective working relationships with allied agencies and multi-disciplinary services.

- The service cared about the work it carried out and patients were central to this. We observed kind and compassionate interactions with patients. Physical and emotional needs were promptly assessed and appropriate treatment options were discussed to secure an agreed care pathway.

- Resilience services were planned and delivered for the benefit of the local population. The service developed robust plans with other services and providers to maintain its core functions to meet patient needs. The service was open to learn from patient concerns.

- The trust had a clear strategic vision which resilience staff felt reflected what the organisation represented. Senior and local managers were engaged. The

Summary of findings

resilience service worked well as a team and was well led by an approachable, supportive and committed management team.

- The resilience team felt collectively responsible for the efficiency and quality of the service. Staff welcomed challenge and dialogue to improve practices. The service had made some impactful improvements to safety in sports grounds and a number of staff were involved in national and international programmes.

- Feedback from incident investigations needed to be more consistent. There was a need to refresh training around base cleanliness in the sluice area and in using the Omnicell system for the management and storage of controlled drugs.

- Data collection for HART response times was incomplete and patient outcomes were not routinely collected.

- There was some confusion within the HART service regarding their deployment in support of general operations. This led to an inconsistent approach in responding to non-urgent calls outside the agreed deployment protocol.

- There was a lack of a formal documented local resilience strategy due to various staffing changes, service restructuring and transient appointments. Staff acknowledged the resilience structure was lean and was "running hot" most of the time leading to concerns being raised about long-term sustainability within the current configuration.

Overall rating:

North East Ambulance Service NHS Foundation Trust

Detailed findings

Services we looked at

Emergency and urgent care; Patient transport services (PTS); Emergency operations centre (EOC); Resilience

Good ●

Detailed findings

Contents

Detailed findings from this inspection

Background to North East Ambulance Service NHS Foundation Trust

North East Ambulance Service NHS Foundation Trust (NEAS) covers the areas of County Durham, Northumberland, and Tyne and Wear, along with the boroughs of Darlington, Hartlepool, Middlesbrough, Redcar and Cleveland and Stockton-On-Tees covering almost 3,230 square miles. The trust employsover 2,700 staff and provides 24-hour emergency and healthcare services to a population of 2.71 million people.

The trust provides an accident and emergency (A&E) service to respond to 999 calls, a 111 service for when medical help is needed fast but it is not a 999 emergency, patient transport services (PTS) and Emergency operation centres (EOC) where 999 and NHS 111 calls are received, clinical advice is provided and from where emergency vehicles are dispatched if needed. There is also a Resilience and Hazardous Area Response Team (HART).

NEAS responds to over 360,000 urgent and emergency incidents per year with over 1,000 emergency calls per day received by the 999 Emergency operations centres.

The front-line A&E staff included paramedics, advanced technicians and emergency care support workers (ECSW) and are supported by community first responders.

The Patient Transport Service (PTS) provided pre-planned non-emergency transport for patients who had a medical condition that would prevent them from travelling to a treatment centre by any other means, or who require the skills of an ambulance care assistant during the journey.

During our inspection we visited both ambulance premises and hospital locations in order to speak to staff and patients about the ambulance service. We inspected the Emergency operations centre that received calls and dispatched ambulances.

Our inspection team

Our inspection team was led by:

Chair: Ellen Armistead, Deputy Chief Inspector, Care Quality Commission

Head of Hospital Inspections: Amanda Stanford, Care Quality Commission

The team of 49 people included CQC inspectors, inspection managers, national professional advisor, pharmacy inspectors, inspection planners and a variety of specialists. The team of specialists comprised of

Paramedics, Emergency Medical Technicians, operational managers, Patient Transport Service Managers, Emergency Operation Centre managers, operations directors and safeguarding managers.

Detailed findings

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

- 111 service

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 ambulance service. These included the clinical commissioning Groups (CCG's), NHS Improvement, NHS England, and the local Healthwatch organisations. We held focus groups and drop-in sessions with a range of staff in the service and spoke with staff individually as requested. We talked with patients and staff from a range of acute services who used the service provided by the ambulance trust. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' personal care and treatment records.

We carried out the announced inspection visit from 18-22 April 2016 and undertook an unannounced

Inspection on 4 May 2016.

Facts and data about North East Ambulance Service NHS Foundation Trust

North East Ambulance Service NHS Foundation Trust (NEAS) covers the areas of County Durham, Northumberland, and Tyne and Wear, along with the boroughs of Darlington, Hartlepool, Middlesbrough, Redcar and Cleveland and Stockton-On-Tees covering almost 3,230 square miles. The trust employs over 2,700 staff and provides 24-hour emergency and healthcare services to a population of 2.71 million people.

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Our ratings for this service

Our ratings for this service are:

Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	Good	Requires improvement	Good	Good	Good	Good
Patient transport services	Good	Good	Good	Good	Good	Good
Emergency operations centre	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Resilience planning	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Notes

Emergency and urgent care services

Safe	**Good** 🟢
Effective	**Requires improvement** 🟠
Caring	**Good** 🟢
Responsive	**Good** 🟢
Well-led	**Good** 🟢
Overall	**Good** 🟢

Information about the service

The North East Ambulance Service (NEAS) provides an emergency and urgent care service to a population of 2.6 million people. The main role of emergency and urgent care services was to respond to emergency 999 calls, 24 hours a day, 365 days a year. NEAS had 53 ambulance stations spread across an area of 3,200 miles, which covered the counties of Durham, Northumberland, Tyne and Wear, along with the boroughs of Darlington, Hartlepool, Middlesbrough, Redcar & Cleveland and Stockton-On-Tees. NEAS had two communications centres, based in Newcastle and Hebburn. They received over 1,000 emergency calls daily, representing more than 360,000 emergency and urgent calls per annum. The Trust had three operational divisions, North, Central and South. A divisional headquarters was located in each division. The NEAS trust headquarters (HQ) was based at Newburn in Newcastle.

NEAS had approximately 1,110 frontline staff and over 90 emergency vehicles. NEAS worked closely with other emergency services, including the police and the fire and rescue service to provide emergency services during major incidents.

We conducted focus groups with staff in each division prior to and during our inspection to hear their views about the service. This included frontline ambulance and support staff. During the inspection, we visited 24 ambulance stations across all three divisions, in cities, towns and rural areas. We inspected 52 ambulances and response vehicles, and reviewed 94 patient report forms. We spoke with 97 staff in various roles including paramedics, student paramedics, ambulance technicians, emergency care assistants, emergency care clinical managers and senior managers. We also spoke with support staff including ambulance resource assistants and station support officers. We observed ambulance crews treating patients. We spoke with 36 patients and 16 relatives.

We visited hospitals within each division where we observed the interaction between ambulance and emergency department staff. We spoke with 21 staff in the emergency departments and other areas of the hospitals where patients had been attended by ambulance staff about their experiences of working with NEAS.

Emergency and urgent care services

Summary of findings

Overall we rated emergency and urgent care services as good because:

There was an open and transparent culture with regard to the management of risk. Staff reported incidents and lessons learnt were shared. Clear escalation procedures were in place and advice was always available. There was effective infection prevention procedures and we found ambulance stations and vehicles clean. Several strategies had been implemented to help recruitment and retention of staff.

Care and treatment was delivered based on National Institute of Health and Care (NICE) Guidance, Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines and the Resuscitation Council UK (RCUK) guidelines and there were a number of Care bundles in place, based on the ambulance quality indicators. The care and treatment of patients following a stroke and a heart attack was above the national average.

NEAS was part of a vanguard programme working collaboratively with North East Urgent Care Network (NEUCN) to deliver projects to facilitate a better service. There were alternative pathways in place to reduce avoidable admission.

Feedback from patients and their relatives regarding the care they received was consistently positive. Where people had cause to complain, there were processes in place for responding to their concerns. Staff were observed to engage with patients in a compassionate and caring manner.

There was a clear vision and strategy for the service and staff had been engaged in the development of the mission, vision and values. Governance systems and process were in place and there was a clear process for escalation of risks. The ECCM's were front line leaders who supported staff and supervised operations. This new role had been well received by staff and positive changes had resulted from the development of this role

Overall staff we spoke with was positive about the leadership of the organisation. Staff told us that the chief executive had had a positive impact, was visible, supportive and approachable

However,

NEAS was failing the national targets for responding to Red 1, Red 2 and Cat A calls.

Between August 2015 and March 2016 the trust breached the 95% standard for the proportion of category A calls responded to within 19 minutes

Staff raised concerns around late or missed meal breaks and late finishes, this was having an effect on staff morale, a pilot scheme was in place which included strategies to reduce this.

Emergency and urgent care services

Are emergency and urgent care services safe?

Good ●

We rated the safety of emergency and urgent care services as good because:

- There was a culture of incident reporting and lessons learnt were shared.
- Staff were aware and confident of when to raise a safeguarding concern and the process was timely
- There were systems in place to ensure good infection prevention and standards were high.
- There were effective processes in place for the timely replacement of equipment.
- Patient records were completed correctly and a process was in place for the safe storage and transfer of paper records.
- There were clear escalation processes in place and staff could access advice for complex cases.
- NEAS had experienced difficulties in recruitment and retention and had implemented a number of strategies to address staffing vacancies; 93% of posts were filled.
- The trust used the national indicator resourcing escalation action plan (REAP) together with a local indicator of hospital demand known as north east escalation plan (NEEP). This allowed an awareness of trends in system pressures.
- Medicines management procedures were robust and safe practice was used for the storage, administration and auditing of medicines.
- NEAS had a major incident plan in place for 2015/16.

However:

- Staff received their mandatory training and completion rates were 86% and they had plans to meet the trust target of 95%.
- Not all frontline staff had received appropriate major incident training.
- Paper records in one vehicle were not secured safely.
- At times two emergency care assistants (ECA's) worked together and at times attended emergency calls.
- Crews raised concerns about the high number of missed meal breaks and late finish times, resulting on them working long hours before taking a break and long shifts.

- The trust was experiencing difficulties recruiting to paramedic vacancies and information provided by the trust before the inspection indicated there was a vacancy of 102.49 wte paramedic posts.

Incidents

- Between 31 January 2015 and 31 January 2016, the urgent and emergency care service received 2296 reported incidents. These incidents included violence and aggression (425), road traffic collisions (303), manual handling (245), and NHS 111 issues (226).
- Themes of more frequently reported incidents included muscular-skeletal injuries and violence and aggression. As a result, the service had introduced a referral system to an occupational health based physiotherapy service. NEAS were developing a fitness test for newly employed staff to ensure they were capable of carrying out work-based tasks prior to employment. A revision of the essential training had taken place to ensure manual handling training was delivered with a practical focus, which aimed to reduce the number of staff related injuries.
- Staff were made aware of any changes in policy or practice as a result of incidents by email and through bulletins and safety alerts which were displayed at each station. The information displayed was consistent at each ambulance station. Staff were able to give examples of changes in practice as a result of incidents for example, the type of needles used to reduce the amount of needle stick injures
- NEAS had adopted a zero tolerance policy on violence and aggression. Closed circuit television (CCTV) was installed on all new ambulance vehicles with a view to prosecuting those who assault staff or steal from vehicles
- The impact of patient safety incidents reported was 25 that met the services criteria for catastrophic, eight major, 26 moderate, 273 minor, 1442 relating to no harm and 176 near misses.
- There were seven Serious Incidents (SI's) reported in the 12 months prior to our inspection. Delayed ambulance responses and issues with triage were the most commonly reported SI's. To reduce these the trust was working on recruitment strategies, and working in partnership with local hospitals to reduce handover times thereby, releasing crews quicker to respond to awaiting calls.

Emergency and urgent care services

- We reviewed serious incident reports and found root cause analysis was robust with thorough investigations being completed. Action plans were developed and we found evidence that actions were completed.
- The service had an effective policy and process for the reporting incidents and near misses.
- Staff were able to explain clearly the incident report process. Staff knew that any incident relating to a patient, the vehicle or themselves should be reported, including any near misses. The majority of staff we spoke with said they were encouraged to report incidents.
- Incidents were reported via an electronic reporting system, widely used in the NHS. Staff we spoke with commented that no allocated time was given during the shift to complete the incident form. Staff completed incident forms during meal breaks or after their shift was finished. This could result in a under reporting of incidents, however, we did not see any evidence of this.
- The emergency clinical care managers (ECCM's) undertook incident investigations, gave feedback to staff and provided an investigation report for staff to review. Learning lessons from incidents was encouraged. Information regarding incidents was displayed in the stations we visited.
- Feedback and support was given to staff via the ECCM's which included debriefing following traumatic and violent incidents. Staff we spoke with told us that the support, debrief and learning from incidents had much improved since the implementation of the ECCM role.
- Regular health and safety assessments were carried out and action taken to address issues found.

Duty of Candour

- The Duty of Candour regulation under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires health service bodies to act in an open and transparent way with people when things go wrong. The majority of staff were aware of the Duty of Candour Regulation when we spoke with them. We were informed the trust was to appoint a family liaison officer to act as the single point of contact for all serious incidents.

Mandatory training

- Mandatory training for emergency and urgent care staff at NEAS was called Essential Annual Training (EAT). The EAT training included a clinical update, CQC regulations, infection prevention and control and safeguarding adults and children.
- Staff completed mandatory (Essential Annual Training) annually. This included two training days which the member of staff attended in person.
- EAT attendance was co-ordinated by the education department and resource scheduling staff who ensured staff were available to attend. To support staff attendance Operational managers monitored attendance through staff appraisal. A core objective for all staff groups was attendance at EAT.
- Resource scheduling staff ensure that all staff available to attend (those not on long term absence or maternity leave) were abstracted to attend EAT on an annual basis.
- Current compliance with EAT attendance in February 2016 was 86% against a trust target of 95%.
- Staff told us that driver competency training was provided and they felt it was an essential part of the training. Staff needed to pass the assessments before they were operational within their role.
- Both verbal and practical manual handling updates were completed.
- Staff received training within the clinical update section of the EAT for any new drugs and new patient group directives that had been introduced.
- Staff told us that the training curriculum varied throughout the year for additional training and that many had recently completed an obstetrics course. However, there were concerns that although mandatory training was supported, additional training and study time was completed in the staff member's own time. Staff
- Staff felt they required additional mental health and maternity training. The service had commissioned an external trainer to deliver training on the Mental Capacity Act, deprivation of liberty standards and lawful and unlawful restraint for frontline crews in 2016. This will then continue through train the trainer for 2016/17.

Safeguarding

- There were comprehensive policies for safeguarding children, young people and vulnerable adults. Staff demonstrated a thorough knowledge of safeguarding procedures for both children and adults.

Emergency and urgent care services

- We observed safeguarding adult and children forms on the vehicles. We observed as a crew member submitted a safeguarding referral appropriately.
- Within emergency care, 86% of staff had been trained in level 2 safeguarding adults and children; this training was delivered in one session. Safeguarding training covered the prevent programme. The prevent programme was one of the Government's responses to the terrorist threat in the UK. This includes the training of all relevant front line staff in the responsibilities of identifying and protecting those who may be at risk of radicalisation. Safeguarding training also included female genital mutilation, human trafficking, domestic abuse and the Care Act 2014.
- Level three safeguarding children and adult training commenced in December 2015, initially for ECCM's and operational managers. Data showed that 83% of those had attended the training by 10th March 2016, with the rest due to attend by 31 March 2016. Level three adults and children safeguarding training was to be rolled out to paramedics from April 2016.
- All staff within the service had access to control logistics 24 hours, seven days a week. Control logistics provided a dedicated phone line for operational staff to raise a safeguarding concern. The Control logistics desk operator logged the call and completed the referral form for social services. The staff member received an email to advise them that the safeguarding referral had been completed. Staff told us the process for referral was simple and not time consuming.
- Approximately 1000 safeguarding referrals were made per month. The referral information was captured in the risk management system that was accessed by the safeguarding team.

Cleanliness, infection control and hygiene

- All staff who attended the induction for new staff had received infection, prevention and control (IPC) training. Staff are then updated annually within their two days essential annual training.
- Staff had access to IPC information through trust policies and from their ECCM.
- We observed crews handwashing and bare below the elbows. We found not all crews washed their hands between patients however, we observed the majority of them using alcohol gel and wearing and changing gloves appropriately. Four sets of crews at one hospital site did not use hand gel (the container was empty) and

hands were not washed on the way in or out of the hospital and no gloves were worn. The majority of crews were not bare below the elbows; they wore long sleeved jackets as part of their uniform in cool weather. We did not see any staff wearing wrist watches.
- Each ambulance station had a daily cleaning schedule and a cleaning regime that was carried out by external domestic services staff. We observed these at each station and they were up to date.
- An IPC manager was responsible for audits of ambulance stations and vehicles. An action plan was in place to implement a rolling audit programme. ECCM's highlighted audit shortfalls to staff to ensure any issues were addressed.
- Station support operatives (SSO) completed monthly station IPC audits and reported issues to the ECCM's. Cleanliness was discussed at the divisional weekly provisions and compliance meetings with actions documented. ECCM's undertook a monthly station walk around to ensure that any issues in ambulance stations were highlighted and areas of good practice were identified and shared. We were told overall since the weekly audits were introduced there was an improvement. ECCM's used the vehicle spot check documents to audit vehicles during accompanied journeys with their staff.
- All vehicles were included in a deep cleaning schedule. The planned cleaning program for all operational vehicles covered in detail the scheduled cleaning processes followed by the Equipment & Logistics teams.
- Vehicle cleaning schedules were generated in conjunction with vehicle Planned Preventative Maintenance (PPM). Statistics we reviewed showed that 207 deep cleans were completed against 223 planned (93% compliance) in January 2016.
- Staff had access to hand washing facilities at stations and in hospitals. On vehicles, staff had access to hand gel. Anti-bacteria wipes were used to clean equipment and surfaces. Sluice facilities were in place at ambulance stations with appropriate chemicals to clean fluid spills and plentiful supplies of personal protective equipment (PPE).
- Ambulance vehicles were supplied with spill kits for fluid spillages. All vehicles we reviewed had clinical waste and non-clinical waste bins in place. At the 24 ambulance stations we visited we observed there was clear signage and instructions for waste management and cleaning policy.

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- We observed good practice for waste disposal at all the 24 stations we visited. Waste disposal was audited weekly by the station support officers.
- At ambulance stations we reviewed the storage of sterile, single use clinical items of equipment. We found that items were stored appropriately. We found a number of sterile supplies (nasal – gastric tubes) on one of the stations that were out of date which may result in them not being sterile. This was raised with the ECCM at the station and they were removed.
- Clean and dirty linen was restocked through arrangements with the hospitals. Staff told us this arrangement worked well. Within the hospitals we visited we observed clean linen trolleys which were placed so that ambulance staff could restock the ambulance vehicles.
- All vehicles had in place sharps boxes and portable sharps boxes within the equipment bags taken into patients' houses.
- We spoke with external domestic staff at three ambulance stations. Domestic staff were clear about their duties and we observed the domestic cupboard, where local policies and guidelines were available to support cleaning processes.
- There was adequate provision of cleaning equipment at all stations we visited. We observed ambulance crews cleaning their vehicle between calls. Crews had up to 30 minutes from the time they arrived at a hospital to the time they left. This time consisted of 15 minutes from arrival to handover their patient to hospital staff and 15 minutes to clean and restock ("make ready") the ambulance vehicle.
- Staff told us that there were occasions when the vehicle "make ready" was unachievable. This was said to be due to high level of calls and delays within the hospitals. To help improve the cleaning and restocking of the vehicle between patients ambulance support assistants were based at four acute hospital sites. The support assistants cleaned and restocked ambulances whilst the crews were engaged with their patient in the hospital. The support assistants also dealt with more minor vehicle maintenance issues. At the sites were these were not available, staff had to clean and restock their own vehicles.

- We checked 52 ambulances and found overall that these were clean. We observed three spinal board straps to be heavily marked with mud and blood on one vehicle. This was addressed with staff who gave assurance these items would be removed.
- If a patient, who was to be attended to, had a known infection, we were informed that an alert flagging system was in place. However, staff told us that it was inconsistent, due to the ambulance service not always being aware if a patient had a known infection.
- When an ambulance crew was transporting a patient with a suspected infection, they pre - alerted the hospital emergency department. We observed a patient with a known infection transferred to hospital. Hospital staff had allocated a single room for isolation on admission and the hospital had been made aware of the infection risks. Staff told us of an incident where they had not been informed that a patient had Tuberculosis. This was reported as an incident but the team did not get feedback or follow up from the exposure.

Environment and equipment

- Staff reported defective equipment using a "red tagging" system. Items of defective equipment were removed from the ambulance, placed in the quarantine area in the ambulance station and reported to control. The equipment was replaced by the ambulance resource assistants (ARA's). The equipment was replaced immediately or the crew were given a replacement vehicle if the equipment was essential. If non-essential the equipment was replaced within a target of four hours.
- Staff reported good arrangements for supply of stock.
- The introduction of the ARAs at local hospitals aimed to reduce the time for equipment replacement as well as restocking of disposable items to assist the crews. Disposable items were available at Hub stations. Hub stations were stations that had main stores, including medicines and oxygen supplies. There were 15 Hub stations within NEAS.
- Vehicle daily inspections were completed by staff at the commencement of or during a shift. The inspection included a checklist of equipment that was available and a check of the vehicle to see if it was road worthy. Ambulance staff alerted the control room electronically to confirm the check had been completed.
- We were informed that vehicles were designed and constructed in accordance with national regulations

and were proved road worthy through registration procedures and Ministry of Transport tests. Planned and reactive maintenance regimes were undertaken at two dedicated workshop facilities in Sunderland and Stockton. Vehicles were serviced six weekly and equipment checks were completed every 12 weeks.

- The trust had a five-year capital program for replacement of the vehicle fleet. This provided for the replacement of approximately 350 vehicles and associated equipment.
- All equipment we reviewed had undergone a current portable appliance test (PAT).
- Staff told us they had experienced some battery and connection problems with their electronic tablets ("Toughbooks"). However, these problems were in the process of being resolved by replacing the faulty equipment.
- We found one vehicle with missing equipment. Head blocks were missing from a spinal board, and some leg splints were missing. Staff explained that the missing items were likely to be at the hospital after having been left there following use for a patient.
- There was no formal system for collecting ambulance equipment left at hospitals. One hospital we visited left ambulance equipment in the ambulance entrance to the emergency department for crews to collect. On the day we visited, there were a number of items left in the doorway of the hospital. This meant that ambulances were occasionally left without the full range of equipment until reported by staff and replaced by the ARA's.

Medicines

- Medicines stored in ambulance stations were kept securely in a locked room, and in locked cupboards.
- Ambulance vehicles contained four colour-coded drugs bags. Drugs were checked on a shift by shift basis. Information sheets contained within each bag were used to record the administration of drugs in order to monitor stock levels. Drug bags were exchanged when stock levels fell below a minimum level or if drugs were deemed to be out of date. Exchange of bags took place at hub locations.
- We reviewed the tagging system. A colour coded tag system was in place. Red tagged bags were returned to the hub stations for renewal as these had been used and were nearly empty. Bags that were still in use because they contained an amount of drugs that could

be used for the current shift were tagged as orange. Bags that had been provided by the pharmacists for circulation and had not been used, and were fully stocked were tagged green. Staff we spoke with felt that overall, the tagging system worked well although occasionally the tags were not renewed. Of 24 drug bags which we reviewed, we found two without appropriate tagging.

- Controlled Drugs (CD) were issued to paramedics and stored within individual paramedics key accessed CD lockers. Paramedics recorded all administrations and wastages. Monthly self-audits were completed by paramedics and quarterly ECCM audits. Audits were also required and recorded at the end of each block of shifts undertaken. Cold chain audits (audits of vaccines) were completed monthly. The December 2015 audit showed improvement in compliance: overall compliance had increased from 89% for November 2015 to 95% for December 2015.
- Monthly audit reports shared with the operational management team identified any shortfalls or omissions and included overall divisional compliance percentages. If discrepancies were found, the ECCM held a one to one meeting with the clinician to ascertain why. If a second incident occurred with the same practitioner, the operation manager was informed. On a third occasion the paramedic was subject to disciplinary or capability procedures. We were advised of one incident where a practitioner had not been auditing the drugs and a reflection piece was completed following a one to one interview.
- Destruction boxes were installed within each ambulance station and a clear process and policy was in place to ensure safe destruction of medicines.
- Procedures were in place for the management of refrigerated medicines. There was only one medicine that needed to be refrigerated. Refrigerators were located at hub stations and daily checks were undertaken to ensure medicines were being stored in line with temperature requirements. Reports were submitted to the Patient Safety Group on a monthly basis. In February 2016, the overall compliance was 96%.Monkton station held what staff called the "back up" fridge although it did not contain any medicines during our visit no regular monitoring had taken place.
- An electronic storage and dispensing system of medicines (Omnicell system) was being trialled at Darlington, Blucher and Monkton Stations.

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- We reviewed a system of over 100 patient group directives (PGD's) used by advanced paramedic staff. All had review dates in place and were in date. Staff stored PGD's for easy reference on iPhone technology. Advanced paramedics held their own stock of antibiotics, and there was a system of peer review for antimicrobial stewardship.
- We observed patients' own medication being transported with the patient to hospital in a designated green medicine bag issued for that purpose.
- Storage of medical gases (oxygen and analgesic gases) was in line with trust policy. Empty cylinders were clearly marked.
- We were informed that the emergency ambulance service worked closely with the clinical care and patient safety directorate to support information and guidance with regards to medicines management. This took place through the operational medicines management group, the strategic medicines management group and the patient safety group.
- Medications held on all vehicles were stored in a locked cupboard. However, we observed that a medication drawer on a rapid response vehicle was broken. This enabled us to directly access controlled drugs. This was reported and repaired immediately by an engineer on site.
- We found one personal CD drug bag, which belonged to a paramedic, who took emergency leave in the middle of a shift. The drugs had been stored by ambulance crew in the locked medicines room which followed policy. However we found the key had been left in the door of the locker. This was reported to staff and an incident form and investigation was commenced. Senior managers told us that the incident would be shared in order to avoid it happening again.
- During our visit we found three Rapid Response Vehicles (RRV) that contained decanted medicines. This meant that these medicines were not part of the stock monitoring system and not accounted for in shift handover. We brought this to the attention of the trust who said they were aware of this practice but it was not approved and was in the process of being addressed by operational managers.

Records

- Staff completed a patient care record for each patient event using the electronic patient record form (EPRF). If the ePRF was not available due to IT or connection issues staff used a paper version of the patient care record.
- In addition to patient care records, EPRF and paper records, staff were required to complete further documentation for individual patients specific to their needs. For example, mental capacity forms were an assessment tool used to assess patients' capacity, and paper forms were required to be completed for patients who had died. Paper records were collated at the end of each shift. These were then placed in a secure box at each station and collected by the station support operative and transported to headquarters within two weeks.
- The EPRF could be accessed by ECCM's using a secure smartcard system. ECCMs carried out sample audits of a staff member's EPRF to inform their performance appraisal and clinical supervision. We observed results of the record audit displayed at the ambulance stations.
- All staff were trained in information governance through an on line learning tool at induction and annually on the essential annual training to ensure any patient identifiable information was stored, secured and transported appropriately.
- We found records were stored securely and did not breach confidentiality, with one exception. In one ambulance we found a mental capacity assessment and a paper report form in the glove compartment. This was removed and reported to an ECCM.
- NEAS was in the process of updating the current electronic patient report device with roll out of the new solution ePRF in July 2016. We were informed that the new system would be more efficient and would incorporate the paper records that were currently used.
- We reviewed 94 care records in electronic or paper versions; these included drug prescription and administration records, capacity assessments and GP letters. We found most records were well documented and completed clearly. In three instances, records had contained errors or other minor omissions. We found that two patients were not left with the paper duplicate copy of the record.
- We observed the process for generating a GP letter and obtaining patients consent for the process. Staff in the emergency operations centre (EOC) could sometimes access information about end of life preferences for

patients such as do not attempt resuscitation decisions (DNARCPRs). They could advice ambulance crews where these decisions were in place, and these could be flagged on the electronic system. However, staff needed to check the correct paperwork was in place and they told us this was not always available. The hospitals we visited reported no concerns with any documentation they received from the ambulance service.

Assessing and responding to patient risk

- Staff we spoke with were confident in escalation procedures and understood processes for requesting additional resources through the control centre and senior staff. Staff recorded physiological observations and early warning scores. They had access to point of care testing and electrocardiograph and cardiorespiratory monitoring.
- In response to the introduction of major trauma centres and midwifery led services in hospitals, NEAS implemented guidelines for staff to bypass departments based on the needs of their patients.
- There were a number of local referral pathways for specialist services in place for patients who may be suffering from a stroke, having a heart attack and requiring a primary percutaneous coronary angioplasty (PPCI), and for patients who have suffered major trauma injuries.
- The ambulance control room provided advice to crews by assessing up to date information. Ambulance staff could request guidance through the 111 directory of services. There was a trial in place providing the directory of services on electronic tablet form, so crews can access the information themselves.
- For complex clinical cases, staff could access specialist advice through an advice line.
- A patient alert system was in place which was used for those patients identified as having specific risks. A pre-alert tagging mechanism stored on the computer system was used to inform ambulance crews of specific risks prior to attendance. For example, if a patient was a previous victim of domestic violence, or an alert was raised.
- Staff told us about the de-escalation of mental health crisis with patients, and appeared confident in their management of scenarios. The involvement of crisis

teams (who give urgent help to people who have a mental health problem) and the police was seen to be a last option although staff were knowledgeable about referrals and support.
- Community first responders (CFRs) were in place in some rural communities. These volunteers responded to life threatening emergencies in their communities while an emergency ambulance was travelling to the patient. They operated within defined parameters which were agreed with the ambulance service. There were 88 CFRs within NEAS working in the rural areas.

Staffing

- NEAS had dual crew ambulances staffed by an Emergency Care Assistant (ECA) and Paramedic, urgent care ambulances staffed by two ECA's or an Emergency Care Technician (ECT)/Advanced Technician and ECA, and rapid response paramedics who respond in cars.
- The trust was experiencing difficulties recruiting to paramedic vacancies and information provided by the trust before the inspection indicated that the planned establishment for paramedics was 642.40 wte. This included staff in management roles and within the urgent and emergency care and resilience core services. The actual number of staff in post was 539.91wte which meant there was a vacancy of 102.49 wte.
- Emergency care operations (front line staff) had an establishment of 1111.28 and 1034.34 staff were in post (93%).
- Staffing for the south division had a vacancy factor of 8.5 whole time equivalent (WTE) ECCM posts, 51.27 paramedic posts and 11 emergency care technician (ECT) posts. The north division had a vacancy factor of 5 ECCM's, 3.80 paramedics and 1.74 ECT posts. The central division had a vacancy factor of 6.5 ECCM posts, 11.20 paramedic and 3.0 ECT posts.
- NEAS had experienced difficulties in recruitment and retention, arising from the national shortage of qualified paramedics. To address the high percentage of vacancies in this staff group, it implemented a number of strategies that included recruitment of qualified paramedics both within the UK and internationally and through attendance at job fairs in the UK. Overseas recruitment campaigns resulted in employing 18 qualified paramedics.
- The south division has faced particular challenges in obtaining qualified staff. Paramedic BSc students at Teesside University received mentoring by NEAS staff to

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encourage and secure their recruitment. The service recruited 30 students (Seven in 2016 and 23 in 2017) with a conditional offer once they qualified as paramedics.

- There were 75 paramedic students undertaking their foundation degree in post who would be qualified between September 2016 and February 2017. These staff were to be employed by NEAS and were contracted to work for NEAS for at least two years after qualifying.
- The development and implementation of new roles for the trust was introduced for example advanced practitioners and clinical hub clinicians.
- There were skill mix changes within teams, including the advanced technician role.
- Each division employed additional emergency care assistants (ECA)'s. North division had 1.63 wte staff, south division had 8.86 and central division had 10.68 wte staff.
- NEAS employed bank staff who had a zero hour's working week contract. We were told that most bank staff had worked for the NEAS and had retired. All had received the full EAT training, refresher courses including driver training and preceptorship training. NEAS also used third party providers at busy times such as the St. Johns ambulance service.
- Staff raised concerns about the usage of double-crewed ambulances with two ECA's. The skill mix of a double ECA crew meant they should be restricted to urgent calls rather than emergency calls. However, lack of resources meant these crews were sent to emergency calls and if appropriate, waited for a paramedic backup. We spoke with ECA's who told us this happened often and there was a delay at times in the paramedic crew arriving as backup. Managers told us that they used the double crew ECA's to respond to emergencies, as they would the community responders, and they were expected to use the skills of which they were trained and await paramedic backup.
- Sickness absence information was provided by the trust. Between December 2014 and December 2015 the sickness levels were above the trust target of 5% each month. They averaged at 7.93%. From July 2015 to December 2015, sickness levels increased each month peaking in December 2015 at 10.46%. The two main trends for reasons for sickness were muscular-skeletal problems and stress.

- The resource scheduling department (RSD) monitored and reported on changes to schedules and staffing levels. The RSD looked at all rotas and planned for shortages. A system was in place for staff to volunteer to cover shifts for overtime payments.
- The trust used a system for absence whereby staff called a designated number to register their sickness. This system provided the means to monitor absence, specific shifts, days and times of repeated absences. The external organisation supporting this system provided nurse advice to staff as appropriate and supported managers in managing the absence process in terms of absence notification, contact call and return to work meetings.
- The Operational managers reviewed cover between stations and were notified of staff sickness. When staff were absent through sickness, the Operational managers contacted the staff member check their well-being and to offer support. When staff reported sick, staff from two stations interchanged to provide cover. Depending on the length of sickness, a follow-up call took place and where necessary a referral of the staff member was made to occupational therapy, physiotherapy or counselling as appropriate. ECCM's also considered the appropriateness of alternative light duties or phased returns to work depending on the situation.
- Staff had access to an Occupational Health service. This provided access to a fast track physiotherapy service, counselling and clinical psychology services. We were informed that the ECCM's had received training in debriefing and supporting staff with post-traumatic stress disorder (PTSD).
- Seven staff we spoke with said they felt well supported following a period of sickness.
- Staff turnover between April 2015 and April 2016 was 6.37%. The highest turnover of staff was in the south division.
- Annual leave was planned eight months in advance to ensure everyone obtained leave fairly and that it was distributed evenly. Staff commented it was difficult to get annual leave at short notice.
- The biggest challenges reported by staff were late finishes and missed meal breaks. Staff reported the impact of this was leading to staff working 13/14 hour shifts. One member of staff shared information on the number of late finishes they had. In January 2016, 68% of their shifts resulted in a late finish. In February 2016

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57% of shifts resulted in late finishes and in March 2016 70% of their shifts had late finishes. Staff told us this had a substantial impact on their personal life, as they could never guarantee finishing on time, and this had an impact on planning child care etc.

- Shift start times were staggered to allow staggered breaks times, which helped to ensure emergency cover was always available.
- At the time of the inspection NEAS was piloting a process of reducing late finish times and missed meal breaks.

Anticipated resource and capacity risks

- The trust used the national indicator resourcing escalation action plan (REAP). This was an indicator of pressure in the ambulance services, which can be used to trigger specific actions when a trust was operating with significant and sustained levels of activity. The levels of REAP range from one (normal service) to six (potential service failure).
- Locally, the service used an indicator of hospital demand known as north east escalation plan (NEEP). The hospitals populated an online portal known as a 'Flight Deck' detailing their current demand, capacity and NEEP level. This was a capacity management system intended to support improved whole system awareness of capacity. Flight Deck showed the current, known demand, in terms of patients being conveyed to hospitals across the north east, allowing hospital providers to be aware of trends in system pressures.
- The system showed forecast activity for the next four hours, based on historical demand and informed by seasonal, weekly and hourly variations. This provided an understanding of potential system pressures therefore, allowing actions to be taken early to reduce pressures, for example having ambulances or RRVs in the areas of peak activity.
- Winter pressures had resulted in the trust operating at increased escalation levels. Regular conference calls took place on a daily basis with executive, strategic and operational leads. Discussions addressed call volume, performance, shift report and resilience as standing agenda items. We observed one of the conference calls and found the meetings addressed the current pressures and actions to resolve these. We saw the REAP

level displayed at one of the stations. Staff told us information on REAP levels was available on the intranet or from ECCM's. Not all staff were aware of current REAP levels.

- The trust had business continuity and recovery plans in place which were updated in January 2016. We were informed that a business continuity dashboard was in place which was updated monthly and included incidents and risks. An example of the use of the business continuity plan was shared. Work involving the electricity supply near an ambulance station caused a temporary loss of power to the station and resulted in the use of a business continuity response.
- We reviewed the trusts adverse weather plan. Business continuity arrangements were in place in the event of adverse weather causing severe disruption to the service. Staff we spoke with were aware of contingency plans that were available including the use of 4x4 vehicles and snow chain vehicles which were deployed to ambulance stations during adverse weather.

Response to major incidents

- A major incident is defined as an event whose impact cannot be handled within routine service arrangements. It requires the implementation of special procedures by one or more of the emergency services, the NHS or a local authority to respond to it. Any incident is considered to be major if the number, severity or type of live casualties; or its location, requires extraordinary response measures.
- NEAS had a major incident plan in place for 2015/16. The plan reflected the responsibilities of the service to alert, mobilise and co- ordinate NHS resources acting in support of the wider NHS response.
- We were informed that in the event of Chemical Biological or Radiological Nuclear (CBRN) incidents NEAS called on a volunteer pool of 124 special operations response team trained staff, each with specialist equipment. The hazardous area support team (HART) provided additional support.
- In the event of Marauding Terrorist Firearms Attack (MTFA) incidents, NEAS had a volunteer pool of 66 trained staff to enhance their response to these types of events each with specialist equipment. This resource was available in addition to HART team staff.

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- We found that these specialist staff identified themselves at the beginning of their shift and were noted in the Emergency Operations Control (EOC) so that EOC were aware of the actual capability to respond in the event of a major incident.
- We reviewed a medical contingency plan which had been prepared to provide a structured medical response to a potential or actual critical, serious or major incident within a premier league football stadium or the outlying grounds on match days. The medical contingency plan included specific details of medical logistics including the doctors' response.
- We were informed that staff were aware, fully engaged and trained in the ways of working related to the Joint Emergency Services Interoperability Principles (JESIP). Two members of staff we spoke with described their involvement in a major incident and the learning that came from debrief afterwards. Staff we spoke with had access to a "flashcard" on the ambulances that explained their role in responding to a major incident. However, the majority of the frontline staff we spoke with said they had received minimal training for major incidents. Staff described their training as consisting of watching a CD in their own time. Training was not audited to check compliance. Many staff said they would not be confident in responding to a major incident due to never taking part in a practice exercise.

Are emergency and urgent care services effective?
(for example, treatment is effective)

Requires improvement ●

We rated the effectiveness of the trust's emergency and urgent care serves as requiring improvement because:

- Overall 70.8% of staff had undertaken an appraisal since April 2015 to March 2016

- The proportion of Red 1 and Red 2 calls meeting national targets had deteriorated. From August 2015 to March 2016 onwards the trust failed to meet the 75% standard
- Between August 2015 and March 2016 the trust breached the 95% standard for the proportion of category A calls responded to within 19 minutes

- The overall return of spontaneous circulation rate for the trust was worse than the England average for 8 months between January 2015 and December 2015. However, using the Ustein comparator group, the trust performed better than the England average for 8 months out of the 12 months between January 2015 and December 2015.
- The proportion of patients discharged from hospital alive following a cardiac arrest was consistently below 12%. This was worse than the England average in all but three months between January 2015 and December 2015. For patients using the Ustein comparator group, the proportion discharged alive was better than the England average in all but three months over the same period.
- The proportion of relevant patients arriving at a hyper acute stroke unit within 60 minutes was above the national average from 60% to 77% of patients from January 2015 to August 2015. However, from September 2015 there was a downward trend with only 45% of patients in December 2015 arriving at a specialist stroke centre within 60 minutes.

However:

- The proportion of suspected stroke patients assessed face to face who received an appropriate care bundle was above 98% for all but 3 months between January 2015 and December 2015. This was above the national average.
- Between January 2015 and December 2015 the proportion of patients receiving primary angioplasty (unblocking of a coronary artery) within 150 minutes was above the England average for 11 out of 12 months.
- Following a heart attack 79% to 96% of patients received the correct treatment in line with ambulance guidelines. This was above the national average between January 2015 and December 2015.
- The proportion of suspected stroke patients assessed face to face who received an appropriate care bundle was consistently above 95% and compared to the England average.
- Care and treatment was delivered based on National Institute of Health and Care (NICE) Guidance, Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines and the Resuscitation Council UK (RCUK) guidelines

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- NEAS has a number of care bundles, which are evidenced based processes, in place, based on the ambulance quality indicators. Consent was obtained from patients prior to assessment and treatment.
- Patients received consistent and effective pain assessments and pain relief was administered appropriately.

Evidence-based care and treatment

- Staff we spoke with had appropriate access to policies, national guidelines, care bundles and pathways. Care and treatment was delivered based on National Institute of Health and Care (NICE) Guidance, Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines and the Resuscitation Council UK (RCUK) guidelines. Paramedics discussed the use of JRCALC guidance. We saw a pocket version of JRCALC. We also noted a pocket version of alternative pathways for major incidents in JRCALC.
- A local handbook was developed in 2015, which was used in conjunction with national guidance.
- When revised guidance or new directives were received, we were informed that the service updated clinical practice guidance which was available to staff through "Patient care update" alerts and Essential Annual Training was updated. Staff were alerted to updated guidance by email and by information displayed in the ambulance station. We observed that recent alerts and patient care updates displayed in the stations we visited. , The update information was also filed for staff reference. We reviewed information on the staff intranet which informed staff of changes in practice. For example, changes in care pathways. The ECAs we spoke with were less familiar with the use of guidelines and evidence based care, and referred to paramedics or seniors for advice when needed. The review of the staff report forms would inform the ECCM's that staff have used the new guidance.
- NEAS has a set number of care bundles (Stroke, ST elevation myocardial infarction (STEMI) , Hypoglycaemia, asthma), based on the ambulance quality indicators, which staff used to ensure patients presenting with a range of conditions received the most appropriate treatment for their condition. We observed staff using care bundles for STEMI, stroke and asthma. We reviewed electronic and paper copies of patient records and saw good evidence of bundles being followed.

- ECCM's monitored staff compliance with care bundles through the electronic systems in place. We reviewed the audit activity against the care bundles for; stroke, PPI and acute MI, febrile convulsion, falls in the elderly, lower limb fractures, asthma and diabetes.
- Audit information was accessed through the staff intranet and updates were sent to ECCM's via email. The ECCM's had appropriate access to information but we found that not all staff had opportunity to review the range of audit results. The range of audit activity was comprehensive, but results from audit was not consistently shared. The asthma audit and NEAS paramedic staff compliance with the care bundle and specifically the recording patients' peak flow measurements were examples of where practice could be improved. The data collected and results were clear but no action plan was in place or monitoring of staff improvements in recording. Monthly governance meetings were held divisionally to highlight concerns with compliance and trends identified and these were shared with the emergency care clinical managers.
- The directorate had links with the clinical department and actively contributed to a number of research programmes and developments for example the Acute Stroke Treatment Assessment (PASTA) trial which commenced in the South division in April 2016.
- We checked three policies on the trusts intranet page and found they were all in date and had a version control number. Staff were able to access the system to view the trusts policies and procedures at stations; however, some staff told us they did not always have the time to do this.

Assessment and planning of care

- NEAS had developed and introduced a number of strategies, care pathways and local care pathways which included bypassing emergency departments to take the patient directly to the appropriate specialist department. For example stroke, major trauma and head injury.
- We observed staff that followed care pathways and we found staff had an understanding of the pathways available. Staff could describe the pathways and protocols used for children, and for patients with dementia or learning disability.

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- National clinical performance indicators were reported twice yearly nationally and monthly within NEAS. These reports identify how the trust was performing, for example with care bundles relating to asthma, lower leg fracture and falls experienced by elderly patients.

- Advanced paramedic staff told us about the introduction of enhanced clinical assessment and referral (which was also known as "see and treat"). See and treat supported patients being left at home or referred to other health care professionals as appropriate. Advanced paramedics said they attempted to keep the patient at home and to refer to other services if they assessed this as the best pathway for the patient.

- Staff described the new 'Toughbook' that was being introduced. The Toughbook enabled interaction with other clinical systems, for example at hospital catheter laboratory systems, which would enable viewing and downloading of heart tracings (ECGs). This allowed medical staff in the cardiac catheter laboratories to review a patient's heart monitoring when they are being transferred by an ambulance.

- Patients who require mental health care were assessed by ambulance crews and transferred with their carer if available. Crews told us the safety and well-being of the patient was the priority and if they felt the patient presented a risk to themselves or others the police provided further assistance if needed.

Response times

- NEAS response times were measured and reported nationally following the agreed national response standards for Red 1, Red 2, and Category A19 calls. The national target for immediately life threatening Red 1 calls was that 75% of calls (the most time critical, where patients were not breathing, do not had a pulse or peri-arrest) were to be responded to within 8 minutes.

- Data showed that between April 2015 to March 2016 out of the eleven national ambulance trusts NEAS was the joint worst performing ambulance service in NHS with responses within target for Red 1 performance. There was a downward trend in the proportion of Red 1 calls responded to within 8 minutes between June 2015 and March 2016.

- Red 2 calls national standard was that 75% of Red 2 calls (still serious, but less immediately time critical, like strokes or fits) were to be responded to within 8

minutes. There was a similar downward trend in the proportion of Red 2 calls responded to in 8 minutes. Data showed from April 2015 to March 2016 the trust was the fifth of the eleven ambulance services in the NHS with responses at 68.6%, although responses in 9 minutes achieved 74.4%. In January 2016, only 61% of calls were responded to in 8 minutes.

- A19 calls national standard is that 95% of Category A calls should be responded to within 19 minutes with appropriate transport to convey the person to hospital. There was a downward trend in the proportion of category A calls responded to within 19 minutes since August 2015 to March 2016. In August 2015, the trust responded to 94% of category A calls within 19 minutes, with a downward trend to 89% in January 2016 to March 2016. In December 2016, the trust responded to only 88% of category A calls within 19 minutes. Between August 2015 and March 2016 the trust breached the 95% standard.

- Green calls were divided into four categories (G1 to G4). A green 1 call should be responded to in 20 minutes and a green 2 within 30 minutes. Green 3 and 4 calls require a 60-minute response for non-blue light emergency calls. For conditions that were not life threatening there were no requirements to report on these standards nationally.

- For patients requiring admission to hospital (classed as "Urgent"), NEAS had four hour, two hour and one hour transport times for GP and health care professional's referrals. These response times were reported live in the control room and available for review on system performance dashboards. This live data was shared across the service through shift summaries, in daily conferences calls and a report was generated every 24 hours to show how quickly the service was responding to patients.

- Resourcing escalation (REAP) cards had been introduced to try and mitigate under performance. This helped to ensured that staff knew of current challenges the service faced, for example, hospital handover delays, adverse weather, or resourcing concerns.

- We found that performance over the previous 18-24 months had not been consistently maintained. Staff told us this was due to a number of pressures across the wider health system, including staffing and sickness absence, and most recently, as a result of an increase in

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the volume of Red incidents. There were long handover times at hospitals due to pressure within the hospitals. At times, this led to diverts to other hospitals to increase capacity to be able to be more responsive.

- Between April 2015 and April 2016 there had been 1364 handovers between 60 – 90 minutes. 477 handovers between 90 – 120 minutes and 218 handovers over 120 minutes. Crews are targeted to handover and turnaround within 30 minutes and to be free to respond to further emergencies.
- Senior managers told us that the pressure and focus to meet Red category calls had a significant adverse effect on the GP urgent and Green responses.
- To alleviate pressure on local emergency departments' ambulance crews were dealing with more patients on scene and pathways were in place to reduce the number of unnecessary conveyance to hospital.
- We were told response times had been affected by the Ambulance Response Programme (ARP). NEAS was one of four pilot sites for ARP, trailing a different approach to responding. The ambulance crew waited for the call handler to reach a disposition (a response category), that enabled them to respond more appropriately. For example a paramedic, an advanced practitioner or an urgent crew, to be despatched dependent on a more accurate assessment of the needs of the patient. The ARP trial commenced in October 2015 and has been extended until summer 2016.
- Response deterioration was more significant in rural localities and in the south of the region for example Durham, Dales, Easington and Sedgefield CCG area which achieved only 56% year to date target at the end of December 2015. We were informed the deterioration in response was compounded by hospital delays in the locality and by an increase in divert that was initiated between the hospital sites.
- To help improve response times NEAS worked collaboratively with four local fire and rescue services to establish a co-responding service.

Pain relief

- Pain experienced by patients was recorded on a numerical rating scale of zero to ten; zero being no pain and ten being the worst possible pain. Verbal descriptors were used such as mild, moderate and severe.

- Of the 94 records we checked, patient's pain score was consistently recorded. We observed staff asking patients about their pain. Each of the 36 patients we spoke with said they were asked about their pain and felt they were treated for their pain symptoms appropriately.
- The Enhanced Care Paramedics and Advanced Paramedic used Patient Group Directives (PGD's) which increased the range of analgesia medicines available for patients.

Patient outcomes

- The trust routinely collected and monitored information about patient care and treatment. Ambulance clinical quality indicators measured the overall quality of care and end-results for patients following care and treatment.
- Following a cardiac arrest, the Return of Spontaneous Circulation (ROSC) which included signs of breathing, coughing, or movement and a palpable pulse or a measurable blood pressure, was a main objective for all out-of-hospital cardiac arrests, and can be achieved through immediate effective treatment at the scene. The ROSC is calculated in two patient groups. The overall rate measures the overall effectiveness of the urgent and emergency care system in managing care for all out-of-hospital cardiac arrests. The rate for the 'Ustein comparator group' provides a more comparable and specific measure of the management of cardiac arrests for the subset of patients where timely and effective emergency care can particularly improve survival. For example, 999 calls where the arrest was not witnessed, and the patient may have gone into arrest several hours before the 999 call are included in the figures for all patients, but are excluded from the Ustein comparator group figure.
- The overall return of spontaneous circulation rate for NEAS was worse than the England average for 8 months between January 2015 and December 2015, ranging from 19% to 28% compared with national average 25% to 31%. However, using the Ustein comparator group, the trust performed better than the England average for 8 months out of the 12 months between January 2015 and December 2015.
- Heart attack or ST segment elevation myocardial infarction (STEMI) is caused by a prolonged period of blocked blood supply within the coronary arteries. Reductions in STEMI mortality and morbidity is influenced by those patients who received the

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appropriate care bundle, those who have timely delivery to the cardiac catheter laboratory for intervention, and those who have timely thrombolysis (clot busting medicines). Between January 2015 and December 2015 the proportion of patients receiving primary angioplasty (unblocking of a coronary artery) within 150 minutes was above the national average other than in March 2015, when they were below, ,this ranged from 82% of patients to 95% of patients.

- Following a heart attack the 79% to 96% of patients received the correct treatment in line with ambulance guidelines. This includes certain drugs being given and observations being taken and recorded was above the national average between January 2015 and December 2015. This was above the national average of between 76% and 84%.

- Survival to discharge from hospital is measured as this reflects the effectiveness of the whole acute healthcare system. Survival to discharge is calculated for two patient groups; the overall group, and the Ustein comparator group. The proportion of patients discharged from hospital alive following a cardiac arrest was consistently below 12%. This was worse than the England average in all but three months between January 2015 and December 2015. For patients using the Ustein comparator group, the proportion discharged alive was better than the England average in all but three months over the same period.

- The health outcomes of patients can be improved, by recognising the symptoms of a stroke or transient ischaemic attack (TIA).Making a diagnosis quickly, and providing early transport of a patient to a stroke centre capable of conducting further definitive care including brain scans and thrombolysis can improve a patient's chance of survival. The proportion of relevant patients arriving at a hyper acute stroke unit within 60 minutes was above the national average between 60% to 77% of patients from January 2015 to August 2015.There was a downward trend to only 45% of patients in December 2015 arriving at a specialist stroke centre within 60 minutes.

- The proportion of suspected stroke patients assessed face to face who received an appropriate care bundle was above 98% for all but 3 months between January 2015 and December 2015. This was above the national average.

Competent staff

- In 2014/15 the service was 100% complaint with appraisal completion for available staff (those not on long term absence, maternity leave, secondments)

- Overall 70.8% of staff had undertaken an appraisal between April 2015 and March 2016. North division had 74.3% completed appraisals; the south division had 66.7% complete appraisals and the central division had 71.7% completed appraisals. Staff commented to us that they found it difficult to arrange an appraisal as they would have to come in early for a shift, stay at the end of their shift or come in on their day off.

- Staff new to the service received a corporate induction and a local induction to their specific area.

- All students received mentoring and preceptorship support with a named mentor for their two year foundation degree programme. Following successful completion of the programme students completed 12 months preceptorship supported by their ECCM. Student paramedics we spoke with said they were being supported and mentored consistently by paramedic staff.

- All urgent and emergency care staff received driving assessments, prior to starting in post. ECCMs assess driving standards during supervision on vehicle journeys. Staff did not routinely receive further driving assessments unless there a concern was raised about their driving. We were informed that from April 2016 driver training will be accredited by an external organisation and delivered in house in common with other NHS ambulance trusts.

- We spoke with staff returning from long term absence who provided examples of the support and training they received to support their return, including an appraisal and clinical supervision sessions.

- We were informed that the service supported training for all staff groups in a number of ways including specific training days internally and training sessions from external providers. Staff also had access to higher education programmes up to master's level and were supported to attend to further develop their skills and knowledge. We observed training opportunities were displayed in ambulance stations.

- Advanced paramedics had extended knowledge and skills to perform the role. In the south division the service had extended the advanced paramedic role and plans were in place to extend this to other divisions. The extended role supported patients to receive care at home where appropriate, which improved patient

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experience without the need for transport into hospital. Staff told us they would have to do any additional training in their own time and felt this created a lack of incentive.

- We spoke with ECCM's who were involved in developing a new programme for NEAS staff to access on the staff intranet that would support their development, learning and competence. This programme was in a pilot stage and had been supported by senior managers.

- The ECCM's told us clinical supervision was promoted and the ECCM's accompanied ambulance crews on journeys with both clinical leads and non-clinical leads to identify best practice and learning needs.

- ECCMs attended a five day induction programme and had accessed further development including safeguarding, stress awareness, debrief training, stress risk assessment training and post-traumatic stress disorder training to support staff operationally in their roles.

- Staff felt competent in their role but many felt they lacked competence and confidence in areas of mental health with most preferring additional training around the care and treatment of children.

- We spoke with emergency care assistants, and we received comments that the training they received was less structured and did not prepare them clinically for their role. A mentor was not allocated to ECA's and staff felt "thrown in at the deep end" once on the front line.

- A recent recruitment initiative had been successful in recruiting a first intake of four paramedic staff from outside the UK who, at the time of inspection were undertaking a competency and adaptation programme designed and supported by the NEAS team. The staff would be operational when assessed as competent and the HPCP registration process is completed.

- The Station support officer (SSO) was a recently developed role. We spoke with two SSO's and they had received an induction programme and reported being well supported.

Coordination with other providers

- The service coordinated arrangements with other providers. Regular meetings took place involving the operational management team and receiving hospitals to discuss logistical, operational and patient care issues. Managers attended Urgent Care Boards and Systems Resilience Group meetings in order to discuss issues and developments.

- The service attended the clinical advisory group which included representatives of a range of clinical specialties and care providers in the region.

- During 2015-16 the service supported hospital emergency departments with hospital ambulance liaison officers (HALOs). The HALO liaised with patients, operational staff, control room staff and hospital managers in order to improve ambulance turnaround times. A HALO could be deployed to the hospitals, when handover times deteriorated. Hospital staff we spoke with spoke very positively about the HALO role.

- The 21 hospital staff we spoke with reported good relationships with NEAS staff.

- The NEAS clinical Hub provided further specialist advice and support. The clinical hub provided specialist end of life, mental health and pharmaceutical guidance to support effective patient care.

- There were established links with the fire service. An emergency medical response (EMR) trial which involved four fire and rescue services (FRS) was underway and was due to complete in June 2016. Each FRS responded to appropriate Red 1 and Red 2 calls according to specific dispatch criteria. During the trial, emergency medical response units (fire appliances) delivered emergency medical services when requested by the ambulance service. The emergency medical services included may involve attending calls where people were suffering from chest pain, difficulty in breathing, cardiac arrest and unconsciousness not due to trauma.

- The service worked with external providers of ambulance services including St. John Ambulance and British Red Cross.

Multidisciplinary working

- We observed the handover of patients between ambulance crews and staff in hospital emergency departments. The handovers we observed were well structured and comprehensive. We spoke with staff in the emergency departments and they expressed no concerns about ambulance handovers or working with NEAS ambulance crews. We saw evidence of staff working closely with staff in the hospitals we visited. We were advised by several hospitals that the ambulance crew attitude was always pleasant, accommodating and that handovers were usually detailed and accurate.

- Ambulance crews pre-alerted hospitals where necessary so that hospital staff were aware when a critically ill patient was due to arrive at the emergency department.

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- If a person appeared to be suffering from mental disorder and was in need of immediate care or control, a section 136 coordinator may remove that person to a place of safety within the meaning of section 136 of the Mental Health Act 1983. The section 136 co-ordinators (police) we spoke with highlighted that ambulance staff were supportive, pleasant and helpful. We found that police and ambulance crew worked well together. However, lack of knowledge about mental health and mental capacity was raised as a concern by staff.

Access to information

- The service distributed patient safety alerts and health and safety updates using an electronic system. Each ambulance station and service base received these update notices and we observed they were displayed clearly in the locations we visited. The ECCMs communicated update notices to their staff through email.

- Ambulance station noticeboards were updated by the ECCMs and we observed consistency across most of the stations. The station notice boards contained alerts and patient care updates, NEAS briefing, health and safety, campaigns and clinical updates showing the care bundle information and any research trails.

- The chief executive provided updates and briefings to communicate with staff about current issues and shared good news stories. Chief executive briefings were available to staff on the intranet, a recently implemented staff app for the smart phone and on station noticeboards. Policies and procedures were available on the trust's intranet system.

- Each of the ECCM's had a smart phone which gave them access to the majority of the information available on the trust intranet, including email access and up to date performance data.

- Staff we spoke with were aware of how to access information and updates. They commented they did not always have time at the stations to read the volume of information available on a range of topics.

- Staff had access to information via mobile phone NEAS app technology, this appeared to be an effective system and plans were reported to be in place to develop it further. Not all staff we spoke with felt that the app was useful for practice and said it needed further development.

- At ambulance stations staff could access computers and IT systems to support them in their role. Most staff were reliant on the cascade of information from the ECCM due to time constraints in the operational role and limited time on station. All staff we spoke with told us that significant improvement had been made in the past year to the sharing of and access to information.

- The control room offered advice to crews who requested more information, and crews could request guidance through the 111 directory of services (DoS). A flexible ("agile") working trial was in progress which used the directory of services in tablet format so that crews could access DoS information.

- Staff were informed by the operations centre if a patient was 'flagged' on the system. This included risk of violence to staff.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent was carried out in accordance with the trust capacity to consent to examination or treatment policy and was supported by a range of specific patient consent forms. We saw examples were appropriately completed in the paper and electronic records.

- We questioned staff as to how they gained a patients consent. Staff demonstrated a clear understanding of gaining consent. Staff told us consent was applied for all patient contacts and where a patient was unable to give consent a mental capacity assessment was completed.

- We observed consent being gained whilst we were observing crews. The patients and relatives we spoke with confirmed that crews had explained their actions and gained consent prior to carrying out any assessment or treatment. Relatives also spoke about being comfortable with raising a concern about treatment if necessary and were confident that staff would listen.

- We found two examples inpatient records of patients refusing to attend hospital. There was evidence of consent to this decision. Patients were given a paper copy of information to support them if they required further assistance. NEAS staff had completed GP letters that were electronically generated to keep the GP informed of the emergency call and attendance and the refusal to convey.

- For patients on their own and who were unconscious, staff acted in the patients' best interest. There was a

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trust policy in place regarding the use of CCTV. Staff told us that patients were informed of the CCTV in operation on all vehicles. Patients were informed by a recorded audible message from the vehicle and by signage displayed. Normally low level footage was recorded. However, if the panic alarm was used or the vehicle was involved in an accident the CCTV recorded in high definition.

- Staff we spoke with were comfortable with the use of CCTV and felt it offered protections. There had been no patient complaints regarding the CCTV. We were informed that footage was only viewed if there had been a specific incident such as violence, an accusation or an accident. Staff received training on consent at their induction (100% of staff inducted into the Trust) and also on mental capacity together with updates at EAT. This included an update on deprivation of liberty.

- Staff in the emergency operations centre (EOC) could sometimes access information on do not attempt resuscitation decisions (DNARCPRs). They could advice ambulance crews where these decisions were in place, and these could be 'flagged' on the electronic system. However, these were not always current, staff needed to check that the correct up to date paperwork was in place.

- Directorate managers received training to Level three for safeguarding to provide additional support to staff when making referrals or dealing with deprivation of liberty. This included ECCM's so staff had access and support if required. Of 63 managers, 58 had completed the level three training.

- No formal complaints had been made about direct treatment without consent.

- ECCM's told us they monitored the effectiveness of staff gaining consent during the clinical observations on vehicles and identified and dealt with any gaps at point of care. Compliance with consent for refusal of treatment, alternative care pathways consent and the refusal of transport to hospital was monitored. Patients had to sign to say they had refused and we were informed that a mental capacity form had to be completed if a patient had refused treatment or transport to hospital, ensuring the patient had the capacity to do so.

Are emergency and urgent care services caring?

Good 🟢

We rated caring in the emergency and urgent care services as good because:

- Feedback from patients who used the service and those close to them was consistently positive.
- We observed staff treating patients with care, compassion and dignity.
- Patients were given explanations regarding their care and treatments and were involved in decisions.
- When appropriate, patients were supported to manage their own health by using non-emergency services such as their GP or local urgent care centre.
- Patients, their relatives and other people important to them received emotional and practical support from ambulance crews.

Compassionate care

- During our observation of care delivery by front-line staff, we saw compassionate care of patients in ambulances, patient's homes and in the hospital emergency departments we visited. We saw staff that staff were polite and courteous with patients and their relatives or carers.
- We spoke with 36 patients and 16 relatives. All patients and relatives spoke very highly of the crews regarding the care and treatment they had received.
- We observed staff handover in a way that supported patient confidentiality and privacy.
- Patients conveyed to hospital were covered in a blanket to maintain their modesty and keep them warm whilst on a stretcher or in a wheelchair. Ambulance doors were closed when patients were inside, to ensure they were kept warm and their privacy and dignity maintained.
- We spoke with a patient who had regularly attended hospital as an emergency admission and they spoke with knowledge about experiences with NEAS staff. They told us of good experiences without exception. NEAS staff had been supportive in ensuring a neighbour cared for the patient's two dogs whilst the patient was admitted to hospital.
- We observed appropriate interaction of crew with a patient's partner and constant attempts at interaction with an unconscious patient. The crew were very caring and compassionate.

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- Patients were asked how they wished to be addressed; the interactions we observed demonstrated that staff respected patients and relatives, including those from particularly vulnerable groups such as the frail elderly and patients with mental health needs.
- We heard examples of staff asking patients if they wanted to get dressed, ensuring patient had warm clothes on before been transferred into the ambulance.
- Relatives and carers told us they were given the choice of traveling in the ambulance. We observed positive interactions with a patient's partner when the patient's condition was poorly and clear explanations by ambulance crews as to what care and treatment was been given. The crew asked the patient's partner questions about the patient's previous medical conditions and what medications they took.

Understanding and involvement of patients and those close to them

- Throughout our visit we observed patients being involved in decisions about their care and treatment. Clear explanations of treatments and procedures were given to the patients prior to them being administered. Ambulance crews ensured that patients understood. If further explanations were required, these were given. We observed staff explaining the findings of their examination of the patient and explaining what they felt could be a problem, or what problem they were ruling out.
- We were informed that the service was working with partners as part of the Vanguard project developing pathways for people with urgent care needs, including people experiencing mental health crisis, with the aim that the service could provide a highly responsive service that delivered care as close to home as possible, minimising disruption and inconvenience for patients and their families.
- We were informed of an example of ambulance staff involving social services with two patients who were homeless. Staff showed compassion and involvement above the requirements of the role and this resulted in a positive outcome for the patients who were supported and given shelter through the agencies involved with their care.
- Carers attending patients experiencing a mental health crisis were involved in their care and were invited to accompany the patient to hospital.

- We spoke with technician crew member who described caring for a patient during transport from a care home to hospital. The patient had dementia and the technician asked for the relatives to be involved in the transfer.

Emotional support

- We observed crews reassuring patients and providing emotional support.
- Staff told us that they would support relatives as much as they could during or after a death of a patient. Literature to assist relatives immediately following the death of a loved one was provided. This contained information as to what happens next, in the subsequent hours and days.
- Managers told us the importance of applying the "6 Cs" had been communicated to all staff and continues to remain at the core of behaviours. Staff we spoke with could explain what these were. The 6Cs were developed by NHS England and stated goals that staff should strive towards when providing care. These included care, compassion, courage, communication, commitment and competence.

Supporting people to manage their own health

- Implementation of the advanced practitioner pilot scheme was expected to produce a greater number of patients who were seen, treated and discharged with advice and treatment to self-manage. This was confirmed by our interviews with two advanced paramedics.
- Patients who received a see and treat service at the scene from ambulance crews enabled them to be safely supported at home so they were not taken on unnecessary journeys.
- The development of the NEAS clinical hub helped to ensure specialist assistance from GPs, mental health nurses, general nurses and pharmacists was available to provide additional reassurance and guidance for both staff and patients.
- Referral processes were in place in order to share information with external agencies for those at risk of falls and for those where safeguarding and self-care concerns had been identified.
- A process was in place where addresses detailing patients with mental health problems and end of life care plans with specific individual arrangements were flagged, and the control staff informed the crews.

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However, crews told us this was not always consistent and we were informed of an incident where staff attended patients without prior knowledge of alerts or special circumstances.

Are emergency and urgent care services responsive to people's needs?
(for example, to feedback?)

Good 🟢

We rated the responsiveness of emergency and urgent care services as good because:

- NEAS was part of a vanguard programme working collaboratively with North East Urgent Care Network (NEUCN) to deliver projects to facilitate a better service.
- There was access to translation services for patients whose first language was not English.
- There were specifically equipped vehicles for the use of bariatric patients.
- Relatives or carers were encouraged to accompany patients with dementia or a learning disability to help alleviate the patient's anxiety.
- The service worked in partnership with commissioners and the police to provide a city centre triage unit.
- The service deployed Hospital Ambulance Liaison Officers (HALO) at times of surge in hospitals where patient flow was compromised.
- Alternative pathways of care were used including 'see and treat,' alleviating inappropriate admissions at hospitals.
- In response to the introduction of major trauma centres and midwifery led services in hospitals, NEAS implemented guidelines for staff to bypass departments based on the needs of their patients.
- Staff were aware of the complaints process and received feedback. The number of complaints had decreased in the last year.

However:

- There were 100% of all complaints acknowledged within policy timescale of 3 days, only 63.4% of complaints responded to within policy timescale of 25 days, and 36.6% of complaints responded to outside of policy timescales of 25 days year to date.

Service planning and delivery to meet the needs of local people

- To facilitate a better service for local people, the service participated in the north east urgent care network (NEUCN) vanguard programme to support delivery of the urgent and emergency care review. This pilot programme aimed to provide additional resources to help ensure a timely response to patients and offer a wider range of treatment options for patients including treating patients and discharging them or referring them to other services, avoiding unnecessary attendances at emergency departments. We saw evidence of this in the south division.

- The service developed the integrated care and transport pilot (ICaT) which used advanced paramedics with ICaT transport staff to attend appropriate calls for their grade. The pilot supported the development of an integrated model of care and transport across the service. The service has developed its strategy around reducing conveyance and avoidable admissions to hospital.

- Other providers supported the ambulance service in meeting the needs of local people. The ambulance service used approximately 90 community first responders. The service developed an emergency medical response (EMR) trial within each of the divisions in partnership with the fire and rescue services.

- Strategic and operational leads within NEAS attended patient reference groups and urgent care networks with commissioners. An example was given of a public engagement event relating to the implementation of the emergency care assistant role working alongside a paramedic.

- Due to the centralising of hospital services and the introduction of major trauma centres, midwifery led services, NEAS implemented guidelines for staff which were well embedded to bypass departments based on the needs of their patients.

Meeting people's individual needs

- For patients whose first language was not English, crews could access translation services though the language line via the emergency operations centre. Crews told us they knew how to access this service. Crews had access to "flash cards" with pictures which patients could use

to describe their symptoms and/or pain. Staff carried a multi-lingual pocket phrase book to help them communicate with patients who spoke little English. Crews could access emergency signs for deaf people.

- Emergency calls could be received via text messaging. There was also a direct single button contact for women in domestic abuse situations and other technologies were used including the text relay service for those with hearing difficulties.

- Staff in rural areas had limited experience with patients of varying ethnicity. One paramedic spoke of having only once met a patient who did not speak English and not feeling entirely competent to interact with them through lack of experience.

- The trust had in place a number of resources to support patient conditions and protected groups of patients. These had been made available to staff to support their patients through patient care updates and available on the intranet.

- The service had two ambulances specifically equipped for bariatric patients. These included a hoist. These ambulances were used for non-emergency work, so could be requested by the crews. Crews commented there was a wait at times for these vehicles to become free. All newer ambulances had stretchers that were appropriate for bariatric weight and had an adjustable width. For situations where crews needed additional support for example lifting patients they would contact the HART team and / or the fire service for further support.

- We asked crews how they managed patients who had a learning disability or dementia. Crews said they would encourage their carers to travel with them to help alleviate any stress and would explain procedures in a manner they could understand. We saw positive interactions with the crews and patients with dementia.

- Patients who needed mental health support were transferred with a carer if available. Crews told us the safety and well-being of the patient was a priority and if they felt the patient was at risk to themselves or others the police were called on for further assistance.

- The service worked in partnership with commissioners and local police to provide a Newcastle city centre triage unit on Friday and Saturday evenings. The triage unit provided an assessment and triage facility and a place of safety for vulnerable people who had excess alcohol.

The service aimed to reduce the number of patients attending the emergency department. During bank holidays, this service was also provided in Middlesbrough city centre.

Access and flow

- NEAS deployed hospital ambulance liaison officers (HALOs) at times of surge in hospitals where patient flow was compromised. We did observe the HALO role.

- Alternative pathways of care were used including 'see and treat,' leaving patients at home if appropriate following assessment, alleviating inappropriate admissions at hospitals.

- In response to the introduction of major trauma centres and midwifery led services in hospitals, NEAS implemented guidelines for staff to bypass departments based on the needs of their patients.

- There were a number of local referral pathways for specialist services in place for stroke provision, primary percutaneous coronary angioplasty (PPCI), and trauma bypass. Twice daily conference calls with directorate managers and on call managers were used to identify pressure areas, hospital delays and staff shortages. Any flow issues relating to hospital delays were then escalated via executives so that hospital diverts or other measures could be arranged to assist with patient flow.

- The service also had a divert policy in place that was managed as part of its escalation plan.

- During winter pressure months, there were daily conference calls with NHS England to discuss the north east escalation plan (NEEP) levels at hospitals and also conference calls with commissioners to assist with flow.

- External assistance was sought as required via third party providers such as St. Johns and British Red Cross to improve and influence patient flow.

- ECCM's told us they visited the hospitals to review access and flow. They stated they helped triage, assisted staff in the emergency department and where necessary they split the crew to enable a crew to leave the hospital whilst the other remained with the patients.

- When the volume of calls was high, the ECCM attend Red 1 calls. A crew in the south division explained that they frequently responded to 999 emergency calls out of area which were up to 30-40 minutes away.

- Local hospitals had introduced areas were crews could admit patients directly which avoided patients

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attending the emergency department. For example, one local hospital accepted direct admission to their ambulatory care unit. We spoke with staff in these areas and received positive feedback.

- The trauma networks provided "Direct Access pathways" and crews could speak directly with a consultant for advice. For example, if they could give additional pain relief or if they felt the patient fit the criteria for a major trauma centre.
- Each hospital we visited had electronic screens that linked with the ambulance service. These provided information about patients on the way to hospital. This enabled hospitals to pre-plan and prepare for the patient's arrival.
- The real-time flight deck concept, detailing the regions hospitals current demand, capacity and NEEP levels, aimed to improve system visibility such as the number of beds available at each hospital, escalation status and incoming patient activity.
- As an approach to help the ambulance turnaround times at the hospitals and reduce late finishes for crews, ECCMs at times attended the hospitals. They would either take over the care of the patient or allow the crew to leave or assess patients waiting to be handed over and if appropriate let one crew look after two or more patients, ensuring patient safety and dependent on the patient's condition, releasing the other crews. Staff said that this approach had reduced late finishes. The arrangement was in place service wide.

Learning from complaints and concerns

- Between April 2015 and March 2016 the service received 561 complaints, compared with 632 in 2014, which showed a decreased of 11.2%. There were 100% of all complaints acknowledged within policy timescale of 3 days, 63.4% of complaints responded to within policy timescale of 25 days, and 36.6% of complaints responded to outside of policy timescales of 25 days year to date.
- During the period February 2015 to January 2016 out of 516 complaints, seven were referred to the ombudsman after being reopened (1%) and three were subsequently not upheld (0.7% of the total trust complaints where the trust were awaiting a decision from the ombudsman)
- The top themes for complaints were related to the action of the crew, the care provided and staff attitude due to comments made.

- We were informed that the service used a 'Learning from Listening' approach to improve the care provided. A weekly report was sent to the chief operating officer and senior managers detailing both due and overdue complaints reports and assurance that learning had taken place and actions required were completed. The managers informed us staff were encouraged to resolve complaints and concerns at a local level as soon as possible. Crews we spoke with said they would attempt to resolve a complaint at the time it was made if possible and appropriate to do so.
- Most vehicles displayed PALs information and carried leaflets explaining how to complain. Patients could also be directed to the NEAS website to make a complaint. We were told that complaint information was available in Braille, large print or in other languages on request to the communications department.
- Staff we spoke with were aware of the complaints process and could explain what to do in the event a patient needing to complain. The process of complaints was explained to us. All received complaints were sent to the operational manager responsible for that staff group. The operations manager had 15 working days to investigate the complaint and complete an investigation report for the patient experience team who then responded to the complainant within 25 days.
- When staff were involved in a complaint, they told us that feedback was given to them. The ECCM's we spoke with said that if a complaint was made about a specific member of staff, they would address the complaint with the staff member in a supportive way so that the staff member could learn from the complaint.
- Outcomes from complaints and information gathered from the friends and family test were gathered and themes and trends were established.
- Staff learned from events by reviewing and reflecting on the case, providing written reflection and learning, further training and development.

Are emergency and urgent care services well-led?

Good ●

We rated the emergency and urgent care services well-led as good because:

Emergency and urgent care services

- There was a clear vision and strategy for the service and staff had been engaged in the development of the mission, vision and values.
- Governance systems and processes were in place and there was a clear process for escalation of risks.
- The ECCM's were front line leaders who supported staff and supervised operations. This new role had been well received by staff and positive changes had resulted from the development of this role.
- Staff we spoke with were positive overall about the leadership of the service. Staff told us that the chief executive had a positive impact, and was visible, supportive and approachable.
- We saw examples of several new initiatives, which had a positive impact on patient care.

Vision and strategy for this service

- We were informed by managers that in 2015 the trust recognised that the vision, mission and values were out of date and required redefining. The mission vision and values were redesigned through staff engagement and consultation to enable the service to communicate its purpose effectively.
- We spoke to staff at all levels, and the majority of staff had a good understanding of the vision and strategy of the service. We saw the vision and strategy displayed in all ambulance stations.
- Staff, stakeholders and partners gave their views in a consultation on the future. More than 800 employees responded to the culture survey and one in seven staff took part in an online discussion on future and purpose.
- ECCM's and operation managers felt that all staff were familiar with the new vision, mission and values set by the trust. Staff engagement resulted in the badge being used as the basis for representing the mission, vision and values.
- The trust had recently renewed their mission vision and values and had a values based recruitment process. NEAS values were respect, accountability, compassion, pride, strive for excellence and making a difference.
- Staff could describe plans for the future, in regard to recruitment strategies, advancing roles of staff, and the impact of the executive team and its restructure. Staff were mostly positive about the changes.

Governance, risk management and quality measurement

- The trust had an organisational risk register that was a high-level record of the risks to the achievement of the trusts objectives. This was linked to the board assurance framework. Each directorate had their own risk register, which was owned by the relevant executive director, and was formally reviewed by the executive risk management group (ERMG). At these meetings directorates reported on their risks scoring 12 or above (assessed within a range of 0-25), to highlight any emerging risks to service delivery. Directorates presented action plans for minimising and managing risks. Corporate risks scoring 15 and above were included in the organisational risk register for scrutiny by the ERMG.
- Risk registers were kept at divisional level. The risks were graded according to severity, with performance ratings risked as the highest risk. Risk registers showed actions that had been taken to mitigate the risks raised. Crews we spoke with did not know how to access their divisional risk registers, and were unaware of their content.
- Several meetings took place within divisions and service wide regarding patient safety relating to incidents and risks. These included the patient safety group meetings, monthly senior management risk and compliance meetings, monthly service-wide resource management meetings, quality committee and the emergency care delivery group meeting.
- ECCM's attended weekly provisions meetings where risks were identified and discussed with estates.
- An electronic safeguard system was used for recording and managing risks registers; this was available on the trusts intranet pages.
- Staff involved in serious incident investigations were invited to be involved in the root cause analysis, so they were aware of the process and allowed to share their experiences. Staff were supported by their operations managers and ECCMs when a concern has been raised about their practice and received timely feedback and learning from the events. However, none of the staff we spoke with had attended an investigation or root cause analysis meeting.

Leadership of service

- The ECCM's were front line leaders who supported staff and supervised operations. This recently established role was to ensure staff received appropriate clinical leadership, which was documented and evidenced via

quarterly one to one meetings. The staff we spoke with had positive experiences of support and local leadership and spoke highly of the ECCM's. Several staff stated that most ECCM's were approachable, visible and pro-active when looking at solutions to problems.

- The ECCM's and directorate managers had received training to ensure that they had the necessary skills and knowledge to provide good, effective leadership to all directorate staff. ECCM's also received additional leadership training including mentoring, coaching and having difficult conversations to assist them in this newly developing role.

- Some staff we spoke with felt there were still issues with leadership but stated changes were moving in the right direction. Some staff told us that the senior management team was not visible. Staff knew their ECCM and the chief executive however, they would not recognise other managers.

- Staff we spoke with were positive overall about the leadership of the organisation. Staff told us that the chief executive had had a positive impact, was visible, supportive and approachable. The chief executive visited the ambulance stations and spoke with the crews. Staff felt confident that they could approach her via email or in person.

- As part of the inspection process we held a focus group, which was attended by community first responders. They expressed to us that they felt their role was not being developed as much as it could be, and that they were not being used to the best of their ability. Additionally, they were unsure of their management structure and told us that there had been many changes recently, which had left them unclear about who managed them.

- Staff were supported through traumatic incidents by a timely debriefing process and referred or signposted following this debriefing if required. The debrief was shared with the managers so they had a clear picture of what staff incidents they had attended and could see collectively over a period of time how this can impact on an individual.

Culture within the service

- Managers told us the culture of being open and honest and learning from mistakes was encouraged within the directorate. This was supported by a number of staff

support networks available. For example links with the occupational therapy department, counselling services and clinical supervision and leadership from ECCM's for all front line staff.

- Senior managers listened to staff though various forms of quality review, a culture survey and staff surveys which informed the directorate management of how staff were feeling. This was confirmed by our observation during the inspection. There appeared to be excellent supportive teamwork amongst crews.

- Late finishes and delayed or missed meal breaks were the main complaints from staff and these had an adverse impact on morale. However, staff were aware of what the trust was doing to try to alleviate their concerns, and mentioned the ongoing pilot scheme which was reducing the amount of late finishes and missed or late breaks.

- Staff told us previously there had been a blame culture but this was diminishing and staff felt they were able to learn from incidents rather than be criticised. ECCM's and staff we spoke with reported no bullying or harassment concerns.

Public and staff engagement

- The trust participated in the annual NHS Staff Survey. The survey results had shown some improvements in the way staff felt. For the 2015 NHS staff survey 36.9% (888 staff) responded. Of the 60 questions asked, the trust was significantly better than the national average for 27 of these, significantly worse for one and showed no significant difference for the remaining 32 questions. The service developed an action plan to demonstrate to staff that they had been listened to and the trust had acted on their feedback. These results were trust wide.

- Within the survey staff highlighted that they had had a performance review, that they had seen positive action taken on health and well-being. They were getting better support from managers, felt more motivated and that the quality of non-mandatory training, learning and development had improved.

- There was a reduction in the number of staff who said they had suffered from work-related stress in the last 12 months and more staff said they would recommend NEAS as a place to work or receive treatment.

Emergency and urgent care services

- The service regularly surveyed patients for their views. The service also, held discussions with local authority health overview and scrutiny committees (OSCs) and local involvement networks (Links) about service delivery and developments.
- The Patient Advice and Liaison Service (PALS) provided advice and support to patients, their families and carers.
- The service had links with local health watch groups and liaised with patient advice and liaison services (PALS,) commissioners and a range of other local community stakeholders to listen to people that used services and their representatives
- Chief executive roadshows, team briefings and quality walk arounds by senior managers took place. Senior managers listened to the views of staff and shared information with staff about the challenges the trust was facing and the ongoing work which was taking place to address the challenges.
- NEAS had introduced an educational ball and staff awards ceremony to recognise achievements where staff were awarded when they had gone above and beyond their duties. Staff were attending this the week before inspection. We saw evidence of previous social and charity events organised for staff that were well attended.

Innovation, improvement and sustainability

- We were informed that the service improvement team regularly facilitated "rapid process improvement" workshops in which operational staff could contribute. This provided a realistic overview of how the service operated in practice and added valuable suggestions and ideas. However, none of the operational staff we spoke with said they had attended these workshops.
- The executive and non-executive directors undertook scheduled quality walk arounds across all sites.
- We saw at Middlesbrough station an example of innovation. An ECCM was working on a website based training and development model that would be accessed by all staff via the intranet. They had support and funding from senior managers through the 'Agile' initiative to develop the IT infrastructure required to deliver this educational package, and although it was in the early stages, the work looked comprehensive and innovative.

- The advanced paramedic programme was an area of work that would benefit patient care and improve treatment pathways for patients. This role was still relatively new in the organisation. The team of advanced paramedics met with their counterparts across the service to discuss strategy and the future of the role within NEAS.
- A station support officer (SSO) was nominated by NEAS for NHS sustainability awards for transport and waste.
- Staff told us about a 'Bright ideas form' which could be downloaded and completed by any staff member and was a way to suggest changes and ideas. We reviewed a completed form, which had influenced a change in practice; this was the introduction of an ambulance station information folder.
- The trust research and development team were involved in a number of trials which were underway at the time of the inspection. These included for example trailing a device that regulated intrathoracic pressure during resuscitation and the PASTA trial which was a multi-centre randomised controlled trial to determine whether a Paramedic Acute Stroke Treatment Assessment (PASTA) pathway could speed up access to stroke patients.
- The Trust had pioneered a Flight Deck methodology for the North East. This was a capacity management system intended to support improved whole system awareness of capacity, quicker and safer diverting of patients to appropriate receiving care locations, and enhanced whole system learning.
- The development of the integrated care and transport service provided more flexible responses that aid appropriate conveyance and make the most effective use of 999 resources.
- The service worked in collaboration with fire and rescue services to support co-responding.
- The service worked in partnership with local police forces, in Cleveland, Durham and Northumbria. The work undertaken by the partnership included the Newcastle Safe Haven project, which was the provision of a service within Newcastle City Centre at weekends.

Patient transport services (PTS)

Safe	**Good**	🟢
Effective	**Good**	🟢
Caring	**Good**	🟢
Responsive	**Good**	🟢
Well-led	**Good**	🟢
Overall	**Good**	🟢

Information about the service

The North East Ambulance Service (NEAS) provides Patient Transport Services (PTS) for the 2.71 million patients within Northumberland, Tyne and Wear, Durham and Teesside. PTS provides pre-planned non-emergency transport for patients who have a medical condition that would prevent them from travelling to a treatment centre by any other means, or who require the skills of an ambulance care assistant during the journey.

The North Division covered the county of Northumberland, Newcastle, and North Tyneside. The Central Division covered Gateshead, Sunderland, South Tyneside, and part of the County Durham area. The South Division covered the remaining area of County Durham and the boroughs of Darlington, Hartlepool, Middlesbrough, Redcar and Cleveland and Stockton-On-Tees.

The total number of patient journeys was 695,760 and the average number of journeys per month was just above 63,000.

The total number of PTS vehicles was 229. Vehicles are held as a single pool to ensure maximum efficiency and flexibility across the region. There were also 180 PTS ambulance cars in operation.

Key hospital sites served by PTS included Wansbeck and Hexham General Hospitals and Northumbria Specialist Emergency Care Hospital (NSECH) in Northumberland; the Royal Victoria Infirmary and Freeman Hospital in Newcastle; Sunderland Royal Hospital; University Hospital of North Durham; James Cook University Hospital in Middlesbrough, Darlington Memorial Hospital and University Hospital of North Tees in Stockton.

We visited 13 ambulance stations and the PTS control centre. We also visited 14 hospitals. We spoke with 90 PTS frontline staff and managers, four senior managers, 17 control centre staff, nine volunteers, 54 hospital staff, and 49 patients and relatives. We also looked at 33 vehicles.

Patient transport services (PTS)

Summary of findings

Overall, we rated Patient Transport Services as good because:

- The service had a clear vision and strategy that was linked to the overarching corporate objectives. Managers monitored the risk register regularly and could explain what mitigating actions they were taking.

- Staff told us they felt proud to work for the trust. PTS crews felt their immediate operational managers supported them in their role.

- All operational staff knew how to keep patients safe through incident reporting, assessing risks and taking appropriate action, and the maintenance and cleanliness of vehicles.

- Staff were caring towards patients and we observed ambulance care assistants and call handlers from the control centre treat people with kindness, dignity and respect.

- The service took into account the needs of different people, such as bariatric patients or people living with dementia, and journeys were planned based upon their requirements. Patients could also book their own transport and some hospitals could book transport for their own patients attending the clinic.

- Managers monitored the performance of PTS on an ongoing basis and held meetings every month to discuss the outcomes. The latest performance figures showed the service had exceeded its target in relation to the time patients spent on a vehicle and local commissioners had extended the contract for the transportation of patients receiving renal dialysis.

However:

- Patients did not always arrive at hospital on time for their appointment. To address this, the service was looking at different ways to improve its performances. This included providing specific information to PTS crews about the patient's actual appointment time and an option to text patients when the vehicle was on its way to collect them.

- Managers only reviewed the performance of ambulance care assistants once a year. There were no arrangements for 1-1 or team meetings, or supervision.

Patient transport services (PTS)

Are patient transport services safe?

Good ●

We rated safe as good because:

- Staff protected patients from avoidable harm and abuse.
- The trust had a safeguarding policy and staff knew what to do if they had any concerns about an adult or a child.
- Staff knew how to report incidents and managers investigated them within an appropriate timescale. People also received an apology when things went wrong and the service made changes to keep people safe.
- Vehicles were well maintained and checked on a daily basis. There was a system for reporting defects and staff had received appropriate training to use equipment safely. There was a supply of stage one, two and three child seats to ensure children travelled safely and the trust did not permit them to travel using their own.
- Staff understood their responsibilities in relation to patient notes and records. Medical notes were transported securely in sealed envelopes and staff applied the appropriate checks to DNACPR (do not attempt cardio pulmonary resuscitation) forms.
- PTS crews, managers, and control centre staff assessed, monitored, and reviewed risks to patients every day. Staff followed a clear pathway if a patient became ill on a journey and the control centre arranged suitable transport based on the information provided at the time of booking.

However:

- The service did not have a formal mechanism for sharing learning from incidents or safeguarding concerns across all teams and divisions. Some teams received informal updates from their team manager while other staff reported no feedback at all.
- Staff reported the mandatory training did not meet their needs. Psychological care training included information about dementia, end of life care and the mental capacity act however, staff told us this was a basic overview and felt it was not sufficient to support them in their role. The service planned to introduce a new essential annual training package from April 2016.

- All staff did not fully comply with the trust bare below the elbow policy.
- Although the majority of vehicles we saw were clean, the service did not have a robust system to monitor the daily cleanliness of vehicles. At the end of each shift, crews had an allocated period of 15 minutes to clean the vehicle but staff told us they did not always have time to do this.

Incidents

- Staff reported incidents of harm or risk of harm using a risk management reporting system. Ambulance care assistants (ACA), managers and staff from the control centre could explain the process and told us they felt there was an open, 'no blame' culture. The member of staff who reported an incident received feedback about the outcome of any investigation via email.
- Staff reported 204 incidents relating to PTS between August 2015 and January 2016. Central and South Divisions had a higher number of incidents reported (75 and 71 respectively) compared with the North Division (58).
- Overall, 68% of incidents resulted in no harm or low harm. At a division level, the Central team reported a higher number no or low harm incidents (80%) while the North and South divisions recorded a higher percentage of near misses (15% and 18% respectively) compared to Central (1%).
- The majority of incidents reported by the Central team were 'slips, trips and falls' (20%). The majority of incidents reported in the North and South were 'vehicle incidents' (19% and 24% respectively) and the North Division also reported a number of manual handling incidents (19%).
- PTS managers told us they discussed incidents at monthly management meetings and explained what changes the service had made as result. For example, a large proportion of incidents, across all divisions, resulted in staff injury related to manual handling. Managers took action when they identified the cause of many injuries in 2015 related to the seatbelt extension for fastening wheelchairs. The manufacturer had shortened the straps on vehicles from 2014 onwards and the trust had purchased new straps to prevent further injury to staff.
- However, staff we spoke with gave mixed responses about receiving feedback from incidents and lessons learned across the whole service. For example, in the

Patient transport services (PTS)

Central division, one of the PTS managers held an informal briefing every Friday morning and updated ambulance care assistants (ACAs) as they signed on for their shift. ACAs told us this worked well. Other ACAs from different teams told us they did not attend any briefings or receive regular updates although they acknowledged that communication was improving. PTS managers showed us the notice boards, displayed in each ambulance station, which held up-to-date information about safety alerts. The majority of staff told us they checked the board for updated however, there was no system to confirm or monitor this.

- There had been one serious incident (SI) reported in 2015. A patient had allegedly sustained a fracture to their right ankle whilst being transported home from hospital. A root cause analysis (RCA) highlighted the inexperience of staff members who did not initially report or escalate the incident. The RCA also identified current PTS procedure did not stipulate the need for the crew member to walk in front of a wheelchair when transporting patients through a narrow space. This would have potentially prevented the incident from occurring. The service amended its procedures to include new guidance and recommended further training about the reporting of incidents. Managers also received additional training about upgrading and escalating incidents.

- Staff told us they apologised to patients when things went wrong. PTS operational and team managers demonstrated an understanding of the principles relating to Duty of Candour. The trust reported two incidents, in November and December 2015, where Duty of Candour had been applied. PTS had two reported duty of Candour incidents for the period 2015/16. The first was in relation to an incident on the 3rd November 2015. An escort accompanying a patient was involved in an incident, when a PTS vehicle applied the brakes, the wheelchair seat that she was sitting on moved and the escort fell to the floor. The patient sustained an ankle injury and was taken by the crew to AE where she was examined and discharged. The seat involved was examined by equipment staff and was not found to be defective.The second duty of Candour was in relation to a patient who allegedly sustained a fractured ankle, after she alleged a PTS crew caught her wheelchair in a doorway whilst pushing her. There was no evidence to prove that this was caused by the PTS crew, as the injury was not reported by the patient until 3 days later.

- We spoke with a manager who had visited a patient and apologised to them in person. The patient had sustained an injury when the PTS crew assisted them onto a vehicle. The manager explained what had gone wrong and informed the patient an investigation would take place.

- Managers investigated incidents in a timely way. Minutes from the PTS Service Line Management Board meeting held in April 2016 showed managers investigated 100% of incidents within timescale in the Central and South division. There were only two outstanding incidents in the North and both were awaiting feedback from external agencies before they could be progressed.

Mandatory training

- Ambulance Care Assistants (ACA), bank staff joining the trust received one week of driver training as part of their induction training. This was provided by the trust's in-house driver training school and staff were required to pass the course before they could progress. Volunteer car drivers are subject to a robust driving assessment carried out by a fully qualified ambulance service driving instructor.

- The Essential Annual Training programme (incorporating statutory and mandatory training) included four modules: safeguarding adults and children, infection prevention and control levels 1 and 2, CQC regulations, incident reporting and record keeping, and psychological care. The target for mandatory training was 95% and information provided by the trust showed the overall compliance rate for PTS staff was 88%.

- Volunteer car drivers joining the Ambulance Car Service (ACS) attended a two-day training course. This included information about policies and procedures, moving and handling, cardio-pulmonary resuscitation (CPR) and safeguarding. As part of their annual refresher training, volunteer drivers were required to complete a workbook. This included a mandatory safeguarding update. The business improvement team monitored compliance for the ACS and explained that drivers who did not complete their mandatory training were removed from duty. Data provided to us by the trust showed the 94% of ACS volunteers had completed their essential annual training by the end of March 2016.

- All of the staff we spoke with, from across all Divisions, told us the training did not meet their needs. ACAs told

Patient transport services (PTS)

us they believed more advanced first aid and life support training would be more relevant to their role rather than subjects such as anti-terrorism. Psychological care training included information about dementia, end of life care and the mental capacity act however, staff told us this was a basic overview and felt it was not sufficient to support them in their role.

- We spoke with senior managers who acknowledged the current package needed improvement and work was underway to improve the training package ready for the 2016/17 essential annual training programme.

Safeguarding

- Safeguarding training (levels one and two combined) was included in the Essential Annual Training programme, and consisted of a 30-minute presentation, incorporating both children and adults. Data provided by the trust showed 88% of staff had completed the training, which was below the target of 95%.

- The named nurse for safeguarding children from a nearby acute trust undertook a review of the training in October 2015 and questioned the relevance of the material to ambulance staff. We also spoke with two ambulance care assistants (ACA) who told us they did not understand why they received information about female genital mutilation (FGM) and human trafficking when the examples did not relate to their work. There were plans for PTS managers to receive level three training. However, it was not clear if this was for both adults and children or what percentage of managers had already attended a training course.

- Volunteers joining the Ambulance Car Service (ACS) received safeguarding training, as part of their two-day ACS training course. This included information about different types of abuse and the possible indicators. Volunteers were also required to carry cards with the contact details for the safeguarding team. We spoke with a volunteer driver who gave an example of when he had followed the process and told us it worked well.

- There was a system in place for staff to report safeguarding concerns. Most staff contacted their manager in the first instance while other staff we spoke with told us they contacted a member of staff from the Logistic Desk, based in the Emergency operations centre, who completed an electronic referral form. The majority of staff we spoke with told us they did not make many safeguarding referrals because they did not have

instances where they needed to refer patients. Data from the March 2016 Quality Governance report showed PTS crews had made 15 safeguarding adult referrals compared to 528 from Emergency Care crews.

- Two PTS crews gave examples of when they had recognised and responded to concerns about patients. One PTS crew told us about an incident at a local hospital. When they arrived to collect their patient, the crew discovered they were in receipt of a DNACPR (do not attempt cardio-pulmonary resuscitation) category 1. This meant the crew were unable to transport the patient home, as the trust's end of life policy stated PTS could only transport patients with a DNACPR category 2 (which deems death is not imminent). However, when the crew informed the hospital staff, a doctor changed the category of the DNACPR to comply with the PTS requirement. The crew did not transport the patient and raised a safeguarding alert. Another PTS crew raised a concern about an elderly patient who lived on their own, and who was in a state of dishevelment and confusion when the crew collected them. The crew were concerned about the patient's safety within their own home.

- There were plans for managers to receive level 3 training. However, it was not clear if this was for both adults or children or what percentage of mangers had already attended a training course.

Cleanliness, infection control and hygiene

- The patient experience annual report (2015) reported 99% of patients said the cleanliness of the vehicle they travelled in was good.

- The trust had an infection prevention and control policy, which outlined the expectations of all members of staff. The trust expected staff to adhere to the national 'bare below the elbow' guidance, an initiative to prevent the spread of infection through effective hand hygiene, and we saw the majority of staff complied with this. The only exceptions we saw were staff who wore uniform fleece jackets, which did not comply with the trust bare below the elbow policy as the sleeves were not rolled up above the elbow. PTS crews also had hand gel attached to their uniform and we observed staff using it.

- PTS crews were also required to ensure their vehicle was fit for purpose, before, during and after they had transported a patient. Decontamination cleaning wipes were available on all vehicles and we saw staff cleaning surfaces, seats, and equipment after each patient.

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- Managers and staff told us they cleaned their vehicle every day and 15 minutes was planned into the end of each shift to give crews the time to do this. There was also a prompt on Terrafix to remind staff and to record their compliance on the device. Terrafix is a software system that enabled the PTS control centre and crews to communicate with other. It also included a route mapping system and produced data activity reports. Crews told us they did not always have enough time to do this and we saw refuse bags that had not been emptied from the previous day. There did not appear to be a robust system to monitor the daily cleanliness of vehicles.

- Managers and ambulance care assistants told us vehicles received a deep clean every 12 weeks. However, when we checked the policy, we saw that deep cleans were carried out at 24 week intervals. At 12 weeks, vehicles underwent an intermediate clean. We reviewed data from October and November 2015 that showed the number of cleans undertaken. The actual number of vehicles that received the required 12 and 24 week clean was only slightly below the planned level.

- Although the majority of staff we spoke with were unclear about the deep clean schedule, they could describe the steps they would take if a vehicle became heavily contaminated or if they had carried a patient with an infection. Staff also described the actions for the disposal of clinical waste. Vehicles carried sick bags and yellow bags in which to dispose of them. However, staff told us there was no place to store them safely in the vehicle. Crews disposed of waste when they returned to base or at a hospital location, if it was safe to do so.

- Staff maintained their own uniforms in line with the trust's Uniform and Dress Code policy and we saw they were visibly clean.

- All stations we visited were clean and suitable for their purpose and had a domestic member of staff for daily cleaning.

- Ambulance care assistants were able to obtain advice and support regarding infection control issues from their team manager and the infection control team.

- The PTS planning and dispatch team informed crews via Terrafix of specific infection and hygiene risks associated with individual patients. We spoke with a crew who told us this did not always happen. For example, when they arrived to collect a patient, the crew discovered the patient had MRSA in their lungs. This information had not been disclosed to the crew so they contacted the control centre who took the appropriate steps to reschedule the patient. In addition, other PTS crews we spoke with explained the information on Terrafix could be out of date. The information sometimes came from a third party booking agent, who initiated the booking, and crews were concerned they may not have asked the appropriate questions.

Environment and equipment

- Equipment was standardised across each division. All vehicles had safety straps and we observed crews securing patients and carers appropriately. Vehicles were fitted with first aid kits and appropriate moving and handling aids, which included lifting belts. Ambulance care assistants (ACAs) we spoke with were confident in the use of all moving and handling aids. Some PTS vehicles carried defibrillators and staff told us they had received relevant training on how to use it. Volunteer car drivers also carried first aid kits, hand gel and cleaning wipes.

- We inspected 33 vehicles across all three divisions. Overall, the vehicles were clean, vehicle defect logs were up to date, wheelchairs had the correct clamping device, oxygen cylinders were appropriately stored, and crews had completed the required vehicle daily inspection checks. We saw one vehicle that had a rusting tail lift (one of the older models in the fleet, with a 58-registration plate) and one vehicle that was awaiting a new part for the driver's door.

- ACAs completed the daily vehicle check at the beginning of each shift. This checklist included inspections of electrical equipment, for example lights, and radios, non-electrical equipment such as lifting aids and chair restraints, and medical equipment including oxygen and first aid kits. We observed crews completing these checks but noticed not all crews in the South division did this at the start of their shift. ACAs reported any faults to the team manager and told us appropriate action was usually taken immediately. Managers reviewed and stored the checklists however; there was no formal system to audit them to identify any themes or trends.

- There was a system for reporting defects and repairs were organised promptly. Staff told us there was a mobile technician who could come out and repair defects. We also spoke with managers from the fleet department who showed us the vehicle maintenance

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schedules. We saw they were up to date. The system was very well organised and the administration manager produced a report every week to ensure there were no overdue jobs.

- The service had a store of stage one, two and three child seats and the trust did not permit children to travel in their own seats. Crews told us they did not dismantle and put together the seats if they required washing. Information provided to us by the trust showed the infection prevention and control manager was involved in discussions about the cleaning of car seats at national level. The deep cleaning of car seats was currently undertaken by the equipment department and crews maintained basic cleanliness using appropriate cleaning wipes.

- The volunteer car drivers we spoke with all told us they had no problems collecting an appropriate car seat from a local ambulance station and felt confident to fit them correctly. We did not speak with any independent taxi drivers however, according to the trust policy; children under the age of 12 travelling on PTS in a pre-booked appointment would not travel in a taxi.

- PTS crews knew how to secure patients who required a wheelchair on vehicles and we observed this in practice. Some patients travelled in their own personal wheelchairs and the crews we spoke with were aware that some did not comply with the trust requirements. One crew told us their manager kept a list of all non-compliant wheelchairs and staff were very familiar with the different types of chairs. Crews could explain what action they would take if an inappropriate wheelchair had been booked by mistake.

- The Equipment Department was responsible for the management of medical devices. Medical engineering technicians maintained oxygen therapy, stretchers, and other appropriate medical equipment carried on PTS vehicles. PTS crews and managers we spoke with did not report any problems.

Medicines

- PTS vehicles did not carry any medicines for emergency purposes with the exception of oxygen. First aid kits were available on all vehicles and staff reviewed stock levels as part of their daily checks. All disposable items on the vehicles we checked had intact packaging and were within their use-by date.

- Staff said they did not administer or manage patients' own medication however, staff showed us where they securely stored any medicines on the vehicle during transit.

- Ambulance care assistants received training in oxygen therapy as part of their induction and annual refresher training. Oxygen bottles were stored securely at the ambulance stations we visited in locked, ventilated storage cupboards, and were in date. However, there did not appear to be a robust system to log or monitor the removal and return of canisters.

Records

- Patient records were held electronically and contained information about the patient's medical history and any risk assessments. PTS crews could access this information via Terrafix, which was linked to the trust's system and provided up-to-date information on people who used the service.

- Patients who had an end of life care plan and who had an up to date DNACPR (do not attempt cardio-pulmonary resuscitation) order were identified on the Terrafix system. In line with the trust's End of Life Transport policy, the service only transported patients with a DNACPR Category 2 order. All of the ambulance care assistants (ACAs) we spoke with were very clear about their responsibilities in relation to patients with a DNACPR order. ACAs told us they checked the documentation to confirm it included an appropriate signature. If there were any problems, the crew would alert the PTS control centre in the first instance.

- PTS crews transported medical notes carried by a patient in a sealed envelope that was stored safely on board the vehicle. Upon arrival at the destination, the crew handed the documentation to the relevant member of staff or carer.

Assessing and responding to patient risk

- PTS crews followed a clear pathway to manage patients who became ill during their journey. Ambulance care assistants told us if the condition was life threatening they would inform the PTS control centre and request an emergency ambulance for assistance.

- PTS managers carried out risk assessments on people in their own homes. Managers we spoke with told us this usually involved assessing restrictions such as access to

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the home and the mobility needs of the patient. We saw an example of a risk assessment concerning a bariatric patient who had steps leading to their home and noted the manager had taken appropriate action.

- PTS call handlers based in the control centre identified patient risks through effective questioning at the time of booking transport. Ambulance care assistants (ACAs) also told us they reported any unexpected risks present at the time of collection to the control centre. A member from the team would take appropriate action, which might include deploying an appropriate vehicle or additional crew (if the ACA was operating a single-crew vehicle). The relevant PTS manager would also undertake a risk assessment of that patient for future transportation.
- If a patient had a specific medical need, such as end of life care, call handlers in the control centre transferred the patient to a clinician to ensure any medical risks were assessed safely. A flag was attached to the patient's name on the system, which would alert the relevant crew via Terrafix.

Staffing

- Managers we spoke with told us they regular reviewed staffing levels within their teams and across the service as a whole. Information provided to us by the trust stated there was no national guidance on safe staffing levels for ambulance service trusts and no agreed methodology for calculating actual numbers of staff per station or area.
- The number of substantive PTS staff in post in April 2016 was 441. The overall vacancy rate was 5% and the turnover rate, across the North, Central, and South divisions, was 8%. Managers and staff did not report any problems in relation to staffing levels and the trust also employed a bank workforce on zero hour contracts. There were 99 bank staff in total and they supported the PTS operation where appropriate. PTS team managers told us they needed to use bank and relief staff regularly to cover the operation and this helped to avoid appointing additional substantive staff.
- Operational managers (band 5) held line management responsibility for PTS team managers and led each division. Team managers (band 4) managed the frontline ambulance care assistants (bands 2 and 3).

There were seven team managers in the North Division, five in Central and five in the South, and they each had responsibility for approximately 25 to 30 ambulance care assistants.

- A transfer policy offered staff the option to move base if a vacancy became available at another station. We spoke with managers who told us the uptake was good and staff welcomed the opportunity.
- PTS crew worked different operational shifts depending upon their base, and some stations provided 24-hour transport. Shifts ranged from eight to 12 hours in length. We spoke with crews and managers who told us they felt the rotas and shift patterns met patient demand. Crews regularly worked across all divisions and not just their own to ensure the appointment-based system worked effectively.
- Within the PTS control centre, managers used a workforce management system to plan staffing levels. A team of analysts forecasted demand and scheduled staff accordingly. There were no reported problems.
- The sickness absence target was 5% and the rate across the whole service was 6.5%. Between July 2014 and December 2015, 18 PTS stations, out of 32 (including management and bank staff), were above the 5% target. However, some stations only had a small number of staff which meant a higher percentage overall. PTS managers told us they felt supported to manage sickness with support from occupational health and human resources.
- There were over 200 PTS volunteers. The majority were drivers within the Ambulance Car Service (ACS) while a smaller proportion volunteered as porters who greeted patients upon arrival at hospital and ensured they were transported home after their appointment. The business improvement team managed the volunteer programme.
- The trust also ran an apprentice scheme and the PTS operation was supported by 24 apprentices. Staff spoke positively about the scheme and two different apprentices from the trust had won the 'apprentice of the year' award. Each apprentice had a portfolio so they could work toward achieving a qualification and managers told us the trust offered many apprentices full time employment at the end of their term.
- Staff told us they generally finished shifts on time and most staff felt control centre staff were considerate when allocating work close to finish times.

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Anticipated resource and capacity risks

- PTS had a business continuity plan and each station held its own specific plan. We reviewed an exercise, facilitated by the Business Continuity Team, where staff from the PTS management team and control centre discussed and 'walked-through' the plan from one station. The exercise highlighted five key priorities, which included updating the relocation strategy for each station, and ensuring a hard copy of each station plan was held at every station.

- We spoke with one PTS crew who told us managers had implemented the business continuity plan at their station successfully when a local access road had become flooded. Patients were transported as scheduled when crews were relocated another station.

- The PTS management team assessed the impact of planned changes on safety in relation to the cost improvement programme and new vehicles. Due in part to the change from banding times to appointment times, the older PTS minibuses, suitable only for patients without any mobility restrictions, were planned be replaced with different vehicles. This would improve efficiency and safety in terms of vehicle usage, maintenance costs and better fuel economy.

Response to major incidents

- The trust's major incident plan included the role of PTS in a major emergency. The plan included potential emergencies locally and nationally. PTS crews had been involved in major incident responses, for example, one manager told us staff had assisted the emergency and urgent care service to transport less seriously injured patients during a major incident involving a bouncy castle. Staff told us they would seek guidance from their team leader in the event of a major incident.

- We spoke with a PTS operational manager who told us the major incident plan was reviewed every year.

Are patient transport services effective?

Good ●

We rated effective as good because:

- The trust followed the Department of Health's eligibility criteria to ensure only those patients who needed transport received it. Staff completed comprehensive assessments of each patient to ensure the service met their transport requirements.

- The service met the performance target set by local clinical commissioning groups for the collection of patients after their appointment at hospital. 86% of patients were collected within 60 minutes of their appointment time and 92% spent less than 60 minutes on the vehicle.

- The control centre exceeded the target for call handling, as staff answered 91% of calls in 60 seconds against a target of 70%.

- There was a robust process to ensure volunteer drivers received all of the necessary checks including MOT and car insurance, plus occupational health assessments and results from the disclosure and barring service (DBS).

- We saw and heard evidence supporting good co-ordination with other providers and multi-disciplinary working. Some hospitals and clinics had access to the PTS booking system, which meant they could book the return journeys for their own patients, and received support from the customer care team.

However:

- The trust did not meet the shadow/aspirational target for patients arriving home for their appointment time in the Central division or the target for the transportation of patients receiving renal dialysis treatment. Despite this, local commissioners in the Central area where the contract for a dedicated renal dialysis service was in place were very pleased with the outcomes from the standards they set for the renal dialysis service and had extended the contract for a further year. There is no dedicated renal dialysis contract in the North and South divisions, and therefore NEAS will not meet the renal NSF transport standards in these areas.

- Although ambulance care assistants received an annual appraisal, there were no formal arrangements for 1-1 meetings within the 12-month review period. This meant team managers did not monitor staff progress towards objectives nor did formally assess performance.

Patient transport services (PTS)

- Most of the staff we spoke with did not have a clear understanding about mental capacity or deprivation of liberty safeguards (DoLS) and told us they had received minimal training to help improve their understanding.

Evidence-based care and treatment

- The trust followed the National Institute for Health and Care Excellence (NICE) guidance in relation to patients who received renal dialysis treatment in South Tyneside and the trust gave patients with other specific medical conditions, such as cancer, priority to use the service.

- The trust also used the Department of Health's assessment criteria to determine whether a patient was eligible for patient transport. PTS control centre staff and hospital staff assessed a patient's eligibility through a series of specific questions about mobility, disability, and access to other forms of transport. If a patient was deemed non-eligible for patient transport, they are signposted to an appeal process led by the commissioners and the Patient Advice and Liaison Service (PALS) provided assistance with other transport options.

- Although there were no national guidelines in relation to the provision of PTS, the trust had adopted a similar service model to those replicated across other ambulance services in England. Patient travel was linked to their actual appointment time rather than a set banding time that determined what time they would be collected. This meant the service was more patient-centred and information from the trust showed there had been an improvement in the number of patients arriving at hospital on time since PTS introduced the new model in October 2013.

Assessment and planning of care

- The PTS control centre call handlers, and other third party providers who handled calls from patients in other areas of the region, assessed patients' needs at the point of making the booking. PTS crews received this information via Terrafix, on their daily job sheets and verbally via radio transmissions. Control centre staff collected relevant patient information such as medical or mental health conditions and patient mobility, and shared this with the PTS crew. However, ambulance care assistants (ACAs) told us there had been occasions when the information was out of date. For example, upon arrival at a patient's home, one crew found the vehicle

was not appropriate. This caused a delay to the patient's journey as the crew told us they had to contact control and arrange to re-book the patient on a vehicle that met their mobility needs.

- Some staff told us GPs and hospital staff who booked transport sometimes underestimated patient requirements, mainly in terms of mobility. This meant PTS crews could arrive in an unsuitable vehicle or without the appropriate equipment to transport patients. The control centre would then have to rebook the patient, causing a delay to their transfer.

- ACAs told us they undertook their own informal assessments upon arrival at a patient's pick-up location. For example, if they arrived at a patient's home address they would make an initial assessment of the environment, surroundings, and the patient's mobility before attempting to transport them. One ACA told us about a situation where the risk assessment was out of date on the electronic patient record and it was unsafe to transport the patient on the allocated vehicle. The driver explained the reasons to the patient and their relative, and the control centre who arranged for a PTS team manager to visit and complete a new risk assessment.

- PTS provided mental health transport services and there were dedicated crews for mental health patients. The crews told us they did not received any additional training however evidence provided by the trust showed that staff had received training about dementia and the deprivation of liberty safeguards (DoLS). Crews also explained patients usually travelled with a carer or escort who ensured the patient's health needs were met.

Nutrition and hydration

- PTS staff did not routinely provide nutrition and hydration for patients during their journey. Staff told us they reminded patients to eat and drink before travelling or to bring some food with them for the journey. During an observation at a local hospital, we saw the PTS crew reassure two elderly patients, who were awaiting collection in the clinic waiting room, that they would wait for them to finish their cups of tea.

- PTS vehicles stored small amounts of bottled water for patient use when appropriate. Staff were aware of the physical signs to look for if a patient became dehydrated and took appropriate action where required.

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Patient outcomes

- Between April 2015 and February 2016, there were 757,856 PTS bookings. Of these, 90,665 were categorised as 'same day' bookings (booked after 5.00pm on the previous day). The total number of patient journeys was 695,760 and the average number of journeys per month was just above 63,000. Although this was lower than in the previous year, it had remained consistent since the introduction of the new eligibility criteria. The level of activity was consistent each month and managers reviewed data in relation to themes and trends at monthly PTS service line management meetings.

- Local commissioners had agreed set performance targets for PTS, which covered planned journeys made during the core hours of each day. Targets for arriving at hospital 'on time' (between 45 minutes early and 15 minutes late) and collection following treatment (within 60 minutes) were 80% and 85% respectively. The latest performance figures provided by the trust showed 76% of patients arrived at hospital within the commissioned target and 86% were collected within 60 minutes.

- The trust exceeded the 90% target relating to the time patients spent on a vehicle. Patients were not expected to be on a vehicle for more than an hour and the latest figures showed the trust had achieved 92%. The trust reported this figure was improving each month.

- PTS operated to a different set of quality standards when transporting renal dialysis patients in the South of Tyne area. The service was required to drop off patients no more than 30 minutes early and not late for their appointment, and collect them again no more than 30 minutes after the scheduled end of their appointment. The target for both measures was 95%.

- Data published in February 2016 showed 85% of patients attending renal dialysis appointments were collected from their residence on time and 76% of patients were collected again from hospital within the required period. Overall, 6% of patients were late for their appointment, which was worse than the target of 2%. The majority of patients who were late for their appointment were only between 0-5 minutes late. The percentage of patients who spent less than 60 minutes on the vehicle, for both inward and outward journeys, was 99%. Although the trust did not meet the contracted renal dialysis standards, the commissioners were reportedly happy with the current performance of PTS and had extended the contracted for an additional year.

- In relation to call handling, staff were expected to answer 70% of calls in 60 seconds on all PTS booking lines, including third party providers. In 2015/16, the trust exceeded the target and call handlers answered 91% of all calls within the required time.

- The number of resource hours lost due to vehicle downtime between October 2015 and February 2016 was low compared to the same period in the previous year. The trust reported the majority of downtime was caused by a lack of staff, either through vacancies or sickness, and the improvement in both measures explained the increase in vehicle availability.

Competent staff

- We found staff had the appropriate skills, knowledge, and experience to do their job. Ambulance care assistants (ACAs) had received training in moving and handling, first aid and specialist driving skills. Staff we spoke with told us they did not feel the training provided met their needs as an ACA, however the majority of them had worked for the trust for many years and were very experienced in the role.

- All new substantive and bank staff attended a three-week training course, which included one-week driver training, first aid, and basic life support. Volunteer car drivers joining the service received a two-day corporate training programme, facilitated by the PTS training team, and spent half a day with the business improvement team before they become operational.

- There were no formal arrangements for 1-1 meetings or supervision between ACAs and team managers. Although PTS team managers told us they accompanied crews on vehicles during a shift, there was no formal documentation or records held, and any assessments of performance were purely visual.

- Staff we spoke with told us they had had an annual appraisal within the last 12 months. However, it was not clear what team managers were basing the appraisal on as no formal 1-1 meetings took place during the year to review an individual's performance or monitor progress towards their objectives. Information provided by the trust showed PTS was 100% compliant for performance reviews for 2015/16.

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- ACAs told us they did not have the opportunity to participate in training opportunities other than their yearly annual mandatory training refresher. The majority of ACAs felt this training was not of a good standard and was too condensed, squashed into one day.
- PTS team managers told us the trust provided a three-day leadership training course that included all aspects of management within the role including managing sickness absence. Team managers also met with their line managers every month to discuss operational performance, risk, quality, safety, resources and staffing.
- Volunteer drivers underwent comprehensive checks before they could become operational, including personal references, disclosure and barring service (DBS), occupational health assessments and car insurance and MOT status. They attended induction and the business improvement team provided each individual with a comprehensive volunteer car driver's handbook outlining their responsibilities to the patient, themselves, and their vehicle.
- Call handlers in the control centre received regular supervision from their team leader to discuss performance. Team leaders completed an audit tool to monitor the quality of the call handler's performance and if staff did not meet the required standard, they attended a coaching session facilitated by their line manager.

Coordination with other providers

- Staff at local NHS trusts reported good working relationships with ambulance care assistants, team managers and control centre staff. However, nursing and administrative staff from outpatient departments told us they did not always know which patients were travelling by PTS. Patients who had late clinic appointments sometimes had to wait for their transport after the clinic had closed which affected the hospital staff who stayed behind with them. Staff also reported PTS crews did not always contact them if there was a delay.
- We spoke with staff from hospital discharge lounges who told us the control centre responded reasonably well to their requests for transport. We also spoke with

patients who spoke positively about the service provided. PTS and hospital staff told us they did work together but as two separate services, and felt there was room for improvement.
- Some hospital clinics had access to PTS Online, the trust's own booking system. Administrative staff could make the booking for their own patients, which included updating the system when their patient was ready for collection. Staff spoke positively about the benefits of having direct access. They told us if they had any problems, the customer care team were very responsive and always provided assistance upon request.
- PTS crews told us they found it frustrating when hospitals called the control centre to advise a patient was ready to be discharged yet when the crew arrived, the patient was still in bed or waiting for medication from the pharmacy.
- In times of high demand, PTS worked with other third party providers to ensure continuity of service, including local taxi firms. The PTS planning and business improvement teams worked closely to ensure they met the requirements in terms of geography, operational hours and patient mobility needs.

Multidisciplinary working

- There was evidence of multidisciplinary working between PTS staff and other care providers, such as hospitals, GP surgeries, and care homes. During our visit, we observed cooperation between hospital staff, third party PTS booking providers, the control centre and PTS crews.
- PTS provided resilience to support the emergency and urgent care service, both operationally and within the Emergency operations centre. The trust was in the process of implementing a project to integrate PTS with emergency care to create an integrated care and transport service. This meant additional capacity would be created to support the transportation of urgent care patients. We spoke with PTS crews who were involved in the project and who worked with emergency care colleagues. They told us it was a good opportunity but felt they required additional training to support them in their role. The high-level project plan identified workforce development, which included support for staff, as an objective however it did not included a specific timeframe for delivery.

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- We observed good working relationships between PTS crew and control staff. We felt this was important as the relationship between control staff; crews and volunteer drivers enabled effective care and promoted good team working. However, a small number of ambulance care assistants (ACAs) told us they felt control centre staff did not fully understand their role or the geographical area in which they worked.
- To improve the relationship between PTS crews and the control centre, and to generate a greater understanding of the different roles, staff from both teams had the opportunity to shadow each other. PTS managers told us they planned to visit the control centre at least once a month. We spoke to managers, ACAs, and control centre staff who had participated in the scheme and they told us they had a positive experience, which resulted in a greater understanding between the two services.

Access to information

- Ambulance care assistants received printed daily job sheets at the start of each shift. These included collection times, addresses and patient specific information such as relevant medical conditions, complex needs, mobility, or if an escort was travelling with them. Information was stored in the driver's cab out of sight, respecting patient confidentiality.
- Terrafix and PDAs also provided crews and volunteer drivers with special notes and journeys requirements. The control centre used radio transmissions to inform crews of any urgent or additional updates. Information and updates could also be communicated via mobile telephones, although some staff told us these were unreliable at times due to network coverage and not accessible whilst they were driving.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had a policy for capacity to consent to examination or treatment and staff showed a good understanding of how they enabled patients to make decisions for themselves.
- We observed PTS crews asking for patients verbal consent for all interventions, including the use of restraints such as seatbelts and chair fixing equipment
- According to the National Ambulance Service Medical Directors (NASMeD) and Association of Ambulance Chief Executive (AACE), there is an expectation that

ambulance staff only act to restrain people to the same level as that of a member of the public. Ambulance services are not required to provide physical restraint training for their frontline staff.
- The trust provided mental health act and capacity act training as part of the annual mandatory training programme and information provided to us by the trust stated a clinician was on call every day to support staff with any queries. However, we spoke with ambulance care assistants who were unsure about their responsibilities in relation to restraining patients and did not have a clear understanding about mental capacity or deprivation of liberty safeguards.

Are patient transport services caring?

Good 🟢

We rated caring as good because:

- PTS staff were caring and compassionate and treated patients with courtesy, dignity and respect.
- Feedback from patients, carers and families we spoke with was positive in terms of the care they received. Feedback from the most recent Friends and Family Test showed 94% of patients would recommend the service.
- PTS crews helped patients feel comfortable and safe on board the vehicle and responded compassionately when patients needed additional help or support.

Compassionate care

- Feedback from patients was unanimously positive about the care they received from PTS crews. One patient described the service as 'excellent' and another as 'very good'.
- Three dialysis patients reported receiving excellent care from ambulance care assistants (ACAs) who they felt went the extra mile to ensure they were comfortable. Examples included staff escorting patients back into their home and making a hot drink, turning the television on and finding blankets for them before leaving, carrying their own personal umbrellas so patients didn't get wet and changing a light bulb in the house for a patient who was at risk of falls.
- Throughout our inspection, we observed ambulance care assistants treat patients with courtesy, dignity, and respect. We saw crews gently supporting patients in to and out of the vehicle, and securing them appropriately

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in their seats. The patient experience annual report 2015 reported 98% of patients said PTS crews showed kindness and consideration towards them and the attitude of the ambulance staff was good. Patients we spoke with said their crew was 'really polite and friendly'. Another patient described their crew as 'lovely'.

- Crews safely escorted patients to the hospital department and to their home. Hospital staff told us crews always waited with the patient whilst they were booked in for their appointment and ensured they were settled in the waiting area before departing. A member of staff at a day unit told us one of their patients had informed the PTS crew, upon arrival at hospital, they would make their own way to the clinic, and the ACA called in to the unit to check the patient had arrived safely.

- The trust participated in the national Friends and Family Test and data published in February 2016 showed 94% of PTS patients would recommend the service. This was an improvement from the previous two months where the results were 88% and 83% respectively. Free format comments included positive feedback from patients who said they felt safe, and staff were helpful and very attentive.

- The trust also reported national comparative data indicated it was the third highest in the ambulance sector for response rates and the fifth highest performing ambulance trust for the number of patients likely or extremely likely to recommend services to friends and family.

- Results from a survey completed by PTS patients who received regular renal dialysis treatment were very positive in relation to the care they received from PTS crews, 80% of patients described their care as 'very good' and 19% as 'fairly good'.

Understanding and involvement of patients and those close to them

- Control centre staff explained the eligibility criteria to patients at the time of making the booking. We heard call handlers explain the process in a simple and straightforward way, checking the understanding of the patient at every stage. Control centre staff also explained the rules about booking escorts. On one call, the patient was not eligible for patient transport and the call handler gave the patient appropriate information about what to do next. This included contacting the

Patient Advice and Liaison Service (PALS) who could provide advice about alternative forms of transport or information about who to contact for financial assistance.

- The trust had a Patient's Charter to help patients understand what to expect when using PTS, particularly those who used the service regularly. The Patient's Charter was available on the trust website and we saw copies in hospital departments and on PTS vehicles. Patients had the opportunity to provide feedback about PTS by completing 'Tell us what you think' leaflets, which were also available on vehicles.

- Patients said they felt informed about their care and treatment. We observed staff asking patients about their personal capability and mobility choices, ensuring patients were involved in the decision making process.

- Feedback from hospital staff informed us the PTS crews transporting dialysis patients were knowledgeable about their patients' health concerns and were professional in how they supported them. Staff told us this was an improvement from the previous private provider.

- Staff at a day unit for people with mental health needs reported good interactions between patients and PTS crews.

Emotional support

- Patients told us they always felt safe in the ambulance and said the crew looked after them, and spent time listening and speaking with them during the journey, which helped to alleviate any distress.

- We observed and spoke with PTS crews who showed a respectful understanding of the impact a patient's care, treatment or condition had on their wellbeing and on those close to them. For example, staff were sensitive towards patients attending regular chemotherapy appointments and the effect treatment and any relapse had on them. We spoke with a crew who explained the care and support they provided to patients during the journey helped to build strong and caring relationships.

- Staff also demonstrated an excellent knowledge of how to support patients who became anxious or upset. For example, we saw an ambulance care assistant providing sensitive support to one patient who was anxious about their hospital appointment and displayed empathy towards another patient who had received upsetting information through the post.

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Supporting people to manage their own health

- PTS staff supported patients to manage their own care needs to maximise their independence. For example, we observed crews encouraging patients to, wherever possible, use their own mobility aids when entering or leaving the vehicle and asked patients if they required assistance with standing or sitting. We also observed crews walking alongside patients and offering their arm for additional support.
- If patients did not meet the eligibility criteria for patient transport, call handlers from the control centre gave patients the free phone telephone number for PALS who could provide patients with information about other transport services.
- Staff we spoke with informed us they supported clients to ensure they had crash safe wheelchairs, by signposting them to hospital services to ensure their wheelchairs were fit for purpose.

Are patient transport services responsive to people's needs?
(for example, to feedback?)

Good 🟢

We rated responsive as good because:

- Managers in PTS planned and delivered the service in a way that met the needs of the local population. For example, the change from banding times to an appointment-based service in 2013 meant more patients arrived at hospital on time. PTS also transported patients 24 hours a days, seven days a week.
- The service took into account the needs of different people when planning journeys, such as bariatric patients or people living with dementia, and assigned appropriate vehicles and crew,.
- Patients could book their own transport by contacting the PTS control centre or one of three third party booking agents. Some hospitals could also book transport for their own patients attending a clinic.
- Information about how to make a complaint was widely available on PTS vehicles and we heard examples of improvements made in response.

However:

- PTS crews told us the annual refresher training they received about equality and diversity, mental health and dementia awareness was not sufficient or tailored enough to meet their needs.

Service planning and delivery to meet the needs of local people

- PTS primarily operated Monday to Friday, 8.00am to 6.00pm. However, the service also operated outside of those hours in specific localities and clinical services such as hospital discharge, renal dialysis, and urgent care.
- PTS provided an urgent care transport service in Durham as a specific contract. The service operated 24 hours a day, 7 days a week. A similar but smaller service operated in Gateshead whilst the main contract also included an element of urgent care, out of hours transport in Northumberland.
- PTS also supported renal dialysis services across the region and clinical services based in the North and South divisions were included in the main core contract. The local CCG had commissioned PTS to deliver a specific contract commissioned for services based around the Sunderland area.
- PTS supported hospital discharge across the region. In the North and South of Tyne areas as well as North Durham, crews transported patients 24 hours a day, seven days a week. In other areas, the trust provided patient transport into the early evening.
- The service used Auto Plan, an automated software planning system, to schedule patient journeys and the system planned approximately 80% of all activity. PTS transported patients based on the time of their appointment and Auto Plan scheduled journeys to ensure patients were collected and delivered within an arrival window of 45 minutes early and 15 minutes late. Staff had to add certain jobs to the system manually, for example, patients with mobility problems who required support from more than two crew members. Staff from Yorkshire and Scottish ambulance services had visited the trust to see Auto Plan in action.
- Some ambulance care assistants (ACA) had concerns about the impact of the automated planning system on other providers. For example, one ACA told us two different ambulances had travelled to the same hospital to pick up two different patients from a ward. Both patients lived in close proximity to each other but travelled separately; this meant the hospital had to send

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two escorts with the patients instead of one. We spoke with patients who told us about a similar experience and who all lived close to each other. They did not understand why the trust each sent different vehicles to attend appointments at the same hospital.

- The target for the number of aborted journeys was 14% and the current compliance rate was 14.9%. One of the control centre managers explained journeys could be aborted for a number of reasons, for example, a hospitals requesting transport when the patient is not actually ready for collection. In such cases, the crew would alert the control centre who would then reallocate them to another job and send a different crew to collect the patient. In March 2016, there were 2,942 aborted journeys. The customer care team were working with providers to minimise this and improve the service.

- We spoke to PTS crews across every division and found some had very positive views about the appointment-based planning system while others held a negative perspective. ACAs told us the new system meant patients received a better experience of using PTS, as they did not have to wait as long for the vehicle to arrive or at the hospital. ACAs who did not share this view told us they regularly travelled outside of their own local area to collect patients and felt Auto Plan did not plan their route schedules very well.

- Some PTS crews were concerned about the number of 'dead miles' (the number of miles a vehicle travels without a patient on board, such as journeys back to base for a meal break or travelling in between pick-ups). However, data reported in the January 2016 PTS service line management and quality report showed the service had seen a 33% reduction in dead miles between July 2015 and January 2016 and mileage in general. Managers told us one of their key priorities was managing capacity and demand and getting patients to their appointment on time. This meant patients who lived in the same vicinity might travel to the same hospital on different vehicles as Auto Plan calculated the journey based on their appointment time to meet the commissioned target.

Meeting people's individual needs

- PTS crews told us the control centre made them aware of vulnerable patients by providing them with relevant information via the Terrafix system and we observed this whilst on board vehicles.

- The control centre team planned and delivered PTS journeys to take into account the needs of different patients. For example, a two-person crew always transported patients living with dementia for safety reasons. An incident had occurred in the previous year where a patient changed their destination during travel and asked the crew to deliver them to an alternative address. It transpired the patient had not lived there for many years and, as a result, crews only amended a planned return journey if they had received instruction from the control centre, the hospital, or GP.

- However, ambulance care assistants (ACAs) told us the automated planning system did not always take into account people's individual needs. Due to the configuration of some vehicles, patients travelling in a wheelchair needed to be the first person on and the last one off the vehicle. Staff gave examples of when they had to remove a patient from the vehicle and assist them on again during the course of the journey to enable other patients to embark and disembark.

- Vehicles were well equipped to transport patients with a disability and control centre staff allocated the most appropriate, for example, one with wheelchair capability to accommodate the needs of patients with mobility problems.

- There was a policy for the transportation of bariatric patients and a pathway for call handlers in the control centre to follow to ensure the service met the needs of the patient. PTS shared two dedicated bariatric vehicles with the emergency care service and had the full equipment inventory including hoists and large wheelchairs. If a bariatric patient required a vehicle and both were in use, the control centre would contact the hospital and rebook the patient for the next day or rearrange the appointment.

- Some, but not all, PTS crews we spoke with were aware they could arrange an interpreter for patients for whom English was not their first language. One ambulance care assistant explained most patients usually had escorts accompanying them on the journey and told us interpreters who had been arranged by the receiving hospital were usually present when the patient arrived. Information provided by the trust reported PTS crews could access Language Line, a telephone-based interpreting service. Currently, crews contacted the service via the control centre; however, the trust was in the process of setting up a separate account so crews could contact the service directly.

Patient transport services (PTS)

- PTS crews told us they had not received specific training about equality and diversity including mental health awareness or dementia training other than a brief overview during their induction and annual refresher training. Their awareness of how to meet patients' needs came from their own experiences and knowledge rather than from training by the trust. However, we did see information leaflets displayed on notice boards in ambulance stations with advice to staff about patients who were deaf and hard of hearing, and people with sight loss.
- We saw evidence of patient leaflets produced in an 'easy read' format, such as 'What is Patient Transport' and 'Making a Complaint'.

Access and flow

- Patients could arrange their own PTS transport and there were different ways in which they could book this depending upon where they lived. Patients who lived in the Northumberland and Newcastle, and those patients receiving dialysis treatment, contacted the PTS control centre directly. Patients from other parts of the region contacted one of three third party booking agents. Patients living in North Durham and Sunderland could also make a booking through their GP. Hospital day units and outpatient departments also had access to the online booking system and could arrange bookings for their own patients. All booking agents had access to the same online system and the customer care team held responsibility for this.
- Although PTS crews and control centre staff told us they tried, whenever possible, to contact patients and hospitals if there would be a significant delay to their arrival at hospital, the trust reported there was no current resource within PTS to do this effectively. The trust acknowledged timeliness of transport was a source of concern and complaint from patients and we reviewed a briefing paper that outlined the trust's plans to improve communication in relation to this. Plans included the introduction of a text messaging service to inform patients if their vehicle was running late and when it was on its way, and advising crews the actual time they should arrive at the patient's place of residence instead of the appointment time.
- We observed good communication between control centre staff and PTS crews when transport issues arose.

For example, a PTS crew reported a minor fault to their vehicle and the control centre immediately arranged an alternative vehicle to take over the planned patient pick-ups.

Learning from complaints and concerns

- PTS vehicles held leaflets or displayed stickers to inform patients and carers about how to make a complaint or how to contact the Patient Advice and Liaison Service (PALS).
- From February 2015 to February 2016, there were 101 complaints about PTS and the most common theme related to the timeliness of transport. The trust had made some changes to improve the service. For example, rather than show the patient's appointment time on Terrafix, the system now showed what time to collect the patient. We spoke with ambulance care assistants who told us this was a positive change and one they found helpful.
- Between October 2015 and 31st March 2016, patients, families, and carers raised 122 concerns with PALS. Of those, 96 related to the Emergency operations centre and reflected the main theme emerging from complaints about the timeliness of transport.
- PTS team managers gave examples of dealing with complaints. They contacted and visited the person who made the complaint and worked with the customer care team to resolve the issue. In one example, a patient complained about vehicle parking and speeding. However, upon investigation, the vehicle and crew in question were not provided by the trust.
- The customer care team handled complaints from providers and we heard positive feedback from hospital staff about the service. Administrative staff from local hospitals told us they always received prompt responses from any concerns they had. One member of staff contacted the team after they had experienced problems getting through to the control centre. The customer care officer liaised with both parties and added an additional option to the call-answering message. This gave hospital staff quicker access to the relevant call handler to inform them the patient was ready for collection.
- A small dialysis unit praised the customer care team and told us changes had been made as a result of a complaint from the service manager in relation to a reduction in the number of late arrivals and pick-ups.

Patient transport services (PTS)

Are patient transport services well-led?

Good ●

We rated well led as good because:

- There was a clear statement of vision and values driven by quality and safety, and senior managers had developed a credible strategy with defined objectives. However, not all staff were aware of it.
- An effective governance framework supported processes and information to manage the current and future performance of PTS. The information used in reporting, performance management and delivering quality care was routinely discussed, reviewed and monitored at management meetings. The risk register included all key risks and senior managers could explain what actions they were taking to manage and mitigate them.
- Most, but not all, staff described a positive culture, and told us they felt proud to work for PTS and the trust.
- Ambulance care assistants (ACAs) felt supported in their role and complimented the leadership skills of their team and operational managers who, in turn, spoke positively about senior managers.

However:

- Some ACAs reported a disconnection between themselves and the senior management team. Frontline staff from rural areas in the North and South divisions felt leaders were not visible while ACAs from other localities said they had attended roadshows delivered by the management team.

Vision and strategy for this service

- The trust had a PTS strategy that set out the vision, intentions, and goals for the service over a five-year period. We reviewed the most recent business plan and corporate objectives, which included a transformation programme that covered nine initiatives. This included an integrated care and transport service in which PTS supported the emergency care service by providing transport for some urgent care patients. Other priorities included demand planning and resource optimisation, and improving the availability of vehicles.
- The trust vision and values were displayed on staff notice boards and staff had access to a regular

communications bulletin via email. Senior PTS managers, and local team and operational managers, could explain the key pressures, plans, risks, and goals of the service. However, most of the ambulance care assistants (ACAs) we spoke with did not have an awareness or understanding of the PTS vision and strategy or their role in achieving it. ACAs told us they had concerns about the future of the PTS contract and were aware of ongoing action in relation to meal breaks however, they did not receive regular updates and did not feel that they were able to contribute to any developments.

- Managers discussed the progress against delivering the strategy at regular service line management meetings and at trust board level.

Governance, risk management and quality measurement

- PTS had an effective governance framework that supported the delivery of the strategy. PTS delivered a monthly quality governance report and regular meetings took place with team and operational managers and senior managers. Agenda items included performance, incidents, risks, finance, and workforce planning however; there was no system to share the minutes from meetings with frontline staff. The PTS business manager also attended the Quality Governance Group to present an integrated quality and performance report, which included key risks and progress towards service objectives.
- The service had a risk management procedure and PTS staff were clear about their role and accountability for reporting incidents however, there was no system to share the learning from incidents with frontline staff across all divisions.
- PTS risks were logged on the trust's Safeguard system and there were 27 risks on the register. The Executive Risk Management Group reviewed the risks every four months. The top three risks were the threat of industrial action from unions in relation to a revised meal break procedure, commissioners not understanding the cost of quality impacting upon the ability of PTS to win and maintain contracts, and the maintenance of PTS vehicles. Most team managers and ambulance care assistants we spoke with had an understanding of some,

Patient transport services (PTS)

but not all, of the key risks. All staff were aware of the meal break proposals and most of them told us their main concerns was about the continuation and maintenance of PTS contracts.

- There were governance arrangements for PTS volunteers such as car drivers from the Ambulance Car Service (ACS) and hospital porters. The business improvement team completed a governance checklist to ensure compliance with safeguarding standards including DBS checks, infection control, health and safety and information governance.

- The ACS had an active committee that met every three months. The group included representation from six volunteer car drivers, the business improvement team, and the control centre. We reviewed the minutes from one of the meetings in which the committee discussed various operational issues such as waiting times between journeys and concerns relating to PDA devices.

- The trust had a lone working policy however; most of the staff we spoke with were unaware of any practices or procedures in relation to it. Staff told us they would contact the control centre if they had a problem. There was a system to track the location of ambulances, but there was no formal mechanism to monitor lone workers, aside from the rota, which identified single-crew vehicles. We spoke with ambulance care assistants who did not feel the trust provided adequate support for lone workers and felt the service should not run single-crewed vehicles.

Leadership of service

- Staff knew who the executive team were and understood some senior managers had visited ambulance stations and hospital departments; however, no operational staff had seen the executive team during their work. We spoke with a team manager who told us the head of PTS and the PTS business manager had recently held a series of road shows at ambulance stations across the area however not all staff could attend due to their work schedules.

- Overall, PTS crews we spoke with told us they felt supported by their team manager and operational manager. We heard examples describing the support for staff during pregnancy and changes to shift patterns to allow staff with long-term conditions or following injury to continue working. Most staff saw their manager every day at the beginning of their shift. Some managers used

this as an opportunity to share updates and information with their team. However, we also spoke with three staff from the South division who told us their manager was not visible and did not share information.

- The PTS business manager met with team managers every month however, there was no system to enable team managers to meet with their staff on a 1-1 or team basis or formally measure their performance.

- Morale amongst staff varied in the different regions. Some PTS staff in the South division, for example, felt separated from and undervalued by managers and the wider organisation while crews from the Central division felt there was less of a divide between managers and staff.

Culture within the service

- We observed staff working cooperatively with each other and respecting each other's roles. We found that most staff were loyal and flexible and many had worked for the trust for a number of years. The majority of staff we spoke with told us they enjoyed their job and were proud to work for the trust. PTS crews and managers also reported positive cultural changes over the last 18 months following the appointment of the new chief executive.

- Employee guidance was available for staff to raise concerns at work. Most staff told us they could raise a concern with their manager and felt there was a 'no blame' culture. Staff described a disconnection between themselves and the PTS management team based at trust headquarters.

- PTS crews from across the whole area told us the relationship with the control centre could be difficult at times due to their frustrations around the automated planning and dispatch of vehicles. Crews did not feel the control centre teams understood the rural geography and therefore were setting unrealistic targets to travel to remote locations. Managers were aware of the issues and had introduced measures to improve the relationships between the two staff groups. Actions included staff spending time within each different service. We spoke with PTS managers and crews, and control centre staff, who had shadowed each other and the feedback was very positive.

Public and staff engagement

- Staff did not feel engaged with the senior management team. A PTS forum took place bi-monthly, chaired by a

Patient transport services (PTS)

member of the senior management team, however, representatives from this group told us the same topics were discussed and senior managers did not appear to act on ideas or information provided by staff. However, one example raised at the focus group led to an improvement in the information available on Terrafix about patient appointment times.

- Noticeboards in ambulance stations displayed staff briefings, education updates, alerts regarding equipment and information on staff wellbeing. A recent project introduced a standard notice board template and we saw this was consistent in each station we visited.

- PTS crews and control centre staff received most communication bulletins and information via email. Staff from the control centre told us they received most of their updates from 'The Lamp', an intranet-based information tool.

- PTS crews did not have protected time to access emails and other communication. Staff checked emails in their own time at the end of a shift, during a meal break or from home; there was a risk staff did not receive essential information. However, the trust had also developed an application (app) for mobile phones and staff we spoke with referred to it as the 'Staff App'. Staff could access information from the trust intranet and their rotas.

- PTS consistently received a high response rate in relation to the Friends and Family Test. The trust had implemented a number of new initiatives to improve the response rate further, which included volunteer porters conducting surveys at one of the large acute hospitals and volunteer car drivers supporting patients to complete the online survey using their electronic PDA device.

- The customer care team met with a patient representative from the South of Tyne renal service every two weeks to discuss any issues or concerns. The team also engaged with patients through patient experience surveys that were undertaken each month,

and had been shortlisted for the Friends and Family Test champions of the year award for their work with the renal service. However, when we spoke with patients who attended regular dialysis appointments, they told us they had never had any communication with the trust.

Innovation, improvement and sustainability

- The trust had recently worked in partnership with Newcastle County Council to allow PTS vehicles to use bus lanes in the city. The use of bus lanes meant fewer delays caused by traffic, and fuel savings. The ambulance care assistant who initiated the project was in the process of contacting other local authorities in the region.

- As part of the continuous drive to improve the timeliness of transport, the trust had introduced a 'traffic light system' in Newcastle where a sensor was fixed on a vehicle which could change a traffic light from red to green on busy stretches of roads across the region. The trust planned to introduce the system across the footprint of NEAS.

- The business improvement team supported approximately 50-60 volunteer porters who greeted patients upon arrival at some of the region's largest hospitals and accompanied them to their clinic. We spoke with one porter, who had learning disabilities and was assisted by a support worker, who told us the support and training provided by the trust was excellent. All of the porters wore uniforms and were easily identifiable.

- PTS fleet managers had looked at different ways to improve the efficiency of the vehicles to support both cost and the environment. For example, vehicles were equipped with all-weather tyres and speed restrictors to maximise the efficiency of the vehicle. The team had also won an award for recycling and waste disposal, investigating and installing solar panels and LED lights on vehicles and ground source heating on stations.

Emergency operations centre

Safe	**Requires improvement** ●
Effective	**Good** ●
Caring	**Good** ●
Responsive	**Good** ●
Well-led	**Requires improvement** ●
Overall	**Requires improvement** ●

Information about the service

The North East Ambulance Service NHS Trust serves a population of around 2.7 million across the North East covering an area of 3,230 square miles.

The 999 service in the emergency operations centres handled 400,484 calls between January 2015 and December 2015. The emergency operations centre was available 24 hours a day, 365 days a year.

The trust had a single virtual emergency operations centre across their two sites meaning all calls were routed to the next available operator.

The emergency operations centres received and triaged 999 calls from members of the public and dispatched the appropriate response to patients.

The trust had two emergency operations centre, Bernicia house and Russell House. Both sites had 999 call handling. Dispatch was only carried out at Bernicia House. Clinicians provided clinical advice to patients at both operations centres.

The service provided 'hear and treat' services to patients who do not require an ambulance and transfer to hospital care.

We inspected both EOC sites during our visit. We spoke with 59 staff including call handlers and dispatchers, dispatch officers, clinicians (including paramedics and nurses), team leaders, duty managers, section managers and senior managers. We listened to 59 calls during our visit and reviewed 6 patient records.

Summary of findings

Overall the emergency operations centre was rated as requires improvement. We rated safe and well led as requires improvement and we rated responsive, effective and caring as good. We found that:

- Concerns were raised regarding the business continuity plans for the emergency operations centre in the event of a major disruption of services. There would be a delay in the setting up of the dispatch function of this service. Management could describe what they would do if dispatch at Bernicia House was unable to operate.

- Clinical advisor staffing levels were highlighted as being a challenge, however management were addressing this by enhancing the number of clinical advisor roles.

- There was a backlog of open incidents which had exceeded the trust timescales for completion. However, staff knew how to report incidents and root cause analysis was undertaken as required.

- Display screen equipment assessments were not always completed.

- Staff we spoke with understood how to report safeguarding concerns.

- The trust used systems which were evidence based and we found staff to be competent in their areas. The emergency operations centre co-ordinated with

Emergency operations centre

other services as required. Hospital advice liaison officers were in place in some hospitals to assist in the communication between the ambulance service and hospitals.

- Mandatory training completion rates were not always achieving the trust targets.

- Appraisal rates were below the trust target.

- The trust participated in the ambulance quality indicators which allowed the trust to monitor performance. Response data varied in the service, call abandonment rates were within thresholds between September 2015 and March 2016, however the proportion of patients who re-contacted the service following discharge of care, by telephone within 24 hours was higher than the England average.

- Staff were caring and compassionate and took into account patient's needs. Staff provided emotional support where required to patients and supported patients during calls to 999. Hear and Treat rates were mostly in line with other trusts.

- The emergency operations centre had access to a language interpreter service and text relay service for patients with impaired hearing.

- There was limited access to training on dementia awareness, mental health or vulnerable adults, however the trust was progressing a piece of work to enhance mental health provision from the emergency operations centre.

- Governance processes were in place and there were clear governance structures. Risk registers were regularly reviewed and management were able to describe the current risks to the emergency operations centre.

- Staff were not always aware of the trusts vision or strategy. Staff views on the culture varied in the different areas of the emergency operations centre and staff told us that senior management were not always visible and they had limited interaction with senior management. However, most staff told us they received good support from their team leaders and duty managers.

- The trust had been involved in a number of innovative initiatives.

Emergency operations centre

Is emergency operations centre safe?

Requires improvement ●

We rated safe as requires improvement because:

- Concerns were raised regarding the business continuity plans for the emergency operations centre in the event of a major disruption of services. There would be a delay in the setting up of the dispatch function of this service.
- Clinical advisor staffing levels were described as a challenge. Although management were actively recruiting to these posts, staff told us there were not always enough clinical advisors for support.
- There was a backlog of open incidents which had exceeded the trust timescales for completion.
- Display screen equipment assessments were not always completed.

However,

- Staff knew how to report incidents. Root cause analysis was carried out for incidents where required.
- Staff knew how to report safeguarding concerns. A logistics desk was available 24 hours a day, 7 days a week for staff to report safeguarding concerns.
- Records were managed securely.
- The trust used an evidence based clinical triage system to assess patients.

Incidents

- The trust had an incident reporting system in place and incidents were reported through the electronic reporting system.
- Between April 2015 and the inspection in April 2016 there were 8 serious incidents reported.
- Between April 2015 and April 2016 there were 164 incidents in 999 triage and 1510 incidents reported in dispatch. Patient safety incidents, G2 response delays and 999 triage were the main causes of incidents.
- Staff we spoke to understood how to report incidents. Staff would alert the on duty team leader and complete an incident reporting form.
- The trust reported 0.18% incident to call activity.
- Learning from incidents was shared locally by the electronic communication system.

- All staff had access to the electronic communication system and could view notifications distributed to staff. We saw an example of a notification which had been sent in response to learning from an incident that had been reported.
- Following a number of incidents, the EOC had changed practice around the delivery of the "Breathing and conscious" question. Although pathways combined these two states, call handlers now asked separately whether patients were breathing and whether they were conscious. Calls requesting an ambulance arrival time were also re-triaged to ensure that no deterioration had occurred in the patient's condition.
- Where a serious incident was identified, a root cause analysis (RCA) was carried out to establish the causes of the incident and to allow staff to identify risks and make appropriate changes to prevent similar incidents from occurring. RCA's were also carried out for non-serious incidents, where no harm was caused but the incident had the potential to develop into a serious incident if not addressed.
- We found that joint reviews of incidents were undertaken with partner organisations if the incident was a serious incident. Staff could describe serious incidents which they had discussed and reviewed with partner organisations.
- Staff told us there had been a backlog of open incident investigation reports being completed. The Trust provided information showing they had 156 open incidents, 55 of which were for the Emergency Operations Centre, 28 of these were within the Trust timescales. The remaining 27 were over the Trust timescales.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Staff we spoke to understood the Duty of Candour requirements and were able to describe candour, openness and being honest.

Mandatory training

- Mandatory training targets within the emergency operations centre were 95%. We found there was an overall compliance with mandatory training of 93%.

Emergency operations centre

- Staff undertook mandatory training in areas such as infection prevention and control, Mental Capacity Act 2005 and safeguarding.
- Completion of training in the clinical assessment and triage system for call handlers was mandatory before they could use the system. Call handlers had to complete module 1 of the system and clinical advisors had to complete module 1 and 2 of the system. Information provided by the trust showed that 100% of staff had completed the training and were compliant with the requirements.
- Staff could access some areas of mandatory training through the electronic communication system used by the trust.

Safeguarding

- Staff we spoke with understood how to report safeguarding concerns.
- Where a call handler or dispatcher had safeguarding concerns relating to a 999 call they would send an alert to the attending ambulance resource to inform them of their concerns. Where a resource was not dispatched or was not attending immediately, staff would make a referral directly to the logistics desk, where a dedicated member of staff would record the details of the job and the concerns and pass this to the local safeguarding team.
- There was a dedicated logistics desk in the emergency operations centre responsible for reporting safeguarding concerns. The logistics desk was open 24 hours a day, 365 days a year.
- Overall safeguarding training compliance was 93% of all staff achieving level two safeguarding. The target was 95%. Clinician and Clinical Hub compliance rates were 69% and operations and dispatch compliance was 94%. Information provided by the trust stated that managers, clinicians and team leaders had attended or were due to attend level 3 safeguarding training, however there were no figures to show how many staff had attended. The intercollegiate document for safeguarding children and young people: roles and competences for health care staff (2014) states that "All clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns" should have level 3 safeguarding training.

- The trust had an in date safeguarding children policy in place. Information provided by the trust highlighted that the EOC had appointed a safeguarding champion in the call handling service.
- The trust had a managing failed contact procedure in place with a date approved of April 2016, however there was no review date attached. The procedure applied to Emergency operations centre clinicians and was in place to ensure patient who are unable to be contacted were assessed using the information available and to measure the risk to the patient. The document included a risk assessment to be completed by the clinician.

Cleanliness, infection control and hygiene

- Infection prevention level 1 training compliance was 93%. The target was 95%.
- Disinfectant wipes were available at workstations through the two emergency operations centres.
- Hand alcohol gel dispensers were available for use in the different areas of the EOC.
- All areas visited were visibly clean and tidy.
- Staff were issued with individual headsets for telephones.
- Staff could describe the action they would take if a suspected communicable disease was identified during the triage process. Staff told us they would log this concern on the system and select the infectious disease checkbox on the system to alert ambulance crews.
- Staff in dispatch could describe the action they would take if a suspected communicable disease was identified. Staff would escalate the concern to the duty manager and the duty manager would communicate with the hazardous and response team (HART) and the on-call manager if out of hours.
- Staff we spoke with were aware of infection prevention and control issues and this was taken into account when dispatching ambulance resources or giving advice. Staff were also aware of the need for Ambulance staff to clean vehicles after patient contact and that some situations may require deep cleaning or isolation of vehicles.
- The EOC at both Bernicia House and Russell house were cleaned daily.

Environment and equipment

Emergency operations centre

- The EOC at Bernicia House was clean, tidy and well maintained. The Emergency operations centre and dispatch area both had large windows to each side, allowing for good levels of natural light.
- Portable appliance tests (PAT) had been carried out on electrical equipment as required.
- The emergency operations centre at Russell House had one room which was used for call handling. Concerns regarding noise and light levels and the suitability of the emergency operations centre at Russell House were raised during our inspection. Senior managers told us this had been added to the risk register and they had sought guidance from health and safety regarding the concerns. The current action plan was to monitor the situation.
- At Bernicia House and Russell House, Identification badge access was required to enter the buildings and individual rooms
- Staff did not have a set desk to work at and altered their desk daily. There was one desk in dispatch which was height adjustable.
- Staff had access to appropriate equipment for their work such as headsets, telephone systems and IT systems.
- Desks had analogue phones available to serve as a backup system if the digital telephony system failed. Standalone digital radio sets were available in case of total telephony failure.
- Some staff we spoke with had not had a display screen equipment (DSE) assessment completed. DSE assessments were available for staff if required, however these were not mandatory and there was no regular review of DSE assessments.
- Staff could have specialist chairs where required through assessment with the occupational health department.
- An incident matrix was in place for IT systems in the Emergency operations centre which specified priority and urgency of the IT failure along with response and resolution times.

Medicines

- The clinical assessment and triage tool used within the EOC for 999 services asked questions around medication use, answers were recorded and appropriate dispositions reached in line with these answers.

- Call handling staff told us they would transfer the call to a clinical advisor if advice regarding medicines was required. Call handling staff told us they would not provide advice on medication to patients and carers.
- Clinical advisors were able to give medicines advice, including advice to take or give medicines as required in line with their skill set and registrations. This information was given in line with the British National Formulary (BNF), the joint Royal Colleges Ambulance liaison committee (JRCALC) and other approved sources.

Records

- Records were held on the computer aided dispatch system and triage was carried out using this system. The system was password protected.
- Call records and details of the 999 triage process were logged on the computer aided dispatch system. The system prompted the call handler with questions for the caller and the response was recorded on the system.
- Records on the dispatch system used by the dispatch team were colour coded to indicate the priority of the call and assist in dispatching the appropriate response.
- The system contained 'flags' to identify pre-existing conditions or safety risks to assist staff in assessing the call and alerting ambulance crews to further information. A dedicated team was in place to update 'flags' on the system and these 'flags' were regularly updated by the team. Staff and managers told us these were not always up to date because the information to update flags came from external sources.
- Duty managers completed a shift report daily and this information was shared with the appropriate staff. Access to the shift report was restricted.
- Paper records were only used as part of a backup if the electronic systems went down and records were added to the electronic system manually when systems returned to normal.
- Information provided by the trust showed that information governance was part of the induction and mandatory training. Mandatory training records showed that compliance rates for information governance was 83.98% between April 2015 and May 2016. The trust target for mandatory training was 95%. The trust provided further information highlighting that manual records indicated that the 95% target had been met, however this had not been recognised by the electronic system.

Emergency operations centre

- Management told us they were transferring standard operating procedures from one system to another. This required a template change and therefore not all procedures had review dates attached.

Assessing and responding to patient risk

- The emergency operations centre used an evidence based electronic system to triage and carry our risk assessments on 999 calls. If the call was complex and clinical advice was required, the call was then referred to a clinical advisor for further assessment.
- All calls to the EOC were via 999 and assessed through 'module zero'. This questioning established whether a patient was conscious, breathing and not suffering from a major haemorrhage.
- The outcome of the call was dependant on the triage and risk assessment. If a patient required an ambulance, then this would be dispatched automatically depending on the assessment.
- Many call handlers were dual trained in 111 and 999 and were able to assess the patient through the 111 process if required. If different services such as mental health or urgent care centre services were required, a directory of service provided information on different services available.
- Where an ambulance response was prolonged or there has been a delay in dispatching a resource, clinicians could call patients back to provide further support and management, carrying out further triage where appropriate and re-grading emergencies if the situation had changed.
- If a clinician was not able to make contact with a caller after three attempts they contacted the nearest emergency department to check if the patient had self-presented. If this had not happened, an ambulance was sent to ensure patient safety.
- Where response times exceed expected thresholds, certain jobs were automatically upgraded to a higher response level. These include road traffic accidents and patients aged over 65 who had waited for more than one hour being upgraded to G1 and G3 calls that had waited more than two hours being upgraded to G2, these calls also get a clinician call back where possible to assess for alternative transport.
- A '999 ring back during clinical escalation policy' was in place. The policy was in date.

- We saw staff using the electronic triage and risk assessment systems appropriately during our inspection.
- Staff were aware of the different skill mix of ambulance response staff and could describe what response they dispatch for different situations.
- Resources were dispatched based on the clinical priority of the call and the ambulance crew's location.
- Clinical advisors provided welfare calls to patients who were waiting for delayed ambulances or during busy periods.
- Staff told us of situations where certain groups of patients such as end of life patients would be automatically referred to a clinical advisor for progression of their clinical assessment.
- Criteria for upgrading falls with a G2 disposition to a G1 response had been established and sent to dispatch staff.

Staffing

- We found 136 out of 291 call handlers were dual trained in 111 and 999. Management had details of staff with additional skills to support other areas of the EOC, for example staff who were trained in '999' call handling or dispatch.
- Staffing schedules were arranged by an electronic system which assessed previous data and service demand and projected staff requirements based on this data. Management told us that acuity across both Bernicia House and Russell House and skill mix were taken into account.
- The trust had 136 '999' trained call handlers who worked in other areas such as '111' and 'PTS'.
- Dispatch had a fixed staffing shift requirement of 13 staff. There were 26 team leaders across the EOC.
- Data from February 2016 showed that the Emergency operations centre had a whole time equivalent of 75.02 for 999 call handlers against a budget of 72.08 whole time equivalents. Dispatch in the Emergency operations centre had a whole time equivalent of 104.5 against a budget of 102 whole time equivalents.
- Administrative and clerical had a whole time equivalent of 10 and an overall vacancy rate of 14%.
- At the time of inspection the vacancy rate for emergency medical dispatchers was 6%. Manager vacancy rates were 4%.

Emergency operations centre

- Emergency Call Handlers and dispatchers were over their funded establishment. Clinical advisors were under the funded establishment.
- Emergency medical dispatch had a staff turnover rate of 2.5% between April 2015 and the inspection.
- Emergency Call Handlers and dispatchers had a staff turnover rate of 18% between April 2015 and the inspection in April 2016.
- Administrative and clerical had a 0% staff turnover rate between April 2015 and the inspection in April 2016.
- Clinical advisor staffing levels were described as a challenge by staff. Staff told us there were not always enough clinical advisors for support. There were 19.7 whole time equivalent clinical advisors and management told us they were currently recruiting with the aim of fulfilling a staff level of 34 clinical advisors. This would enhance the ratio of clinicians to non-clinicians to 1 to 7. Staffing records showed several occasions over the three months prior to inspection where only one clinician was available across both the emergency operation centres, however, there was at least one at all times.
- Staff told us that during weekends and nights the service often felt understaffed.
- Staff received two 30 minute and two 15 minute breaks during shifts. These would be cut short to 10 minutes if the 999 escalation plan had been activated.
- 999 calls were answered by both EOC's and by the next available call handler.
- Staff used and followed the pathways system and pathways prompts when dealing with children callers. Information provided by the trust highlighted that training was provided to staff as part of the triage system and training on how to handle a call made by a child for a parent in communication skills training. The system also allowed for an early exit answer which provided a G2 as the lowest response.
- Agency and bank staff were not used in the emergency operations centre.
- Service levels provided by the trust for a week in April 2016 showed that planned service levels were above 95% apart from one day where it was 94% and the actual service levels were all above 95%.

Anticipated resource and capacity risks

- Business continuity plans were in place for Russell house and a trust wide business continuity plan included a section on the control room and Emergency operations centre.
- Anticipated resource and capacity risks during major events had been taken into consideration. We saw operational plans addressed capacity, resource, risk, command and control during the events.
- A resource escalation action plan (REAP) was in place. REAP is a structured process for all UK ambulance trusts using the joint decision model as part of the Resource Escalation Action Plan (REAP).
- Resource requirements were managed by the trust staff rota system. Staff told us they could adjust this system to allow for further resource or capacity risks if there was a major event or potential increase in capacity requirements.
- A call handling escalation plan was in place for use where demand was greater than the resource available. This plan was implemented when certain capacity levels were met.
- Management told us that if there was a planned major event, the EOC would operate a mini-control room at the event which had access to the computer aided dispatch system.
- A hospital escalation policy was in place.

Response to major incidents

- Staff told us that in the event of a major incident, they would complete an METHANE report and notify the ambulance crews of the situation. The METHANE protocol is used to report major incidents in the emergency operations centre.
- In the event of a major incident being declared, a command centre would be set up within the EOC to manage resources and maintain effective communication with ambulances, hospitals and other resources.
- Concerns were raised regarding the business continuity plans for the emergency operations centre in the event of a major disruption of services. There would be a delay in the setting up of the dispatch function of this service.
- Management could describe what they would do if dispatch at Bernicia House was unable to operate. A Bernicia House business continuity plan was in place and detailed the action the 999 dispatch would take.
- Senior staff told us that it was difficult to release staff for training in major incident awareness due to staffing

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limitations and finance. However, dispatchers and duty managers had been involved in JESSIP (joint emergency services serious incident planning) training exercises with the fire service and an emergency control room course had been developed.

- All staff had completed training in chemical, biological, radiological and nuclear (CBRN) awareness and initial operations response.

Is emergency operations centre effective?

Good 🟢

We rated effective as good because:

- The triage and risk assessment systems used were evidence based. The systems took into account national guidance and were used by staff to carry out the triage and risk assessment of patients which established the most appropriate response. Additional information and resources was available if required.

- The service had introduced an integrated care and transport team (ICAT) within the dispatch centre to assist with the transport of patients where non-urgent transport may be appropriate.

- The call abandonment rate target was less than 1%. Between September 2015 and March 2016, the trust was achieving levels less than 1%.

- The trust had hospital advice liaison officers in place to assist with communication between NEAS and the hospitals they were based.

- The EOC co-ordinated with other services where required.

- We found staff to be competent at their roles. Staff could describe the process for call audits and feedback from audits. Staff told us these audits were regular and they received feedback at their monthly 1 to 1 with their team leader.

- Staff had access to a trust information system which allowed them to view notifications and information disseminated to EOC staff.

However:

- Appraisal rates for staff varied between the services.

- The number of 999 calls resolved by telephone advice was below the England average of 9.1%.

- The EOC did not always achieve the 95% target to answer calls within 5 seconds.

- The proportion of patients who re-contacted the service following discharge of care, by telephone within 24 hours was worse than the England average.

- There was no mental health support available in the EOC, although managers were is discussion with a mental health service to progress work on mental health provision from the EOC. Staff could describe that patients contacting the service with mental health concerns would be referred to a service they were known to or referral to other services if required.

Evidence-based care and treatment

- The electronic system used to triage and carry out risk assessments on 999 calls was evidence based and took into account National Institute of Care and Clinical Excellence guidelines.

- The triage system used prompts on the screen with questions that were asked to the caller to establish the appropriate response. At the end of the triage and risk assessment, the system highlighted the most appropriate response.

- Where clinicians required further information, BNF online, JRCALC and other recognised resources could be used to ensure information given was accurate and in line with national best practice.

- The trust had included a metronome system on the staff electronic communications system, to assist staff in providing CPR advice.

- The dispatch team allocated the appropriate response and vehicle based on the requirements of the patient. The dispatch team were able to identify where ambulances were and what ambulances were available for dispatch. The dispatch team dispatched ambulance crews and vehicles based on clinical priority. The dispatch system showed calls in order of clinical priority on the waiting stack.

- The emergency operations centre had implemented a new service called the integrated care and transport

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team (ICAT). This service was developed to assist with the transport of patients where non-urgent transport may be appropriate. The service was developed for non-urgent calls.

- Clinical advisors were a mixture of registered nurses and paramedics and were available to call handlers in 999 to refer patients who required further clinical assessment. If call demand was greater than the number of clinical advisors, they were placed on the call stack until the next available clinical advisor became available.

Assessment and planning of care

- Calls were handled through the clinical assessment and triage system and were allocated a priority rating of Red 1, Red 2, Green 1,2,3 or 4. Red 1 and Red 2 calls were the highest priority calls.

- Clinical advisors were available on each shift to respond to calls which required a clinician for further advice and assessment.

- Staff told us they referred mental health patients onto a mental health team if the patient was under their care already. Those who were not known to mental health teams received an ambulance response or alternative response based on the assessment carried out by call handlers and clinicians.

- The triage system used 'flags' which allowed the call handler to identify any pre-existing conditions such as mental health if this had been added to the system previously. Management told us they were currently working with a local mental health service to implement further provision and advice available from the EOC. There were no timescales in place for this work, however managers confirmed the discussions had started and progressed with the local mental health service.

- Staff in dispatch told us patients detained under section 136 would be highlighted on the dispatch system. Section 136 is part of the mental health act 1983 which police can use to take a person to a place of safety when they are in a public place. A memorandum had been sent to control and Emergency operations centre staff detailing the process of logging section 136 on the systems.

- A number of electronic systems were used to triage and risk assess patients and the dispatch of the appropriate

resource was carried out through a computer aided dispatch system where dispatch staff could assess resource availability and location. An electronic system was in place to provide the EOC with up to date information on the current demand and bed availability in regional hospitals.

- Staff were able to describe how they dispatch fire responders and community first responders. Fire responders and community first responders were managed and deployed by the regular dispatch team.

- The EOC dispatch team were divided into regional teams. The ICAT service, recently implemented in the emergency operations centre, had enabled dispatch of a non-urgent vehicle if appropriate.

- Challenges and concerns regarding the availability of vehicles were documented in shift reports by duty managers in dispatch. We saw one shift report which included details on the challenges during the shift previously where ambulances had been queuing at a hospital. Where this happened there was an escalation plan which involved contacting senior management staff and liaising with senior hospital staff.

Response times

- The 999 service was required to answer 95% of calls within 5 seconds. Information provided by the trust showed that this rate varied between January 2015 and February 2016. Between June 2015 and November 2015, 999 call performances were between 89% and 95%. In December 2015, 999 call performance was 96.5%.

- The median shows that the trust was performing better for time taken to answer calls when compared to the average of all ambulance trusts.

- Calls were triaged and divided into Red 1, Red 2 (Category A) or Red 19 or Green 1, 2, 3 or 4. Red 1 and Red 2 calls were immediately life threatening calls. Green 1 and 2 were serious but not life threatening calls and Green 3 and 4 were neither serious or life threatening.

- The proportion of calls abandoned before being answered between July 2014 and December 2015 was worse than the England average aside from February 2015 and December 2015. Data between July 2014 and January 2015 showed that the call abandonment rate varied between 1% and 5.5%. Data between February

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2015 and December 2015 showed that the call abandonment rate varied between 0.5% and 2%. The proportion of calls abandoned before being answered in December 2015 in England was 0.5%.

- Data provided by the trust showed that call abandonment rates in January 2016 was 0.34% and call abandonment rates in February 2016 was 0.30%.The call abandonment rate was less than the 1% threshold between September 2015 and March 2016. The call abandonment target for 999 calls was less than 1%.

- Data showed from April 2015 to March 2016 the number of calls abandoned before being answered was 0.8% compared to an England average of 0.6%.

- The proportion of patients who re-contacted the service following discharge of care, by telephone within 24 hours was between 12% and 16% between July 2014 and December 2015. The trust re-contact rate was higher than the England average by an average of 7% per month. The proportion of patients who re-contacted the service following discharge of care by telephone within 24 hours data showed between April 2015 and March 2016 was 14.2% compared to an England average of 6.3%.

- Frequent caller data showed the trust had a higher frequent caller rate than the England average between July 2014 and March 2015. The trust frequent caller rate varied between 1% and 1.6% between July 2014 and March 2015. From April 2015 to December 2015 the performance was better than the England average. The trust frequent caller rate varied between 0.8% and 0.2% between April 2015 and December 2015.

- Staff told us that they were seeing an increase in patients waiting long times for ambulances. This had led to higher numbers of patients calling back for updates as to expected time of arrival of ambulance resources. Clinicians told us that calls often had to be upgraded in order to get an ambulance response and that this was putting further pressure on the R1/R2 response times.

- Real time call handling availability and call volume data was available and displayed electronically across the EOC to highlight where there were pressures.

Patient outcomes

- The trust participated in the ambulance quality indicator national benchmarking data. The national benchmarking data provides comparisons between ambulance trusts in England and provides information on performance such as time to answer call and percentage of calls resolved with telephone advice.

- The percentage of emergency calls resolved by telephone advice was lower than the England average between July 2014 and December 2015. The percentage of emergency calls resolved by telephone advice was 7.4% in December 2015. The England average was 9.1%.

- The trust participated in the 'Hear and Treat' survey. Results showed the trust were mostly in line with other trusts and better in some areas.

Competent staff

- Appraisal rates varied between the different staff groups. For example appraisal completion rates for call handlers between April 2015 and the inspection was 72.47% and appraisal completion rates for dispatch officers between April 2015 and the inspection was 27.27%. Information provided by the trust highlighted that the appraisal figures were under review, as they may not be accurate. The trust provided further information highlighting the appraisal rates had been verified and the EOC was at 88% compliance overall as of March 2016.

- Staff told us they had appraisals with their line manager.

- Staff told us they had their NHS Pathway licence to use the system and they had monthly audits where four calls were checked. Staff told us these were regular and received feedback at their monthly 1 to 1. Some team leaders were NHS Pathway trainers.

- Where call handlers were being developed or issues had been identified, more call audits were carried out. Due to staffing constraints, the call audit team told us that they were currently one month behind on call audits. Information provided by the trust identified that 231 call handlers were audited in February 2016 in which 89% of call handlers achieved three or more audits. 781 calls were audited of which 85% achieved a score of 86% or more. The average score for audits was 92%. The EOC produced call audit trend summaries which allowed analysis of call audit information.

- Call handlers referred to a clinical advisor based on their knowledge and expertise.

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- Information provided by the trust indicated that the NHS Pathway training included children callers and using the Pathway system. The system included an early exit option which gives a G2 as the lowest response.

- All new staff initially trained as 111 call handlers and when competent and ready, were trained in 999 call handling. Staff received a 6 week induction and staff had to successfully complete three audits.

- All new staff were required to attend a trust corporate induction.

- Staff in the EOC told us they did not have regular team meetings, however most staff told us they had regular 1 to 1 meetings.

- Information provided by the trust showed that all appropriate EOC staff had completed the initial operational response (IOR) training. In 2015/2016 there were 179 new starters, 122 people completed this training.

- Information provided by the trust highlighted that all appropriate EOC staff had completed the JESIP awareness and Airwave course. JESIP is the Joint Emergency Services Interoperability Programme.

- Trends and themes from audits were shared with the wider staff via the electronic communication system and the learning hub newsletter. This allowed call handling staff to develop and learn from others' practice.

- Where updates or information was released on the staff electronic communication system, team leaders monitored who had read updates. This allowed them to monitor uptake and understanding of changes.

- Clinical advisors were required to maintain their professional registration as paramedics or nurses. In line with their registration they were expected to be able to provide appropriate support and advice, however there was limited dedicated clinical training for the role, and no specific training around assessment and triage of children was provided.

- Clinical advisor calls were audited. Staff told us that feedback could be limited and tended to only be shared when it was negative or there had been an incident.

- Dispatchers understood the skill levels of staff, both NEAS ambulance staff and private contract staff. Guidelines were available as to what type of incidents certain grades should respond to and staff respected these guidelines when dispatching.

- The trust developed Emergency operations centre training bulletins which provided training information on different subjects to staff. An example was a training bulletin which highlighted training information on patients who call with a Tracheostomy.

- Staff had access to a leadership programme; however there was limited training opportunities offered to staff. A project group was planned to address education and training.

Coordination with other providers

- The emergency operations centre used voluntary services to respond to different types of calls. A policy was in place to describe the use of the voluntary crews by the EOC.

- Hospital ambulance liaison officers (HALO) had been placed in some hospital trusts to facilitate communication between the ambulance service and the hospital trust.

- Staff told us they would sometimes pre-alert hospitals to potential patient arrivals and dependent on the situation.

- The dispatch team contacted the police and updated them on current operational challenges if the service was under pressure. This was documented in the shift report.

- Memorandums of understanding were in place with the police and mountain rescue. It was not clear whether these procedures had been reviewed.

- A memorandum of understanding was in place between the fire and rescue and ambulance services HART team, however the review arrangements documented were September 2013.

- 111 and 999 call handlers were co-located in the same operations centre and many call handlers were dual trained in 999 and 111. Dual trained staff could handle both calls when received. 999 call handling trained staff could refer to 111 or a clinical advisor if required.

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- Information provided by the trust highlighted that the EOC had implemented a system where operational crews were able to contact the logistics desk within the EOC and the logistics officers would complete the paperwork for falls referrals and submit this to the relevant falls assessment team.

Multidisciplinary working

- We saw staff at the different emergency operation centres work together when required and staff between dispatch and 999 call handling communicated between the services when required.

- Clinical advisors provided support to call handlers when required.

- IT systems allowed the automatic transfer of information and referral between call handlers, clinical advisors and dispatch. Flags on the system to highlight important information to ambulance crews were automatically transferred to the crew during dispatch.

- Clinical advisors told us that referring patients to mental health professionals or district nursing was challenging as they were not able to refer patients that were not known to the service, patients who were intoxicated or patients with any possible physical health needs. Clinicians often felt the need to send patients to emergency departments as other services were not accessible to them.

- Duty managers had informal handovers between shifts to discuss operational challenges and discuss the shift report.

- The emergency operations centre was in discussion with another provider around enhancing mental health advice and services from the emergency operations centre.

Access to information

- Staff had access to an information system which allowed staff to read procedures, view overtime options and view new information disseminated by the trust.

- Special notes were available on the system to highlight further information to call handlers during the call. A project team had been set up in November 2015 to regularly update system flags. Management advised us that often this information was not always up to date.

The information detailed in the flags on the system was often provided by external sources and therefore the EOC were reliant on regular updates to keep the system up to date.

- As NEAS used a shared system for both NHS111 and the 999 service, they were able to identify if a caller had already contacted NHS111 or 999 previously.

- Where three calls had been made within 24 hours to either service, this was identified on the patient demographic screen, helping to ensure the caller received appropriate care and calls were not duplicated inappropriately.

- The customer care team were responsible for managing frequent callers on a multidisciplinary basis. This team engaged with patients GP, the hospitals, police and social services as appropriate as well as reaching out to the patient themselves. The trust had a frequent caller procedure flow chart in place and had recently established a frequent caller working group to develop their work around frequent callers.

- Staff told us that they discussed first time frequent callers with the appropriate GP and discussed the care plan in place.

- Staff told us they had taken action in response to NHS England's 2015 patient safety alert, 'Harm from delayed updates to ambulance dispatch and satellite navigations systems?' Staff told us that maps in the control room were updated every three to six months. Maps in vehicles were updated each year.

- A verbally abusive caller policy was in place dated March 2016; however there was no review date attached.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Mental Capacity Act training compliance was 93%. The target was 95%.

- Information provided by the trust highlighted that implied consent was assumed by the caller contacting the 999 service.

- There was currently no mental health support in the emergency operations centres where advice could be sought by call handlers. However management were currently in discussion with another provider to develop their services in mental health provision.

Emergency operations centre

Is emergency operations centre caring?

Good ●

We rated caring as good because:

- Staff spoke to patients and carers in a caring and professional manner.
- Hear and treat rates were mostly in line with other trusts. The survey showed positive results for call handlers showing dignity and respect to patients.
- Family and friend test survey results showed that 92.3% of respondents were likely or extremely likely to recommend the service to friends or family.
- Staff engaged with callers and were responsive to patient's needs. Staff provided callers with extra time if required to answer the questions and would alter the way they communicated with callers to help the caller understand the question.
- A frequent caller procedure flowchart was in place and frequent callers were managed by the customer care team within the trust.

Compassionate care

- We listened to 59 calls during the inspection. Staff spoke with patients and carers in a caring and professional manner.
- 'Hear and Treat' is the telephone advice that callers who do not have serious or life threatening conditions receive from an ambulance service after calling 999. The trust participated in the 'Hear and Treat' survey.
- Staff spoke with people in a compassionate way and treated people with dignity and respect. The hear and treat survey showed that the trust scored 9.2 out of 10 for call handlers showing dignity and respect to patients.
- Staff spoke with people in a way they understood and checked that patients understood the questions.
- 'Hear and Treat' survey results showed that the trust was mostly in line with others trusts results. The trust performed better for understandable instructions from the call handler, waiting for a call back from a clinical advisor and it being possible to follow the advice given. All others results were in line with other ambulance trusts. 333 patients responded to the survey.

- The emergency operations centre family and friend survey was incorporated into the emergency care survey. Results from the March 2016 survey showed that 92.3% of respondents were likely or extremely likely to recommend the service to friends or family.

Understanding and involvement of patients and those close to them

- Staff engaged with people during calls to ensure questions were understood and staff referred patients onto clinical advisors where necessary. The Hear and Treat survey showed that the trust scored 8.3 out of 10 for the clinical advisor being reassuring. The survey showed that the trust received 8.8 out of 10 for the feeling that the call handler understood what they were being told.
- The trust received 10 out of 10 for patients who spoke to a second person, understanding the instructions about what to do if their situation changed. This was better when compared with most other trusts.
- Staff were responsive to callers needs and provided callers with extra time if required to answer questions.
- Staff were able to access interpreter services if required.

Emotional support

- The 'Hear and Treat' survey showed that the trust scored 7 out of 10 for patients who called and had fears or anxieties and had the opportunity to discuss these with a clinical advisor.
- Staff provided caller's assurance that help was being arranged if appropriate and remained with callers on the telephone until the ambulance crews arrived. Staff provided support to patients and callers during 999 calls.
- Staff showed empathy for patients with mental health illnesses and altered the way they communicated with patients as required.

Supporting people to manage their own health

- Frequent callers were identified through flags on the system. Frequent callers were managed by the customer service team and discussed the support required for frequent callers with the appropriate services. A frequent caller flow chart was in place which described the process for managing frequent callers. This process

including the responsibilities of call handlers and team leaders and described what action the customer care team would take, for example working with general practitioners.

- The call handling services team had access to a directory of service which provided call handlers guidance on the services available to patients locally. This service was used to refer callers to the most appropriate service in response to their 999 call if appropriate. For example, the call handlers could refer patients to urgent care centres.

Is emergency operations centre responsive to people's needs?
(for example, to feedback?)

Good 🟢

We rated responsive as good because:

- The trust had taken into account major events and documented plans for the events. Staffing levels were taken into account and adjusted according to the potential demand on the service.
- The trust had access to interpreter services and text relay services.
- The dispatch team communicated with hospital trusts where there were capacity and demand challenges.

However:

- The trust did not routinely offer training on dealing with patients with complex needs, dementia awareness or mental health concerns.
- There had been a back log of complaints for the EOC, however this was being addressed during our inspection and staff told us this was reducing. The trust provided further information showing these were within trust timescales.

Service planning and delivery to meet the needs of local people

- The trust had dual trained many call handlers in 999 and 111 services which management told us allowed them to be flexible in times of peak demand on the 999 service.

- The trust took into account local events which increased demands on the service. Information provided by the trust highlighted that staffing demands for local events were planned in advance and staffing rotas were adjusted as required.
- Management told us they had plans to progress work on enhancing mental health provision in the EOCs. Work was also being progressed for palliative care transport provision. Management told us commissioners had been involved in the work around mental health provision.
- Escalation plans were in place for times of high call demand in the EOCs. The plans detailed what action team leaders would take if demand increased beyond anticipated capacity levels.
- In the event of a system failure at one of the 999 call handling sites, Bernicia House and Russell House. Calls would divert to the other emergency operations centre automatically.
- Dispatch was located at Bernicia house only and in the event of system failure to dispatch or Bernicia house not being able to facilitate dispatch services, staff told us they would move the dispatch team to Russell House. Staff told us this would take around 20 minutes and dispatch would use radios from the car park during that 20 minutes to manually dispatch ambulance crews. A draft procedure was in place; however staff had not received training in dispatch resilience procedures.
- During technology failure, staff told us they would use a simplified paper version of the NHS pathways system in call handling and dispatch. Staff told us this was part of their initial training. Staff in dispatch told us they would rely on more experienced staff for support.
- During changes in demand and seasonal weather challenges, hospital ambulance liaison officers (HALO) would communicate information between the hospitals they were at and the ambulance service.

Meeting people's individual needs

- The trust had access to a language interpreter service which was used by EOC staff if required.
- Staff in the EOC had access to a text relay service for hearing impaired patients who contacted the EOC.
- The trust did not routinely provide staff in the EOCs with dementia training and awareness; however the EOCs had developed a vulnerable adults document which included a section on dementia for staff to work through. This had been developed by the training team.

Emergency operations centre

- Mental Capacity Act training was part of the trusts mandatory training schedule; however the trust did not offer training to staff on dealing with patients with complex needs or mental health concerns.

Access and flow

- Call handling was operated from the Bernicia House and Russell House and operated as one virtual control centre for 999 calls. Dispatch operated only from Bernicia House, however the same systems were used at Russell House and dispatch could operate from there if the team moved to Russell House. 999 calls were answered by the next available call handler at either site.
- The dispatch systems allowed dispatch staff to view where vehicles and crews were located. Dispatch was responsible for dispatching an appropriate vehicle to the scene. The ICAT desk at Bernicia House was responsible for sending vehicles to non-urgent calls where alternative transport may be appropriate.
- Calls to the 999 service were prioritised according to the outcome of the pathway triage system which identified what response was appropriate. Once the system had assigned an assessment outcome and response, dispatch viewed what response was required and the priority of the call on their systems and dispatched the appropriate vehicle.
- Clinical advisors received approximately 45 calls per day. In February 2016, over ten shifts, 361 jobs were assessed by clinicians. Of these, 66 were re-graded as lower category responses, 107 were passed for alternative transport, 60 were not answered, 18 were re-triaged as a higher category and 110 were not changed.
- A total of 22% of 999 calls were revalidated by clinicians in April 2016.
- Information between October 2015 and March 2016, provided by the trust, showed that 9.5% of calls to emergency operations centres were expected time of arrivals calls.
- If there were capacity challenges in hospitals, the duty manager in dispatch would call the hospital bed manager to discuss the issues and request a situation report. A North East divert policy was in place.
- Calls into the emergency operations centres were monitored in real time. The EOCs had display screens located around the centre which showed information

such as the number of calls waiting to be answered, the number of calls in progress and how many staff were available to answer calls. Staff told us the 999 escalation plan was implemented if calls started to stack.

Learning from complaints and concerns

- Between February 2015 and February 2016 there were 357 complaints about the emergency operations centres, 81% of the complaints made to the emergency operations centre were related to waiting for resource. Staff told us there had been challenges with dealing with complaints and there had been a backlog. The trust provided further information showing these were within trust timescales.
- Management had responded to this by seconding staff from the EOC to assist and help manage complaint handling and response. Staff told us there was still a backlog of complaints, although this was reducing with the staff secondments. Information provided by the trust highlighted that there were 54 outstanding complaints.

Is emergency operations centre well-led?

Requires improvement ●

We rated well-led as requires improvement because:

- Operational staff were not always aware of the vision or strategy.
- Staff views on management and the culture of the service were mostly positive; however this was not always consistent throughout the emergency operations centre. Staff told us there was limited interaction with senior management.
- Staff culture survey results were mixed.

However, we found that:

- Governance arrangements such as regular governance meetings and risk register reviews were in place. Performance, patient safety and compliance were standing agenda items at the delivering consistency meetings.
- The trust had set up a culture group to address challenges involving the culture of the service. The EOC had also carried out a culture survey to understand the causes of variance in the culture of the EOC.

Emergency operations centre

- The trust had been involved in a number of innovative pieces of work and had developed their internal communications system to support staff.

Vision and strategy for this service

- A final strategic plan for the ambulance service was in place dated between 2015 and 2020. The plan set out the vision and strategy over the next five years and included the strategic goals set by the trust.
- The trust had recently developed its strategy and the key themes were to be progressed through four project groups. These groups were culture, integration and collaboration, new ways of working and education and training. Information provided by the trust highlighted that further engagement with staff around the strategy and implementation was required.
- Operational staff were not always clear on the vision or strategy of the service.

Governance, risk management and quality measurement

- An electronic risk register was in place for dispatch and the call handling centres. We saw the relevant areas of the risk register to be appropriately completed and actions documented. Many actions had documented review dates. Management told us that the risk register was reviewed weekly.
- We found that management staff were able to describe the risks to the service and what they had in place to mitigate the risks.
- The head of service was the nominated governance lead for the EOCs and attended a weekly senior management meeting to discuss the risk register, duty of candour and complaints.
- Governance and risk concerns were escalated where required through regular governance meetings such as the delivering consistency meetings. We saw the minutes from delivering consistency meetings from November 2015 and found that performance, patient safety and compliance were agenda items at these meetings.
- Staff told us they received four monthly call audits and received feedback at their 1 to 1 meetings. The quality and performance team produced monthly call audit reports. We were told during our inspection that call audits were behind one month.
- The trust had systems in place to monitor and analyse data and information available to the EOCs.

- Management were able to describe what they would do if the dispatch centre at Bernicia House was unavailable. A Bernicia House business continuity plan was in place and detailed the action the 999 dispatch would take .
- An action plan tracker from the operational delivering consistency meeting in March 2016 showed that most actions had been completed or were on track for achievement. One action was overdue and not achieved by the target date.
- A red rate group had been set up to investigate the causes of the reduction in performance with the red rate. The red rate related to performance targets and response rate targets. An action plan was in place for the group.
- The EOCs had a backlog of incidents and complaints which had yet to be completed. The EOCs had a team in place to address the backlog of complaints.

Leadership of service

- Each shift at the EOCs had a mixture of team leaders associated with each team and a duty manager. During the day, there were section managers and senior management on site. Senior management rotated through an out of hour's on-call system to ensure senior management were available when required. The EOCs had a clear leadership structure in place with roles and responsibilities clearly defined.
- We found that staff felt team leaders in call handling and duty managers in dispatch were supportive, approachable and visible.
- We found that staff views on senior management being approachable and visible varied, some staff told us that there was limited interaction with senior management.
- Staff told us that they had regular one to one meetings with team leaders. However we found that not all team leaders had regular one to one meetings with their line managers.
- Clinicians were supported by a clinical supervisor and a clinical service manager. The management team were visible, approachable and well respected by staff. Staff felt engaged in the development of the service and clinicians told us that they were positive about the changes coming to the clinical hub.
- Senior management told us they had recently started conducting exit interviews.

Culture within the service

Emergency operations centre

- Sickness rates varied between the different staff groups in the EOCs. During December 2015, the sickness rate in operations was 9.36%. Clinician and training sickness rates were 0%. Clinical Hub sickness rates were 7.20%, management sickness rates were 4.3% and dispatch team sickness rates were 6.4%.

- Overall, staff we spoke with enjoyed their role and most staff were generally positive about the culture of the service, however this was not always consistent throughout the EOC. The trust was addressing the culture of the service and had carried out a culture survey to assist in addressing the challenges. The EOC had also set up a culture group to address the issues.

- Results from the survey were mixed. The survey of the culture of the trust carried out in 2015 found that 76% of people felt pride in working for the trust; however the survey also showed that 54% of staff rarely felt cared for by the trust. 73% of respondents felt neutral or not encouraged by their manager to put forward ideas for improving the service they work in. Feedback regarding how often staff felt supported by their line manager was positive with 40% of staff stating often and 37% stating always.

- Most staff described the culture of the emergency operations centres as open and honest and a culture of teamwork within their teams.

- The trust provided further information showing there was a monthly team meeting schedule for clinical advisors, however some staff told us there were no regular team meetings. Information provided by the EOCs highlighted that culture and engagement was a weakness, however management were in the process of setting up a culture project group to progress the strategy.

- The integration of the clinical hub had improved the culture amongst the clinicians on duty, as they had previously been in separate teams. By amalgamating the teams, staff were better able to support each other and provide a more effective service.

- Team leaders had received training in recognising stress in colleagues and in providing debrief sessions after stressful or upsetting calls. The EOC had a culture of supporting staff following difficult jobs and calls. Staff told us they were regularly offered time out and were supported well by team leaders.

Public and staff engagement

- Staff had access to the electronic communication system which was an internal communications system used for communicating with staff and providing updates to staff across the EOCs.
- Staff in the EOCs told us they had regular one to one meetings with team leaders.
- Staff in dispatch told us they had input into the design and layout of the dispatch centre.
- A newsletter called 'the pulse' was provided to staff by internal communications.
- Information provided by the trust highlighted that as part of the strategy going forward, the trust intends to start staff engagement workshops.
- Information provided by the trust highlighted that the trust had hosted a number of site visits from patient groups to show what they do and how they do it.
- The trust had developed a hot topics leaflet which was distributed to staff. The January 2016 leaflet covered topics such as incident reporting and dementia awareness.
- A number of staff focus groups were carried out prior to recent rota changes. Staff engagement was also encouraged via the electronic communication system.
- Team engagement meetings took place within the EOCs; however, senior staff told us that attendance was low due to the number of staff working evenings and weekends.
- Monthly engagement meetings took place with Operations and EOC staff to develop communication between the staff in the EOCs and the staff working on ambulances, improve understanding and to learn from incidents and concerns.

Innovation, improvement and sustainability

- The trust had worked with hospital trusts to develop an IT system which allowed the ambulance service to identify current hospital waiting time data and bed management data in trusts.
- The trust had enrolled in the Mind blue light mental health programme and had encouraged staff to take on training to support colleagues with their mental health.
- The trust provided national support for a motorcycle application. This is a mobile phone application, that uses smart phone technology to identify if a motorcyclist has had an accident, and sends location

Emergency operations centre

data to the NEAS EOC, allowing staff to contact the nearest appropriate ambulance service to arrange an emergency response. The trust had been recognised at a national level for this.

- The trust was a foundation member of the 999 Application certification board, a mixed disciplinary group that supports programmers to develop applications.
- The trust had been nominated for a national innovation award for the development and use of the electronic communication system.

- NEAS was involved in the development and changes to the Pathways system. On a recent update, 26 of the 46 changes were a result of input from NEAS EOC staff. The service was involved in the development of a minor injury pathway within the system, reducing the need for callers with minor injuries to answer a full triage. The trust was also working with Pathways to improve sepsis screening following a number of incidents locally and nationally

Resilience planning

Safe	**Good**	🟢
Effective	**Good**	🟢
Caring	**Good**	🟢
Responsive	**Good**	🟢
Well-led	**Good**	🟢
Overall	**Good**	🟢

Information about the service

North East Ambulance Service NHS Foundation Trust (NEAS) provided NHS ambulance services across North East England covering the counties of Northumberland, Tyne and Wear, County Durham and Cleveland to a population in excess of 2.5million. The trust formed in 2006 and secured foundation status on 1 November 2011.

The NEAS resilience department was based at Russell House, Hebburn in the trust central division approximately 6 miles east of Newcastle.

NEAS resilience core service provided services, planning and business continuity functions to deliver its statutory obligations as category 1 responder under the Civil Contingencies Act (2004) working collaboratively with multi-agency services. The resilience department was responsible for:

- Major Incident Planning;
- Business Continuity;
- Emergency Preparedness, Resilience and Response (EPRR);
- Special Operations Response Team (SORT); and,
- Hazardous Area Response Team (HART).

The NEAS EPRR and HART functions operated under service specifications set out by the National Ambulance Resilience Unit (NARU) aligned to NHS England's core standards and key strategic guidance for health.

The NEAS EPRR team planned for and responded to a wide range of incidents and emergencies that could affect health or patient care. These ranged from extreme weather conditions, outbreaks of infectious diseases, major transport accidents or planning safety for large public events.

The NEAS HART specialist paramedic team, set up in 2010, formed part of the NHS ambulance service initiative devoted to providing medical care to patients in the inner cordon ('hot zone') of hazardous or dangerous environments. HART dealt with:

- Incident Response Unit (IRU) – Chemical, Biological, Radiological and Nuclear (CBRN);
- Hazardous material (HazMat) incidents;
- Urban search and rescue (USAR);
- Safe work at height incidents (SWAH) and confined space (ConSpace) operations;
- Inland water operations (IWO), including water rescue and flood response; and,
- Marauding terrorist firearms attack (MTFA/TMO).

Our inspection team conducted a planned inspection at the Russell House base. We spoke to 20 members of staff including managers involved in the resilience service, staff in EPRR, SORT and paramedics from HART. We attended a number of internal training events and external multi-agency meetings. We inspected specialist HART, major accident (MAJAX), CBRN and national vehicles (PODS) on-site along with equipment, breathing apparatus and medical bags. We inspected vehicles at other base sites around the region namely Coulby Newham (south division), Backworth (north division), Blucher (north division) and Pallion (central division). We also attended a number of calls (resilience and 999) with HART operatives.

Resilience planning

Summary of findings

Overall, we rated the resilience service as good.

- Staff understood their responsibilities to report incidents and raise concerns. There were a low number of reportable incidents with none resulting in patient harm. There were clearly defined processes to keep people safe and these were underpinned by robust national guidance. Staff shared and learnt lessons from debriefings.

- Safety risks were assessed, planned and responded to accordingly. Resilience functions and business continuity plans were embedded and ensured service continuity.

- Staff within the service were trained and proficient in their role. This was supported by a sound evidence base, in line with national standards and competencies, informing practice and clinical skills. The service fully utilised the NARU Proclus database.

- Marauding terrorist firearms attack (MTFA)

- There was evidence of outstanding co-operation and effective working relationships with allied agencies and multi-disciplinary services.

- The service cared about the work it carried out and patients were central to this. We observed kind and compassionate interactions with patients. Physical and emotional needs were promptly assessed and appropriate treatment options were discussed to secure an agreed care pathway.

- Resilience services were planned and delivered for the benefit of the local population. The service developed robust plans with other services and providers to maintain its core functions to meet patient needs. The service was open to learn from patient concerns.

- The trust had a clear strategic vision which resilience staff felt reflected what the organisation represented. Senior and local managers were engaged. The resilience service worked well as a team and was well led by an approachable, supportive and committed management team.

- The resilience team felt collectively responsible for the efficiency and quality of the service. Staff welcomed challenge and dialogue to improve practices. The service had made some impactful improvements to safety in sports grounds and a number of staff were involved in national and international programmes.

However;

- Feedback from incident investigations needed to be more consistent. There was a need to refresh training around base cleanliness in the sluice area and in using the Omnicell system for the management and storage of controlled drugs.

- Data collection for HART response times was incomplete and patient outcomes were not routinely collected.

- There was some confusion within the HART service regarding their deployment in support of general operations. This led to an inconsistent approach in responding to non-urgent calls outside the agreed deployment protocol.

- There was a lack of a formal documented local resilience strategy due to various staffing changes, service restructuring and transient appointments. Staff acknowledged the resilience structure was lean and was "running hot" most of the time leading to concerns being raised about long-term sustainability within the current configuration.

Resilience planning

Is resilience planning services safe?

Good 🟢

We rated safe as good because:

- There was a well-established incident reporting system that staff confidently used. Overall, incidents in the service were low and none were attributed to patient harm.
- There was an excellent debriefing process to learn from calls allowing reflection, peer support and learning.
- Compliance with mandatory training requirements locally and nationally was good.
- The resilience base was well maintained, HART vehicles were ready for use and stocked in accordance with national requirements. Equipment checks were completed.
- Staffing in the HART service was good and in accordance with NARU requirements.
- The service assessed and responded well to potential risks to patients, service demand and capacity. Policies were underpinned by recognised national protocols and were implemented within local policy.

However,

- There was local inconsistency in feedback to individuals following incident investigations.
- There was a lack of consistency in reporting thresholds for delays in being released from general operational calls.
- The cleanliness of the sluice area was compromised due to boxes and cleaning fluids being stored around handwashing facilities.
- The storage and monitoring of medicines was not always managed according to the trust policy.
- Staff needed additional training on the Omnicell system for the management, storage and dispensing of controlled drugs.

Incidents

- The service used the trust web-based risk management incident reporting system to report incidents and concerns. These were locally referred to as 'NEAS07' or '07s' for short.

- 1,697 National Reporting and Learning System (NRLS) incidents were reported across the trust between February 2015 and January 2016.
- From July 2015 to December 2015, 40 incidents were attributed to the service. Of these, the inspection team were able to identify 11 related to patient incidents, five related to equipment, nine related to staff and 15 were other incidents for example, vehicle related issues and broken drug vials. Whilst there were no particular themes, it was noted that four of the 11 patient related incidents (no harm) involved bariatric patients and three of the five equipment issues related to breathing apparatus issues during a training exercise. With the exception of one, all incident investigations had been completed.
- From January to April 2016, the service recorded 18 incidents. Three related to patient incidents (no harm), three related to equipment, four related to staff and there were eight 'others' relating to drug vial breakage and vehicle incidents. There were no particular themes identified.
- One serious incident (SI) was reported in February 2016 relating to controlled drugs. In accordance with local and national guidance, the trust had appointed a lead officer and an investigation team. The investigation was on going at the time of our inspection.
- The service presented incident data with sufficient detail on background, circumstances, outcomes and actions taken/being taken. This showed that incidents were effectively reviewed and learning points identified.
- Staff in the service knew how to report incidents using the incident reporting system. They provided examples of the kind of concerns they would submit, such as violent patient events and vehicle or equipment issues. Staff also informed us they logged incidents via the operations centre.
- HART operatives did not agree on the incident reporting threshold for delays (to be released from a call or in handing over a patient to an accident and emergency department) as many considered this as 'normal' activity.
- We discussed incident reporting thresholds with the service managers. They confirmed they would discuss the variances with staff. They would revisit the incident reporting policy and consider devising a guidance document to reinforce reporting thresholds.
- Overall, feedback from incidents submitted was good in the team meeting forum. HART paramedics provided

Resilience planning

examples where learning was shared between the team and across the trust following incident reporting. For example, HART staff raised concerns about a heater in a vehicle. Staff discussed the incident at the team meeting where concerns were shared with colleagues. Service managers shared this information with other divisions to prevent further incident.

- Direct individual feedback to the staff member submitting the incident was variable. Some staff confirmed they received email feedback following incident submission whereas others did not. The reporting system allowed managers or incident reviewers to opt to send feedback to the individual submitting the incident. This was not being consistently applied therefore some members of the team did not receive any update. During the inspection, service managers spoke with the relevant staff about the inconsistencies and the issues were promptly rectified.

- The service had well embedded debriefing practices in place following training exercises and actual events to share reflection on practice, group and individual feedback and learning.

- Staff held very detailed and thorough debriefing processes adapted to the matter in question. We observed 'hot debriefs' taking place during calls. We observed structured debriefs following calls and exercises. The inspection team saw examples of lessons learned from debriefs which were then translated into documents for presentation at training days and wider team learning, for example, use of the MIBS stretcher (stretcher for use in narrow spaces) and rigid cervical collars.

- The HART training team uploaded relevant lessons learnt from debriefings after training exercises and 'real-time' calls to the NARU National Lessons Database called PROCLUS (incident management and team development software package). This package was used by all HART services across the country therefore allowing wider learning and the development of an evidence base to improve clinical care and performance.

- The resilience service were signatories to 'resilience direct' and 'lessons direct'. This was an on-line resilience forum for specialist personnel to discuss incidents such as response to the terrorist attacks in Tunisia and Paris and to storm Desmond and Eva. Resilience staff shared best practice around planning, training, exercising, response and recovery.

- The inspection team viewed on-line evidence of compliance with NARU/NHS Service Specification for HART 2015/16 Administrative Standards (32-34, Appendix 3). The service acknowledged and responded to NARU safety notifications in the requisite timeframe. They shared lessons learnt promptly from deployment activity relevant to the interoperability of the service.

- The service managers confirmed an understanding of the Duty of Candour (a legal duty on healthcare providers to inform and apologise to patients if there have been mistakes in their care leading to significant harm) and the internal process that flows from an incident trigger. The service manager informed us the investigating team and allocated officer would make a personal visit to the individual subject to the incident in addition to providing a written letter of apology.

Mandatory training

- NEAS mandatory training for resilience staff (including HART) covered topics such as clinical updates, infection prevention and control, fundamental standards, psychological care (including end of life care, dementia and mental capacity act) and safeguarding adults.

- The resilience team were 93% compliant with clinical update, infection prevention and control, fundamental standards and psychological care. Compliance in safeguarding adults and children (parts 1&2) was 97%. NEAS target for mandatory training was 95%. The slight shortfall in some mandatory training figures was due to long-term sickness.

- The HART service complied with NARU National Training Standards in accordance with NHS Service Specification for HART 2015/16 Competency Standards 21-25. The appointed HART training manager and five team educators monitored compliance as an on-going concern using the PROCLUS system.

- All HART operatives completed 1:5 weekly training cycles to meet the required 180 competencies under each of the capabilities covering IRU, IWO, USAR, SWAH, TMO and vehicles. Each competency had a completion target date and upon completion allowed the HART operative and the HART training manager and team educator to comment on performance. We reviewed training records and competency compliance records detailing this training.

- The inspection team viewed the resilience training calendar for the coming year. The specific HART team training calendar covered those competencies that

Resilience planning

required quarterly assessment and those elements that required assessment of a lesser frequency. The resilience team also prepared a training calendar of external events such as mandatory water operations and breathing apparatus training.

- The training manager recorded compliance against competencies and target date using a RAG (red/amber/green) system. With the exception of staff sickness, maternity leave and dates pending, the five HART teams were fully compliant with all required NARU mandatory training and recertification requirements.
- The inspection team observed HART operatives complete the mandatory six monthly physical competence assessments (PCA). The team educator timed each operative against 16 physical assessment elements such as carrying weights to simulate equipment, performing various medical procedures and dragging of a 75kg manikin to simulate a patient. NEAS HART operative compliance and pass rate was 100%.
- NEAS resilience provided mandatory training to SORT volunteers by way of initial two-day training and six-monthly refreshers covering decontamination, tent erection and the use of powered respirator protective suits (PRPS). The resilience team extracted staff from rostered duties to attend the mandatory training therefore compliance was 100%.
- The resilience team have also trained staff to deal with MTFA/PLATO (medical response for firearm incidents) and have a bank of staff (in excess of 100 NEAS personnel) in addition to HART operatives who can assist in such circumstances.

Safeguarding

- The trust had children and adult safeguarding policies along with a visitor access policy.
- All resilience staff and HART operatives we spoke with were aware of the safeguarding policies, how to refer and how to access further information.
- HART operatives confirmed if they had safeguarding concerns whilst on a call they would initially contact the logistics desk for advice. Access to alternative pathways of care could be arranged via the logistics desk and the safeguarding team.
- HART operatives completed safeguard alerts and referrals at the scene. The completed documentation triggered automatic referral to the safeguarding team. Staff confirmed such referrals would be followed up by telephone within 24 hours to confirm receipt.

- We reviewed the information leaflet left with patients when the ambulance staff made a referral to an alternative pathway of care such as an appointment with a GP or a call or visit from a healthcare professional.
- 97% of staff in the resilience team (including HART operatives) completed mandatory safeguarding training.

Cleanliness, infection control and hygiene

- We inspected the whole of the resilience base at Russell House.
- The base was a new purpose built accommodation to house the resilience and HART service. The overall structure, including fixtures and fittings, were in a good state of repair, which enabled the environment to be easily cleaned.
- The general areas of the base, such as toilets, changing rooms and offices were visible clean. There was a designated member of domestic staff that ensured general areas were cleaned in-line with a specific cleaning schedule.
- The garage area was spacious and in a good state of repair. The vehicle areas within the garage were well maintained.
- There was a designated sluice area and a sluice cleaning schedule. The schedule stated that the area should be cleaned every 24 hours and we viewed schedules to confirm this had been completed. The standard stated on the schedule said 'Sluice area should be free from clutter, waste, no items stored inappropriately, visibly clean and free from dust, dirt or spillages'. Taking into account the sluice was in an open garage area, it was clean.
- There was a designated hand washbasin with wall mounted soap and hand paper towels. There was also a separate sluice hopper.
- Colour coded mops were appropriately stored in the sluice area and colour coding guidance was clearly displayed. Single use mop heads were used and disposed of appropriately. Clean unused mop heads were stored in two boxes on the floor that impeded effective cleaning in that area.
- A selection of cleaning fluids was stored on an open shelf in the sluice area. This was cluttered and made cleaning the sluice area more difficult.

Resilience planning

- The inspection team observed vehicles being parked close to the sluice area exposing the area to fuel fumes and exhaust particles. Whilst not ideal in terms of layout, the regular cleaning of the sluice area ensured there was no build-up of dust and dirt.
- We reviewed the infection prevention and control (IPC) annual report published in 2015. Key IPC benchmarks namely observed IPC practice, vehicle cleanliness, station cleanliness, deep clean practice and vehicle swabbing were recorded. The central division (where the resilience base sits) reported 36.3% compliance and 63.7% partial compliance. There was no reported non-compliance.
- The IPC lead identified key achievements from the audit with good IPC awareness, good training, good communications with regional hospital trusts and Public Health England. No formal complaints or concerns were raised regarding IPC throughout 2015. The IPC team highlighted a number of areas for further consideration and improvement, summarised as management and disposal of sharps and deep cleaning procedures. The IPC team identified priority actions for the 2016 programme and the resilience team confirmed their engagement with IPC audits in the coming year.
- Staff audited vehicle cleaning and compliance with vehicle cleaning schedules in November and December 2015. This included HART and resilience vehicles. 201 of 203 planned vehicle cleans across the trust were carried out in November and 196 of 199 in December. Vehicle audit compliance across the trust confirmed 94% to be fully or partially compliant against policy.
- From the full range of resilience and HART vehicles we inspected across the trust (10 HART, four MAJAX, four CRBN and two PODS), we found all to be well maintained and clean internally and externally.
- Staff completed daily vehicle checks, which included vehicle cleanliness, and these were completed accurately. Historic records showed consistent compliance.
- We spoke with HART operatives about cleanliness and infection control. Staff accurately described how to locate the trust's infection prevention and control policy and who to contact for specialist advice. Staff also advised of particular decontamination arrangements when a vehicle had CBRN exposure such as Ebola and referred to vehicle decontamination protocols.

Environment and equipment

- The HART base was a relatively new building, specifically designed and located to meet the needs of the resilience service including HART.
- The Russell House facility met NARU/NHS Service Specification for HART 2015/16 Resource Standards 14-18, 20) in terms of estate, technology, capital and revenue depreciation schemes. All equipment met national requirements and was maintained in accordance with manufacturer's recommendations and best practice.
- The HART base environment was in a good state of repair, spacious and provided a suitable working environment to meet the needs of the service and staff.
- Equipment was stored in several designated areas including vehicles, storerooms and secure cages.
- There was a range of equipment within the base ranging from standard equipment bags through to specialised vehicles and breathing apparatus (BA).
- We inspected a wide range of medical and non-medical equipment for direct patient use, for resilience staff use and specialised kit for specific types of calls such as breathing apparatus.
- We inspected individual equipment bags and vehicle stock including equipment designed to be used in mass casualty situations.
- All equipment checked was in date, appropriately stored and ready for use.
- We checked the processes for managing BA. Staff completed safety logs twice daily.
- We also observed the BA cylinder room and there was a clear a process for recharging the oxygen tanks. Staff were clear about which tanks were empty and which tanks needed recharging with appropriate segregation, storage and labelling visible. Medical gas cylinders were stored securely in a racking system. There were sufficient numbers of BA and charged cylinders for HART paramedic use and in accordance with NARU standards.
- HART operatives used specialist equipment such as MIBS stretchers to deal with bariatric patients in a safe manner.
- We also inspected vehicles and enquired about vehicle maintenance. There were appropriate processes in place for ensuring vehicles were roadworthy and fit for purpose. The medical engineering equipment technician aligned to the resilience service provided the inspection team with vehicle maintenance logs, vehicle equipment check logs and showed evidence of work orders generated following equipment checking.

Resilience planning

- The resilience service followed NARU Mass Casualty Vehicle (MCV) Checklist (July 2015) for vehicle content, activation, mobilisation, maintenance, medicine safety and security guidance.
- It was recognised that some vehicles were nearing the end of their operational life and plans were in place for the replacement in accordance with NARU specification and the trust five year fleet capital plans.
- We inspected new rapid response vehicles used by HART operatives. The new cars were chosen specifically for their use in the resilience service as they provided generous equipment storage space. The relatively powerful engines supported manoeuvrability in difficult circumstances.
- The resilience service used the 'Make-Ready' specification log for vehicle preparedness and the replenishment of stock against an agreed specification.
- The resilience base had appropriate access to suitable waste management facilities for the disposal of clinical waste and sharps. The on-site waste bins were safely located and secured. Signage was also apparent to reinforce correct disposal procedures and segregation.

Medicines

- The storage and monitoring of medicines were not always managed according to the trust policy.
- The trust had drug hub stations across the region that resilience and HART staff accessed for replenishment of stock. The trust had outsourced its supply of medicines and systems were in place to ensure this was effectively managed.
- Medicines including controlled drugs and medical gases were stored securely and access was restricted to authorised personnel.
- The HART team were part of the Omnicell pilot scheme (a secure electronic facility for the storage and dispensing of controlled drugs). The pilot highlighted a number of discrepancies and these were being monitored closely as part of the trial. HART staff identified the need for further training on the use of the Omnicell system and this was being progressed at the time of the inspection by the trust medicines management team.
- We checked both the Omnicell and personal supply systems for controlled drugs. Controlled drugs were appropriately managed and audited in line with trust policy.

- Staff completed daily fridge temperature checks on mass casualty vehicles (DPU and DPV) and these were found to be within recommended ranges. There was no procedure in place to cover staff annual leave which led to some daily checks being omitted. Staff were not aware of what to do if temperatures were outside the recommended ranges. On one national vehicle we found a batch of out of date medicines this was brought to the attention of the medicines lead during our visit. On one HART vehicle we found one expired oxygen cylinder. There was also a static on-site fridge for the storage of medicines requiring refrigeration however this was empty at the time of our inspection.
- Some medicines were stored on the HART vehicles. Staff checked these on a monthly basis and after use. Staff completed a drug check log which was endorsed by two staff members to confirm accuracy following check and replenishment. On one vehicle we found an out of date batch of medicines. Staff had correctly identified and replaced the medicines however had not removed the expired batch from the vehicle.
- We found an expired oxygen cylinder on one vehicle and this was removed and replaced immediately.
- Resilience staff were given access to 'event' drugs when the need arose and these were managed in accordance with the medicines management policy.

Records

- Resilience and HART staff completed the electronic patient record when on a call. The trust information governance team managed the electronic storage of patient information.
- Staff securely stored paper records or observations printed on paper directly with the patient notes in locked cabinets within locked rooms (security pass protected) on site.
- The inspection team reviewed a number of electronic and paper records which showed relevant demographic details, accurate background information regarding the presenting complaint, details of observations recorded, any treatments given and the patient outcome.
- A designated operative or a suitable qualified member of logistics support under the supervision of the commanding officer or HART team leader on scene maintained record keeping of triage decisions at mass casualty events.

Assessing and responding to patient risk

Resilience planning

- Resilience staff stated prioritisation of patient risk and patient safety was the core component of their activities.
- Comprehensive and thorough risk assessments were carried out in line with national protocol, NARU and EPRR recommendations, business continuity plans and Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines.
- Standard Operating Procedures following national guidelines were in place for specific patient risk activities such as working near water or at height.
- Resilience management confirmed that the constant monitoring of risk and the impact the risk could have on service provision and continuity was fundamental to the ability to assess and respond to patient need.
- The resilience management confirmed the service had implemented a number of robust policies aligned to the assessment and response to risks that may affect patients such as major incident plans.
- When assessing and responding to patient risk with other agencies, the resilience service followed The Joint Emergency Services Interoperability Programme (JESIP). This doctrine developed principles of joint working between different agencies involved in responding to emergency situations. It provided key joint working directions (the 'five' principles) and communication frameworks (METHANE) to promote effective response to risk.
- The resilience service developed memorandum of understanding (MoU) with multiple specialist agencies when dealing with patients in specific risk situations such as mountain rescue for urban search and rescue incidents.
- NEAS resilience had developed mutual aid links with neighbouring ambulance providers and other emergency services whereby when certain resilience thresholds were met, the resilience management could request support from linked signatories.
- HART operatives were all qualified paramedics with additional skills and equipment to deal with deteriorating patients and medical emergencies in difficult situations. This allowed changes in patient condition to be rapidly assessed and dealt with in accordance with national policies and best practice guidelines.

Staffing

- The inspection team saw the resilience team organisational and staffing structure.
- The Head of Resilience and Special Operations led the resilience department. Within the management structure was the HART and Resilience Manager, HART Development and Education lead, Deputy Emergency Planning and Resilience Manager, Emergency Planning Officer and the Business Continuity Manager (situation vacant at the time of our inspection).
- A Capacity Co-ordinator and a HART Support Officer supported the resilience department.
- In accordance with NARU/NHS HART Interoperability Standards 2015/16, the service complied with overreaching standards 1-7 providing HART capability across the core standards to nationally agreed standards for safe staffing and systems of work.
- The resilience department recruited HART staff in line with recruitment and selection guidance provided by NARU.
- The HART function comprised five teams of eight named Tweed, Wear, Tyne, Tees and Derwent. Each team comprised a team leader, a team educator and six HART operatives. All trust HART operatives were qualified paramedics within each team were able to provide cover across the core services, IRU, USAR, IWO and TMO.
- The resilience department planned for a minimum of six HART staff on duty at all times, in excess of the minimum requirement of five, in accordance with NARU national requirements for HART interoperability. There were currently no vacancies within the HART service and staff turnover was low (one whole time equivalent equating to 2.8% in 2015).
- The resilience manager reported some on-going long-term sickness and a revision in HART operative job evaluations in the early part of 2016 led to staffing levels being less than planned. From December 2015 – March 2016 based on a 14 shifts per week pattern (being seven day shifts from 7am to 7pm and seven night shifts from 7pm to 7am), and planned numbers of six HART operatives per shift (equating to a total of 84 points), all weeks showed a shortfall in actual numbers.
- The rotas viewed showed an actual weekly deficit ranging from one point (98.8% against planned) to a maximum of 17 points (80% against planned). The resilience manager and HART operatives managed shortfalls proactively and maintained HART capability at 100% by adjusting rotas and by offering overtime shifts that were recorded on the duty sheet.

Resilience planning

- The trust supported the resilience manager request for additional overtime coverage following the terrorist attacks in Paris and Belgium.
- The resilience manager confirmed if HART staffing capability fell below NARU national requirements and all local resilience measures to replenish staffing had been exhausted, then the local HART function would be suspended for the duration of the shortfall. The resilience manager confirmed the internal escalation process and the national procedure in the event of this occurrence.
- Resilience staff record numbers of all SORT trained staff on duty at any given time in order to meet national EPRR standards of 1%. Currently, NEAS had 127 SORT trained operatives, below target of 140. The EPRR team were offering additional training sessions in the coming year to increase SORT capability.
- Sickness absence across the service in October 2015 was less than 1%.However in December 2015 was reported as 8.4% across all staff groups. Overall, these figures coincided with reported sickness rates across other divisions.
- Vacancy data provided by the trust confirmed no vacancies in HART or in resilience administrative and clerical roles.
- On inspection, the resilience manager confirmed there had a period of restructuring and back fill of vacancies by way of internal secondment. Recent departures within the resilience team, namely the emergency care business manager and the business continuity manager had brought about a further reconfiguration. Recruitment was in progress for vacant posts however in view of the current changes within the service, the exact arrangement was still to be confirmed.

Anticipated resource and capacity risks

- The trust had an Emergency Preparedness, Resilience and Response (EPRR) policy which detailed statutory duties of a Category 1 responder under the Civil Contingencies Act (2004) aligned to NHS England EPRR Framework (2015).
- The Resourcing Escalatory Action Plan (REAP) policy was aligned to surge management plans, business continuity procedures, clinical escalation plans and major incident plans.

- Risks to resource and capacity were well detailed and took into account potential challenges to the service such as adverse weather, terrorist activities, staffing shortfalls, CBRN incidents and major accidents.
- Business Continuity Plans (BCPs) were in place across all divisions detailing roles and responsibilities of staff members in the event of particular resource or capacity risks. A number of BCPs had been through live exercises following flooding at the Hexham site and telephony issues at control.
- Command and Control procedures were current to deal with anticipated resource and capacity risks.
- Local risk assessments were completed in accordance with national guidance from NARU to meet service specification standards.
- Staff in the resilience department knew their role in response to such incidents and where to locate additional policy information on the intranet.

Is resilience planning services effective?

Good ●

We rated effective as good because:

- The delivery of care and treatment was supported by robust evidence based practice and guidelines.
- Care planning was prioritised according to patient need and not compromised on grounds of age or disability.
- Staff in the resilience department were well trained, experienced and thorough in their work practices. There was excellent use of the PROCLUS system. The HART Training Manager devised individual bespoke training sessions for individuals who had specific learning requirements.
- Co-ordination of services with other providers and multi-disciplinary team working was excellent.
- There was a sound understanding of consent and mental capacity issues.

However,

- The quality of data to support HART compliance with national response times was incomplete.
- The collation of patient outcomes specific to the resilience service and HART functions was not routinely captured.

Evidence-based care and treatment

Resilience planning

- There were numerous examples of evidence-based care and practice across the resilience service both in policy documents and observed in clinical practice.
- The resilience team followed Joint Royal Colleges Ambulance Liaison Committee (JRCALC guidelines) providing sound evidence based clinical advice to ambulance services. The service also followed a number of national recommendations from NARU and The National Institute for Health and Care Excellence (NICE guidelines).
- Clinical practice updates were cascaded throughout the organisation from relevant departments.
- A number of HART operatives were specialists in particular core competencies such as USAR and provided care and treatment updates to colleagues.
- HART operatives followed training and competencies to inform evidence based care. Every five weeks each HART team completed evidence based training covering clinical practice and procedures, skills and current practices.
- The resilience department received care and treatment updates from national bodies such as NARU that were shared with the team electronically via PROCLUS and during team meetings.
- Aligned services shared care and treatment updates at multi-agency gatherings.
- The trust training department monitored compliance with evidence based care and treatment changes and updates.
- The HART Training Manager monitored compliance with all NARU skills and competencies.
- Staff in the resilience team also delivered evidence based clinical updates for the team on a regular basis.

Assessment and planning of care

- Resilience staff received training in dealing with patients with mental health issues and those subject to care provided under the Mental Health Act.
- Resilience staff confirmed the assessment and planning of care was not limited or constrained on grounds of age or disability. Staff delivered care in the best interests of each individual patient according to physical and emotional need by seeking consent and approval of care plans. Where consent could not be obtained HART operatives confirmed they would always seek to ensure the most appropriate care pathway was followed.
- HART operatives accessed specialised equipment for personal protection and to support better patient care

and treatment. They had trialled a number of technologies to enhance care delivery such as vessel clamps to reduce blood loss and automated resuscitation equipment.
- HART operatives assessed and delivered care based on the individual needs of the patient. For example, staff accessed intravenous fluids (IV) for patients considered to require fluid replenishment.
- HART operatives used pain assessment tools to monitor effectiveness of pain relief and non-invasive pain relief measures. Under clear guidance, they accessed intravenous pain relief such as ketamine, midazolam and morphine. The use of such medication was monitored and audited.
- Standard Operating Procedures (SOPs) were in line with NARU guidelines.

Response time

- The trust operations team collated data on patient outcomes and response times.
- Data relating to HART operatives responding to general operational calls, namely R1 and R2 calls (urgent calls), were captured within general trust wide data on response times. The HART and Resilience Manager monitored response times to HART calls and release times (time taken for an operations vehicle to allow the HART vehicle to depart) from operational calls.
- From January to April 2016, the inspection team found response times varied from two to 12 minutes achieving policy compliance with NHS HART Interoperability Standards 8-11. These standards required HART staff to be on scene within 15 minutes of a call.
- The location of the HART base facilitated access to major road networks in the region. This allowed the requisite number of HART operatives to be present at the majority of strategic sites of interest as defined by Home Office Model Response Strategy within 45 minutes.
- In the event of a 'notice to move' for mutual aid to support adjacent ambulance services, it was acknowledged by staff due to the size of the trust area, it would not always be possible to meet the 30 minute target. To mitigate this, the service stationed a number of HART and resilience vehicles at stations in the north and south regions. Mutual aid requests within the trust area were more likely to meet this standard.

Resilience planning

- The inspection team were not provided with specific data on the 30 minute and 45 minute targets. However, resilience management confirmed no time breaches had occurred in 2015. This was evidenced with reference to PROCLUS.
- The inspection team noted where HART operatives were being utilised for general operational activity, the HART deployment policy allowed for immediate release from general operational calls to attend HART incidents. The HART and Resilience Manager confirmed the release to attend HART calls were unchallenged and timely upon request.
- We noted back up release times varied. Between January and April 2016, the times recorded were between 9 – 31 minutes (providing time difference to back up ranges from 7 – 29 minutes) however, these figures included all calls and were not specific release times for HART incidents. There was one recorded back up time in excess of one hour. The HART and Resilience Manager confirmed this data would be analysed further to ensure compliance was maintained with NHS HART Service Specification Standards.
- The trust operations team monitored patient outcomes against various national and local benchmarking targets such as return of spontaneous circulation (ROSC), cardiac survival to discharge, PPCI compliance (patients receiving treatment for blocked arteries within 150 minutes), STEMI care bundle (patients receiving treatment for heart attack), arrival times at hyper acute stroke centres within 60 minutes and stroke care bundles given. There was no specific data for the HART service although HART operatives were able to see data captured where they supported general operations.

Patient outcomes

- Staff did not routinely collect and monitor patient outcome data in the resilience service.
- Staff were commended on their work when meeting targets and where positive patient outcomes were achieved in difficult circumstances.
- The inspection team reviewed a Medical Emergency Response Incident Team (MERIT) Impact Report that was compiled in conjunction with the Great North Air Ambulance. The report discussed six case studies (fall from height, road traffic collisions, trauma injury, cardiac arrest) where positive patient outcomes were highlighted and areas for improved working were recommended.

- HART operatives confirmed they often followed up patient outcomes for their own feedback and to reflect on practice for learning outcomes.
- The resilience managers were keen to capture more HART benchmark measures and patient outcomes. It was planned to develop this further to align with NHS Outcomes Framework 2014/15 looking at survival from major trauma.

Competent staff

- All HART operatives and team leaders were qualified and registered paramedics in accordance with NHS HART Service Specification 2015/16 Standard 23.
- All resilience staff were trained in accordance with local and national requirements.
- All HART operatives were recruited and trained in line with NARU Competency Standards 21-22 and 29 which required compliance with 180 competencies under each of the capabilities covering IRU, IWO, USAR, SWAH, TMO and vehicles. Each competency had a completion target date and upon completion allowed the HART operative and the HART training manager and team educator to comment on performance.
- In addition to the NARU requirements, the HART Training Manager devised individual bespoke training sessions for individuals who had specific learning requirements.
- The HART Training Manager sourced approved external training providers to provide advanced training against NARU competencies. This resulted in a number of the team becoming specialists in particular competencies such as USAR.
- HART teaching plans, learning objectives, competency framework standards and training records were monitored on PROCLUS. Each HART operative had access to the system.
- Every five weeks, HART teams completed a training cycle allowing time to discuss individual learning requirements. This included coaching, mentoring and clinical supervision. The inspection team observed HART operatives and SORT staff carrying out a joint mass casualty CBRN training exercise. This involved full incident briefing, team co-ordination, use of decontamination equipment (tent erection/ decontamination cleaning procedures); use of powered respirator protective suits (PRPS) and post-incident debrief including team/individual feedback.

Resilience planning

- All HART staff received annual appraisals which they commented were helpful in identifying areas of good practice and themes for improvement. At the annual appraisal meeting, staff would agree developmental objectives for the coming year that were monitored on a regular basis.
- All staff working in resilience confirmed their appraisal to be current and up-to-date. This correlated with figures provided by the trust confirming 100% appraisal rates across the resilience service for the past three years.
- The HART Training Manager monitored individual and team performance. Performance reviews were held with Team Leaders and Team Educators. Progress against core competencies were measured and poor or variable performance would be highlighted within an individual training log on PROCLUS. Any deficits are highlighted immediately within the PROCLUS system as non-compliance. Collective feedback was reviewed from the Team Educator and the Team Leader to understand why an operative may be exhibiting shortfall in standards. The HART Training Manager then worked with the operative to provide bespoke training to support the operative to meet and maintain performance targets.
- The HART Training Manager confirmed there had been previous positive outcomes with bespoke training. Additionally, when such training competence was not achieved and where safety for staff and patients could be compromised, the operative would be removed from the HART rota. The resilience management, occupational health and human resources departments provided support during this phase.

Co-ordination with other providers and multi-disciplinary working

- The resilience service worked with various agencies to assess, plan and deliver resilience function and care for people at multiple locations in an assortment of scenarios.
- The service had a number of memorandum of understanding (MoU) documents detailing joint working agreements with a number of other providers such as Northumbria Police, The Royal Victoria Infirmary and Mountain Rescue. The inspection team reviewed a number of the MoUs and noted all considered care co-ordination with the respective partner involvement. For example, the MoU produced with the North East Fire

& Rescue Services (NEFRS) outlined the agreement between the NEFRS and HART in relation to working together within the inner cordon at an emergency incident attended by both organisations.

- The inspection team viewed documented evidence of Joint Emergency Services Interoperability Programmes (JESIP) and working with Local Resilience Forums (LRFs) across the region which detailed the joint working relationships and shared agenda in the case of specific incidents.
- The inspection team reviewed debriefing documents detailing the outcomes from a number of multi-agency co-ordinated table top and practised exercises. A number of these highlighted care being co-ordinated within the JESIP joint decision model testing EPRR functions at a COMAH site (Control of Major Accident Hazard). Each debrief provided findings, actions and recommendations for future consideration.
- The inspection team observed multi-agency resilience planning at a local airport with NHS colleagues, police, fire services, local authority and airport security staff involved. The NEAS resilience team made a very positive contribution to the agenda and plans for training exercises on site.
- The resilience service spent considerable time and resource proactively planning for local and national major public events such as premiership football matches, stadia music concerts, air shows, national sporting events and other public gatherings. There was a resilience calendar detailing all upcoming events into 2017 which the team were responding to.
- The resilience function also reacted to ad hoc events planned within local authorities and specific issues at short notice such as the junior doctors' industrial action. Here, the resilience service engaged with multi-agencies, led by NHS England, to provide support to local acute NHS services particularly around the timely discharge of patients and ambulance build-ups in accident and emergency departments. This involved a co-ordinated approach internally to ensure business continuity whilst providing additional capability to support colleagues and patients within the acute services.
- The inspection team attended a stadia event that brought together police, fire, other healthcare agencies, local medical provision and security services. The co-ordination of the medical services to ensure spectator safety was managed by the NEAS resilience

team and the multi-agencies were briefed accordingly. The team informed all relevant personnel of the medical provision in the stadia, liaised with private medical personnel in attendance and responded promptly to spectator incidents during the event. The agencies involved commented on the professionalism and "slickness" of the NEAS service.

- The resilience service had worked closely with the multi-disciplinary team at the Regional Infectious Diseases Unit in Newcastle and national partners in response to the Ebola outbreak in Africa.
- EPRR policy and major incident plans detailed activation, response, management and mutual aid arrangements for NEAS in the event of such incidents. The plans integrated operational and management arrangements for all NEAS divisions. On a day-to-day basis, the resilience team were in regular contact with operations to monitor business continuity and EPRR function across the whole service.

Access to information

- The resilience team and HART operatives felt they had sufficient access to internal organisational information, role specific material and clinical evidence to support their roles. The majority of this information was contained on the trust intranet and PROCLUS packages.
- Staff confirmed trust wide bulletins were cascaded within the team and regular emails were received with various updates.
- Resilience staff used electronic records and all staff had access to relevant trust wide databases.
- HART operatives completed electronic patient report forms (EPRFs) to manage information about patients using the service. This included all relevant demographics, call classification, background, patient complaint, care and treatment given and patient outcome. Where technology could not be accessed, staff completed a paper patient record form. This data was then updated into the electronic format at the earliest opportunity.

Consent and Mental Capacity Act

- The trust had specific policies relating to Mental Capacity and Consent to Examination or Treatment.
- HART paramedics we spoke with were aware of the policy and how to access information.

- We observed the 'assessment of capacity' form used by the trust including HART operatives. This form captured key and relevant questions to support staff in determining whether or not a patient had capacity to consent to care and treatment.
- Staff left a copy of the assessment with the patient and/ or their carers for reference.
- When a patient lacked capacity, staff made decisions in the best interests of the patient according to physical and emotional need. HART operatives advised these sometimes required alternative care pathways such as access to specialist nurses or primary care services.
- When dealing with patients who lacked capacity and were at risk to themselves or others, HART operatives confirmed they sought support from other emergency services and specialist mental health practitioners. Staff considered physical restraint as a last resort option. This was used when necessary and proportionately to ensure the safety of all concerned.
- HART paramedics described how help and advice in relation to mental capacity was available via the logistics desk or the safeguarding team.

Is resilience planning services caring?

Good 🟢

We rated caring as good because:

- HART operatives interacted with patients with concern and kindness.
- There was a prompt and efficient assessment of physical condition and consideration of emotional wellbeing.
- HART operatives respectfully involved the patient, their family and their carers when considering care pathways and treatment options.
- Resilience staff provided support for professional colleagues following traumatic incidents.

However,

- The inspection team had limited exposure to the full and wider HART functions therefore evidence in this domain is incomplete but sufficient to provide a provisional rating.

Compassionate care

Resilience planning

- The inspection team attended calls with HART operatives and found patient concerns were dealt with promptly and with compassion.
- We saw HART operatives interact with patients and paramedic colleagues respectfully.
- Staff from HART explained they were always conscious when entering a patient's home of particular personal and cultural needs. They said this was important when gaining patient trust in making an initial healthcare assessment.
- One patient was embarrassed about his personal appearance when HART operatives attended. Staff supported the patient with personal hygiene and dressing in a dignified and private way to minimise distress prior to transfer to hospital.
- HART staff supported a patient with mobility difficulties to gain a comfortable position in bed and moved personal belongings within reach.
- HART staff prioritised pain relief to a very distressed patient making the transfer into hospital less traumatic.
- Two patients who received treatment from HART paramedics at a stadia event commented on the promptness of their response and the efficiency in which they dealt with their injury.
- SORT staff commented HART colleagues had "a special way" of caring for those patients who required additional specialist paramedic support where their particular skills were needed such as major accidents.

Understanding and involvement of patients and those close to them

- HART staff efficiently gained a rapid understanding of the patient needs and health issues. They recognised the importance of involving the patient, their family and carers when obtaining information and planning care.
- Consent was obtained for all treatments and care recommendations.
- When carrying out observations and using particular pieces of equipment, HART staff fully explained and informed the patient and their carer what was being done and the reasons for this.
- HART staff informed the patient, their family and care staff of their proposed plan of care and sought agreement.
- HART staff invited questions from patients and their family members to ensure the care plan was understood.

- A relative of a patient who suffered an injury at a stadia event felt thoroughly reassured by the professionalism of the HART paramedics attending and was fully informed of the proposed treatment plan. The relative added, "If it wasn't for the speed of their response, I think the outcome would've been a lot worse".
- Staff knew how to access interpreters and advocates for specialist advice when required.
- Information leaflets and contact details were provided to families and carers.

Emotional support

- HART staff paid attention to the emotional needs of a patient in addition to physical care needs.
- The inspection team observed HART staff spend time with a very anxious patient with a specific phobia who required transfer to hospital for immediate care.
- HART staff provided constant reassurance to a patient with mobility difficulties who needed support with a specialist stretcher in order to exit the premises for conveyance to hospital.
- HART staff spent time actively listening to a patient (whilst doing clinical observations) to get a greater understanding of fears and concerns.
- The inspection team observed staff from the HART team provide emotional support to colleagues from other emergency services following an extremely traumatic multi-agency call.

Supporting patients to manage their own care

- HART staff were observed asking patients how well they were able to manage their own care needs and when safe, encouraged them to do so.
- The HART team clearly understood safeguarding issues. The inspection team observed a HART operative make a safeguarding referral, with the patient's knowledge and consent, due to concerns about inability to self-care, lack of safe facilities within the home and no existing support structures being in place.

Resilience planning

Is resilience planning services responsive to people's needs?
(for example, to feedback?)

Good ●

We rated responsive as good because:

- The whole functionality of the resilience purpose was centred on providing safe and efficient services for the needs of the local people.
- The resilience team developed robust and workable plans to meet the demands placed upon it and worked well with other agencies to maintain its core services.
- The service had received no formal complaints and there was a real openness to learn from all patient concerns.

However,

- There was some confusion amongst HART operatives regarding their deployment to non-urgent calls that could affect operational performance and release to attend HART specific calls.

Service planning and delivery to meet the needs of local people

- The resilience facilities were purpose-built and located strategically for optimum geographical coverage, ease of access to those areas of greatest populous and highest risk.
- The resilience service took the lead in assessing, planning and resourcing for events that had the potential to affect the 'normal' running of the service.
- NEAS resilience and HART response was available 24 hours a day, seven days a week to meet the needs of the local population.
- Service planning and delivery was influenced by national requirements, regional demand and local events. The utilisation of the resilience function involved co-ordinated planning with commissioners, other emergency services, stakeholders, NHS providers and where appropriate, private sectors.
- Day-to-day resource planning followed a structured approach using the NARU and Association of Ambulance Chief Executive national decision model known as REAP (Resource Escalation Action Plan). The

trust adopted REAP into local policy to inform escalation procedures due to surge and disruptive challenges. REAP was implemented to protect staff, patients and the organisation when difficult situations arose.

- The REAP policy followed four numbered levels and detailed roles and responsibilities of each service at each level. For example, call taking, duty management, emergency care, operational, patient transport (PTS), tactical, strategic, executive and support services. The REAP policy was aligned to surge management plans, business continuity procedures, clinical escalation plans and major incident plans.
- The inspection team were shown all the relevant policies and REAP levels during the course of the inspection. Due to recent changes in national guidance and the development of the ECCM role (Emergency Care Clinical Manager), the major incident plan had been updated along with MERIT and JESIP protocols.
- During REAP escalation, in December 2015 and January 2016, HART resource supported general operations for short periods whilst maintaining overall operational cover and training competencies.
- In accordance with NHS HART Service Specification 2015/16 Administrative Standard 31, the resilience department had bespoke plans and risk assessments for certain public areas such as shopping complexes and COMAH sites (Control of Major Accident Hazards) to protect local people from location specific risks. This involved planning with public utilities, local authorities, Health and Safety Executive (HSE) and voluntary organisations.
- The resilience team were involved in service planning and delivery of wider JESIP projects such as airport emergency planning and DEFRA (Department of Environment, Food and Rural Affairs) plans.
- The resilience department was responsible for training and planning SORT and HART capability to meet service need for specific events such as CBRN or MTFA incidents.
- The trust operations used two HART rapid response vehicles (RRVs) under a strict deployment plan stipulating the release of the vehicle in the event of HART requirement. A HART deployment procedure was in force detailing this process which provided HART vehicles were only to be used for calls classified as R1 and R2 (urgent calls with eight minutes response time).

Resilience planning

- HART vehicles were rapidly released from general operations calls. In 2015, the Resilience and HART manager confirmed there had been no delays for the release of HART RRVs to attend live incidents in accordance with NHS HART Service Specification 2015/16 Response Time Standards 8-11. At the time of our inspection, the back-up performance was not formally captured however a recording system was planned for release.
- The inspection team saw case study evidence where the deployment of the Medical Response Incident Team (MERIT) in conjunction with HART operatives brought about positive patient outcomes.

Meeting people's individual needs

- Resilience staff and in particular HART operatives were provided with advanced information about a patient prior to attending a call. This allowed staff to adapt their approach when dealing with individuals with particular needs.
- Resilience staff had training to deal with patients who had particular individual needs or who required reasonable adjustments to be made to support them such as those living with dementia or patients with learning disability.
- The resilience department obtained information from various professional and community groups to support their understanding in meeting particular religious needs.
- Resilience staff have basic phrase and picture books to support communication with patients and their relatives who do not have English as their first language.
- The resilience service had worked with other blue light services to help remove some barriers faced by those individuals with hearing difficulties by providing staff with basic sign charts for reference and use by patients at a scene.
- HART staff accessed specialist equipment for patients with particular physical needs for example flexible stretchers.
- Where appropriate HART staff considered alternative care pathways for patients who had specialist needs. They would consider care delivery from an alternative source such as specialist nurse practitioners or mental health care providers.

Access and flow

- Excluding general operation support, HART staff attended 1805 reported HART incidents between April 2015 and January 2016, ranging from 241 in September 2015 to 121 in January 2016.
- From November 2015 to January 2016, the majority of these calls related to USAR (34.4%), trust/agency support (32.4%), IRU (24.5%), IWO (6.6%) and TMO (1.9%).
- Two HART vehicles and operatives covered general operational activity on a daily basis. HART vehicles were only used for R1 and R2 (urgent calls) in accordance with local policy to ensure prompt patient attendance and swift release from back up crew. HART operatives advised that there had been occasions where they had attended non-urgent calls due to inaccurate triage of patient presentation and clinical need. Staff reported this to be a rare occurrence and that they fed this back to the HART manager.
- During the HART operative focus group, staff stated there was some inconsistency in determining if HART operatives should exclude themselves from all non-urgent calls when operations requested attendance. The resilience management team confirmed HART operatives will attend urgent calls only. In view of the inconsistency, resilience management confirmed they would provide a refresher to their team to reinforce policy. The inspection team reviewed response times for all calls where HART resource was used. From January 2016 to April 2016, average first response times varied from 2 to 14 minutes. Back-up response times averaged between 9 to 31 minutes providing time difference to back-up ranges between 7 and 29 minutes. There was one occasion where the back-up time exceeded an hour and this was due to demand on operations at that time.
- These timings showed HART operatives were on scene in a timely manner reducing the time patients had to wait for treatment or care. Where HART operatives had completed their assessment, there were variable waits from general operations crew to release them for other emergency calls or HART related incidents.
- There were no breaches of NARU response time interoperability standards based on the data provided.
- The Resilience and HART Manager and Team Leader monitored HART operative whereabouts, workload and usage by general operations throughout the shift.
- The Resilience and HART Manager and Team Leader would recall HART operatives at any given time, in

Resilience planning

accordance with the HART deployment policy, in the event of need. HART operatives were released immediately by operations and there had been no occasions of conflict when requested.

Learning from complaints and concerns

- The trust recorded 673 complaints in 2015 but none were related to the resilience service.
- Resilience staff were aware of the complaints process and how to direct patients should they have any concerns or queries regarding the care and treatment received.
- Staff advised there was an openness "all cards on the table" approach to dealing with concerns to identify key issues to respond and to provide learning opportunities to the team.
- Resilience staff confirmed all informal patient complaints and concerns would be escalated to the resilience managers and a 'NEAS07' incident form would be completed.
- Lessons from complaints and concerns were shared internally via their respective group meetings. Nationally, the resilience managers shared outcomes from relevant resilience and HART related matters via PROCLUS.

Is resilience planning services well-led?

Good 🟢

We rated well-led as good because:

- The resilience management team were fully conversant with trust strategy.
- Local and national governance compliance was good.
- Leadership of the resilience service was excellent. Staff were motivated and described a real team approach with peer and managerial support at all levels. Staff spoke of a 'can-do' culture where constructive challenge was welcomed as a means to improve resilience services.
- There were some innovative practices particularly around sports ground safety, the development of the medical advisory group and bespoke medical services for events. The quality of NEAS resilience services had wide recognition with a number of the team involved in national and international programmes.

However,

- There was an absent local formal strategy specifically for resilience services.
- Due to recent changes, managers acknowledged the service structure was lean. Managers described the service as running at capacity and concerns had been highlighted on the sustainability of the resilience function with current pressures in the long term.

Vision and strategy for this service

- The resilience management team articulated the NEAS mission and values.
- Resilience managers confirmed they had been involved in the development of the 'new' vision and strategy and spoke passionately about 'the badge'. They confirmed there had been a real shift in emphasis toward patient engagement and staff wellbeing. This was reinforced by the NHS Staff Survey 2015 where it was reported trust management had a real interest in staff health and wellbeing (better than national average, 3.34 against 3.15).
- Staff confirmed safety and quality were the cornerstones of the organisation. There was a real desire to "bring the values to life".
- Due to changes, restructuring and realignment of divisions, the resilience department did not have their own formal vision and strategy specific to resilience functions.
- Resilience managers confirmed their alignment to the NEAS strategy and added they were current working on their own vision for the service to coincide with organisational objectives.
- National directives drove the resilience strategy from NARU, NHS England, EPRR frameworks and HART interoperability standards. These were embedded within the service although had not been formally captured in a local resilience document.
- Staff working within the wider resilience function knew of the NEAS strategy and understood the reasons behind the recent review of values and visions.
- Staff were able to detail their specific roles and responsibilities in achieving local and national aims and objectives.

Governance, risk management and quality measurement

Resilience planning

- There was a clear governance structure for managing resilience function within NEAS which fully encompassed EPRR, business continuity and HART services.
- Due to recent NEAS restructuring, the governance arrangements within resilience were in a state of flux. This was evidenced by seconded positions into the team, recent departures and restrictions applied on existing staff expanding into other areas.
- Resilience managers acknowledged the existing resilience governance structure was lean and the service was running at capacity. Long-term sustainability within the current framework was being looked at and resilience managers had highlighted this as a concern to the Chief Operating Officer.
- National governance requirements for EPRR and HART services were embedded.
- The service reported excellent outcomes in the NARU EPRR Quality Assurance Framework Core Standards Compliance Report in October 2015. Governance, duty to assess risk, command and control, duty to communicate with public, information sharing, co-operation and training and exercising all recorded 100% compliance with duty to maintain plans for emergency and business continuity recorded at 86%. Overall scoring was recorded at 97%.
- The service met governance obligations set in accordance with NARU/NHS HART Service Specification Interoperability Administrative Standards (26-28 and 30). Governance and performance was reported on the national PROCLUS system. Governance compliance against the HART standards was 90% or above for all core functions.
- Resilience staff monitored business continuity governance within the organisation closely. The business continuity manager compiled monthly dashboards detailing business continuity processes deployed, business continuity exercises carried out and any business continuity incidents.
- Governance was measured against recognised business continuity management standards (ISO 22301 – international organisation for standardisation specified requirements to plan, establish, implement, operate, monitor, review, maintain and continually improve a documented management system to protect against, reduce the likelihood of occurrence, prepare for, respond to, and recover from disruptive incidents when

they arise). In February 2016, compliance against ISO 22301 standards was at 94%. Internal audit in the same month reported 100% policy compliance and 96% exercise compliance.
- Following outputs from the 2015 Annual Business Continuity Audit, the service highlighted three issues for improvement. These were to meet NHS Commissioning Board Standards for business continuity, to develop emergency officer roles and to further develop business continuity training across the organisation. Action plans were implemented and the inspection team viewed lessons learnt and changes made, such as the development of work instructions for each service covering business continuity procedure and the integration of specialist business continuity software package (Continuity2 – to provide business impact analysis, plan management, compliance and incident management).
- We saw risk registers covering business continuity management, EPRR (including HART) and resilience. Each register was current, contained detailed descriptions of risks, impact, gaps in control, current effectiveness, actions and progress updates. Some historic and completed risks still appeared on the register.
- Staff discussed local and national risks at all levels within the resilience department and we reviewed minutes of meetings in business continuity, EPRR and HART where risks were presented as agenda items.
- Staff used both local and national risk reporting systems to highlight concerns and disseminate information. This was especially useful in sharing learning across national resilience and HART functions. HART staff referred to recent back plate failure on BA sets that was shared nationally via NARU.
- There was clear evidence of risk management processes in place across the resilience department.
- The resilience department represented NEAS on a number of working groups and partnerships with local resilience forums (LRFs). The resilience department followed JESIP principles for joint working. The inspection team observed NEAS resilience actively engage with a number of agencies such as the police, fire service, local authorities, public health, NHS services, environmental agency, other ambulance services, local airports, industry groups and volunteers.

Resilience planning

- The resilience department was involved in a number of local and national quality benchmarking measurements such as Pandemic 'Flu, Ebola and HART reporting.
- The resilience department worked with local and national agencies in 'flu planning. 100% compliance with key benchmarking measurements in reviewing plans with partners and LRFs, exercise completion and board sign-off were reported. The resilience department responded to requests for improved training around PPE (in particular FFP3 masks – a protective mask to prevent against exposure from patients who may have respiratory infections) by rolling out training to key personnel.
- The resilience team provided guidance on Ebola symptomatology and patient care updates for partners during the recent Ebola outbreak. Internally, the resilience department developed flowcharts covering background, implications of exposure, steps to take and key contact details for call centre staff in the event of a suspected case.
- Quality measurements in HART at NEAS were reported in May 2015. This national benchmarking report assessed 27 risk indicators against risk category grouped under workplace features, preparedness and health and well-being. Benchmarking scores were generated against risk, rank, change direction and change score to provide a risk rating (safe, low, medium, high or dangerous risk). NEAS resilience risk rated safe in 23 of the 27 indicators and a low rated in the four remaining. There were no medium/high/dangerous risks identified and auditors did not make any improvement recommendations.

Leadership of service

- The Head of Resilience and Operations led the resilience service. The service was supported by a HART and Resilience Manager, HART Development and Education Lead, Deputy Emergency Planning and Resilience Manager, Emergency Planning Officer and the Business Continuity Manager (situation vacant at the time of our inspection).
- Staff within the resilience management structure felt supported by the trust executive board. The HART operatives and resilience support staff felt part of a team and confirmed their line managers to be approachable.

This corresponded with NHS Staff Survey 2015 findings which positively reported support from line mangers to be better than national average (3.50 compared to 3.39 nationally).

- NEAS management were visible and performed regular station visits to engage with staff. These were "never cancelled".
- Resilience staff were knowledgeable and experienced in their roles with many having been in post for a number of years.
- Staff acknowledged pressures to achieve high standards and quality outcomes for patients. While recognising this as a stressor, staff found this motivational and were proud of their achievements.
- The resilience service had strong supportive relationships and a real team ethos was apparent throughout the department. Open plan offices, one site location and wider resilience integration reinforced a commitment to the team.
- Local resilience leadership recognised the benefit of integrating resilience services with wider front line staff and coordinated joint training exercises and education sessions for operational staff to attend.
- There was evidence of defined leadership structures and management support to the LRFs.

Culture within the service

- The resilience service was professional, focussed and thorough. There was constant drive to ensure the safety and wellbeing of the public served.
- Resilience support staff and recent starters in the service felt welcomed, supported and valued. Staff described a real positivity, "can do" culture with everyone "pulling in the same direction". The HART staff focus group discussions reinforced these views. This was further emphasised when the inspection team observed a true team spirit with colleagues encouraging each other during a PCA exercise.
- With many of the resilience team residing within trust boundaries, there was a real ownership and determination to provide the best possible service.
- The resilience staff felt informed and aware of strategic issues due to the accessibility of resilience management and the cascading of trust-level information through briefings, summaries and intranet updates.

Resilience planning

- Resilience staff were clear their specific role and the efficiency of the service had to be based on openness and honesty. There was a culture of constructive challenge that was used to drive personal, team and service improvement.
- Staff confirmed a shift in focus in the last 12 months or so toward a greater emphasis on staff wellbeing. HART operatives had access to an on-site gym.
- Resilience staff were actively encouraged and expected to engage in structured debrief following calls. Debriefs were routinely held irrespective of the nature of the call and were generally in the team domain. Resilience managers also offered a formal structured debrief approach for individuals who may have been particularly affected by a traumatic event.

Staff engagement

- Resilience staff engaged with senior managers and felt as though they could influence local departmental services.
- Staff said there had been improvement in dialogue with senior managers in recent months. They felt more able to contribute to developments in the wider organisation. This followed a negative indicator in the NHS Staff Survey 2015 that highlighted only 43% of staff (compared to 46% nationally) felt able to contribute towards improvements at work.
- Resilience managers gathered views and comments from both internal staff and external partners following calls and debrief sessions to develop and improve the service.
- Senior managers and senior staff from other areas within the trust (such as human resources and medicines management) were invited to resilience team meetings to engage in constructive dialogue.
- Resilience staff attended and contributed to focus groups during the recent review of strategy, vision and values.
- Staff in resilience invited paramedic colleagues (SORT/MTFA) to engage in joint exercises to engage and integrate with wider frontline staff in the trust.
- Resilience staff engaged with other professionals in relation to their national responsibilities and attended various engagement events with the fire service, police, other NHS partners and LRFs.

Public engagement

- Resilience staff received professional students on-site to see the services provided across the department.
- Resilience staff attended school events with and without professional colleagues to educate and promote key themes such as road traffic safety.
- The resilience department engaged with the trust wide agenda in collating patient feedback to monitor service provision.

Innovation, improvement and sustainability

- Staff in the resilience department were actively encouraged to bring new ideas, innovations and suggestions for better ways of working to the team for consideration.
- Any improvement proposals or innovations in HART procedures were reported to NARU in accordance with NHS Service Specification 2015/16 Resource Standard 16 via PROCLUS for consideration and approval.
- The resilience service developed strong working relationships with the Sports Ground Safety Authority (SGSA) following innovative approaches to improving medical safety standards at stadia events such as premier league football matches and music concerts.
- The resilience managers have been asked to contribute to the 'First Aid and Medical Provision' section of the Green Guide to Safety at Sports Grounds publication.
- The resilience service, in partnership with stakeholders, developed new systems, procedures and safety themes for event management in the form of Medical Advisory Groups (MAG) and Safety Advisory Groups (SAG) moving away from a "one size fits all" approach to the adaptation of risk-based medical provision.
- Within the MAG, the resilience department developed enhanced medical provision at sports stadia by developing group terms of reference, agenda and minutes. The resilience team revisited existing medical provision at these events developing location specific medical contingency plans, medical standards and job descriptions for stadia medical staff.
- NEAS resilience and medical support at large public sporting gatherings such as the Great North Run was recognised nationally and staff had been involved in London Olympics and Tour de France events.
- Resilience and HART staff provided training on a national level with NARU and have been involved in overseas work supporting international healthcare communities dealing with local, national and global healthcare issues.

Resilience planning

- Resilience staff have been involved in national JESIP programmes with the Cabinet Office.
- Resilience staff influenced trust wide surge management working group procedures for implementation during periods of increased demand.
- HART staff presented evidence in support of the use of ketamine in certain patient incidents. This innovative improvement in patient care management had been implemented and learning outcomes were being shared internally and nationally with NARU.
- HART operatives embraced the use of new technological advances in patient care by trialling 'iTclamp', a medical device used to reduce blood loss from a traumatic blood vessel injury. They have also trialled the Lucas device, an automated electronic chest compression system used with patients who have suffered cardiac arrest.
- The resilience team were also part of the trust wide trial of the Omnicell system, a secure electronic facility for the storage and dispensing of controlled drugs.
- The trust recognised innovation by way of service improvement awards.

Outstanding practice and areas for improvement

Outstanding practice

- The trust had enrolled in the Mind blue light mental health programme and had encouraged staff to take on training to support colleagues with their mental health.
- The trust provided national support for a motorcycle application; this was a mobile phone application, that used smart phone technology to identify if a motorcyclist had had an accident, and sent location data to the NEAS EOC, allowing staff to contact the nearest appropriate ambulance service to arrange an emergency response. The trust had been recognised at a national level for this.
- The resilience service developed strong working relationships with the Sports Ground Safety Authority (SGSA) following innovative approaches to improving medical safety standards at stadia events such as premier league football matches and music concerts.
- The advanced paramedic programme was an area of work that would benefit patient care and improve treatment pathways for patients.

- The trust research and development team were involved in a number of trials which were underway at the time of the inspection. These included for example trailing a device that regulated intrathoracic pressure during resuscitation and the PASTA trial which was a multi-centre randomised controlled trial to determine whether a Paramedic Acute Stroke Treatment Assessment (PASTA) pathway could speed up access to stroke patients.
- The Trust had pioneered a Flight Deck methodology for the North East. This was a capacity management system intended to support improved whole system awareness of capacity, quicker and safer diverting of patients to appropriate receiving care locations, and enhanced whole system learning.
- The trust had been nominated for a national innovation award for the development and use of the electronic communication system.

Areas for improvement

Action the hospital MUST take to improve
Action the trust MUST take to improve

- The trust must review and ensure there are appropriate arrangements in place to provide dispatch in the event that Bernicia House was unavailable to operate as a dispatch centre.
- The trust must ensure at all times there are sufficient numbers of suitably skilled, qualified and experienced staff.
- The trust must ensure all staff have completed mandatory and role specific training relevant to their role.
- The trust must ensure all staff receive an appraisal and are supported with their professional development. This must include support to maintain the skills and knowledge required for their job role.
- The trust must continue to address the complaint and incident backlog and ensure systems and processes are put in place to prevent a re-occurrence.

- The trust must ensure that clinical records are stored securely.

Action the hospital SHOULD take to improve
Action the location SHOULD take to improve

- The trust should ensure all relevant staff have received appropriate major incident training.
- The trust should ensure staff within the emergency operations centres are involved in the development of the strategy and vision of the service.
- The trust should ensure staff are supported and encouraged to report incidents and feedback is provided to staff on the outcomes of the incident investigation.

Outstanding practice and areas for improvement

- The trust should review the training requirements for operational staff for vulnerable groups such as patients living with dementia and patients experiencing mental health concerns.

- The trust should ensure there is a robust system in PTS to monitor the daily cleanliness of vehicles and ensure deep cleans are carried out to planned levels.

Requirement notices

Action we have told the provider to take

The table below shows the fundamental standards that were not being met. The provider must send CQC a report that says what action they are going to take to meet these fundamental standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	**Regulation 17 HSCA (RA) Regulations 2014 Good governance**
	Regulation 17 (1) Systems and processes must be established and operated effectively to:
	(2) (a) assess, monitor and improve the quality and safety of services; (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users; (c) Maintain securely and accurate, complete and contemporaneous record of care; (e) seek and act on feedback from relevant persons and other persons on the services provided for the purpose of continually evaluating and improving such services.
	How the regulation was not being met:
	There were concerns about the resilience of dispatch at the trust. Dispatch was located at Bernicia house only and in the event of system failure to dispatch or Bernicia house not being able to facilitate dispatch services, there would be a delay in the trusts ability to dispatch ambulance crews to patients.
	There was a lack of clarity within the trust regarding the line management, clinical oversight and governance of the community first responders we raised this as a concern with the executive team during our inspection.
	There were occasions where paper records were not always stored securely.
	Learning from incidents, complaints and audit was not always consistently shared across staff groups.

Requirement notices

There were concerns identified during the inspection regarding the regarding the emergency operations centre in relation to the management of clinical risks when the 'stack' of calls was increasing.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Reg. 18 (1) There must be sufficient numbers of suitably qualified, competent, skilled and experienced staff on duty.

How the regulation was not being met:

There were 24 clinical advisors against a planned establishment of 34 clinical advisors.

The planned establishment for paramedics was 642.40 wte. The actual number of staff in post was 539.91wte which meant there was a vacancy of 102.49 wte.

Reg. 18 (2) (a) Persons employed by the service provider in the provision of the regulated activity must receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out duties they are employed to perform.

How the regulation was not being met:

Mandatory training across services did not always meet the trust targets.

Appraisal rates between staff groups across the trust did not always meet the trust targets. |