South Central Ambulance Service NHS FT

Quality Report

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

Summary of findings

Letter from the Chief Inspector of Hospitals

South Central Ambulance Service NHS Foundation Trust (SCAS) was formed on 1 July 2006, after the merger of the Royal Berkshire Ambulance Service NHS Trust, the Hampshire Ambulance Service NHS Trust, the Oxfordshire Ambulance Service NHS Trust and part of the Two Shires Ambulance Service NHS Trust. It provides NHS ambulance services in Berkshire, Buckinghamshire, Hampshire and Oxfordshire in the South Central region. This area covers approximately 3,554 square miles with a residential population of over 4 million. On 1 March 2012, the trust achieved foundation trust status.

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 logistics and commercial services. There is also a Hazardous Area Response Team (HART) based in Hampshire. Services are delivered from the trust's main headquarters in Bicester, Oxfordshire, and a regional office in Otterbourne, Hampshire. Each of these sites includes an emergency operations centre (EOC) where 999 and NHS 111 calls are received, clinical advice is provided and from where emergency vehicles are dispatched if needed. There was a PTS contact centre at each EOC.

Our inspection took place on 10 and 11 September 2014 with unannounced visits on 30 September and 1 October. We inspected the trust as part of our first wave of comprehensive ambulance inspections. We looked at three core services: access via emergency operations centres, patient transport services and emergency and urgent care. The 111 service provided by the trust was not inspected on this occasion. The logistical and commercial training services were also not inspected as these do not form part of the trust's registration with the Care Quality Commission (CQC).

The team of 48 included CQC inspectors and inspection managers, an analyst and inspection planners and a variety of specialists: The team of specialist was comprised of a consultant physician in intensive care, two nurses working in accident and emergency departments, four paramedic staff, one emergency care practitioner, a paramedic clinical supervisor and development manager, three managers with an operations role, a head of governance, a director of service delivery, two chief executives, a pharmacist, a safe guarding lead, two people with a role in an operations centres and three experts by experience.

We did not provide ratings for this trust because this inspection was part of our first wave of ambulance inspections to apply our methodology and develop our understanding of inspecting in this sector.

Key findings

Is the trust well led?

- The trust had a vision and clinical strategy to provide excellent, sustainable services, and to coordinate mobile responsive healthcare services so that people received the right care at the right time in the right place (including care that could be closer to home).
- Governance arrangements were clear and there was an integrated performance report to benchmark quality, operational and financial information. The trust had also identified its quality priorities and could demonstrate progress against these. However, much of the data on risk and quality was at a high level and some risk issues, such as safeguarding and significant delays in patient transport services (PTS), needed a better focus.
- Many areas had team meetings and monthly operational performance meetings to review quality and operational issues. These reported to the trust's Level 2 meetings (operational leadership level) and then senior management meetings. This structure needed to be replicated in all areas to consistently identify the action taken in response to risks and performance issues.
- The leadership team showed commitment, enthusiasm and passion to develop and continuously improve services. Most staff reported that the trust culture reflected an effective and responsive service rather than a target-driven organisation. Leadership at team level varied in terms of effectiveness and the trust needed to improve in this area to develop its strategic priorities.

Summary of findings

- Public engagement took place through a variety of means, such as liaison work, use of social media and through its membership. Patient feedback through surveys, interviews and liaison work, was being used to improve the service.
- Staff were positive about working for the trust. They said it was a friendly and positive place to work but not without its challenges; namely, managing tight resources against an increasing demand for services. The NHS staff survey 2013 demonstrated that the trust was better than average for staff engagement when compared to other ambulance trust. Staff engagement was well developed, although staff indicated the need for more ongoing dialogue around service changes.
- The trust had a highly innovative culture and staff were encouraged to suggest new ideas to improve service delivery. This was seen as important against a background of tightening resources, but also essential to develop services in response to the needs of patients. There were many examples of service improvements developed by the trust and its staff.
- The trust demonstrated proactive and effective financial management to invest in new technology and service developments, and to ensure that services were sustainable. Cost improvement programmes were demonstrating savings and were monitored. Mitigating actions were identified to reduce the potential impact although the action taken in some of these areas needed to improve.

Key findings across the core services:

- Staff were caring and compassionate, and treated patients with dignity and respect.
- Staff were positive about the quality of care they provided for patients and were proud to work for the trust. There was low morale in places and the pressures faced by the trust were recognised. Staff however "lived" the values of the organisation: "Towards excellence – Saving lives and enabling you to get the care you need".
- Patients told us their experiences of care and treatment was good. They were positive about emergency ambulance response times but there were concerns about the punctuality of patient transport services.
- Incident reporting was increasing on the newly introduced reporting system. The trust was taking action following incidents, but there needed to be earlier and quicker investigation for some incidents. Learning was shared via clinical bulletins, the trust intranet, noticeboards and email. The trust had introduced SCAScade to improve organisational learning from when things go wrong. This included anonymous cases and reflective tools for staff to use on the trust intranet. However, staff in the EOC and PTS needed to be encouraged to use and take responsibility for reporting incidents and also required feedback and shared learning in their areas.
- Staff in the emergency and urgent care service had good knowledge of the Mental Capacity Act 2005, but staff in EOC and PTS needed to have better knowledge to ensure the best interest of patients.
- Safeguarded procedures were being used but needed to improve and the safeguarding lead had a limited capacity to deliver the safeguarding agenda across the organisation. Safeguarding champions in geographical areas were to be developed but this needed to be prioritised.
- Staff had good training opportunities and specialist training on dementia care, learning disabilities and mental health was being improved. Staff were supported with funding for further qualifications and professional development, However, some staff did not always have access to computer facilities to undertake training or the dedicated time to complete it, and attendance at mandatory and statutory training was low.
- Most complaints were responded to within the trust's target time of 25 days and action was being taken to improve services as a result. Complaints were analysed to identify themes and the trust aimed to share learning, for example, through teams and noticeboards. There was evidence of actions taken as a result of complaints in all services. However, staff told us they did not always get feedback on complaints or concerns raised.
- The trust understood its duties under the Civil Contingencies Act 2004 and all staff were aware of what to do in the event of a major incident. Staff had appropriate training, there was joint working with partner organisations (such as the fire service, police and military), and rehearsals were undertaken as part of preparation and planning exercises.
- The trust had worked with partner organisations including fire and rescue, police, and the environmental agency during the floods in the Thames

Summary of findings

Valley area in early 2013. The Hazardous Area Response Team (HART) had worked throughout the region and specifically in Wraysbury, Berkshire, 24 hours a day over 4 days, to assist with the rescue and support operation.

Emergency Operation centres (EOC)

- Emergency 999 calls were triaged through NHS Pathways (which is a software system of clinical assessment for triaging telephone calls from the public based on the symptoms they report when they call). There was good compliance to prioritise and categorise calls for ambulance dispatch according to the clinical needs of patients. However, staff knowledge of appropriate dispatch times for mental health patients in crises under a Mental Health Act Section 136 and needing a place of safety, needed to improve.
- There were dedicated triage lines for GPs and healthcare professionals, and for patients who were critically unwell and needed the air ambulance (the Helicopter Emergency Medical Services, [HEMS]) or other specialist services, such as the Hazardous Area Response Team (HART).
- Safety procedures were followed but some needed to improve, such as incident reporting and raising safeguarding concerns, and some staff needed a better understanding of the Mental Capacity Act 2005.
- Staffing levels were a concern and staff worked long hours, sometimes without breaks. Action was being taken to manage peaks in demand but staff were not meeting target times to answer emergency calls.
- Overall, the trust had referral rates of 8% from NHS 111 to 999 services, and these were better than the service level agreement performance of 10% and one of the lowest in the country. Staff identified the need for further action on managing the demand created by the NHS 111 service, and the trust's long-term planning against the rising increase in demand for services was ongoing.
- The staff were supportive to patients who called in distress. They listened carefully, explained their actions and involved patients in their decisions.
- Clinical advisors were available to help staff and to support patients to manage their own health when appropriate. The clinical adviser also undertook welfare checks over the phone to ensure a patient's condition was not deteriorating while they were waiting for an ambulance. The trust was below the national average for 'hear and treat', which is the proportion of calls that are dealt with based on provision of telephone advice only. The re-contact rate within 24 hours of 'hear and treat' was higher than the national average in 2013-14 but had decreased this year and was below the national average in (April to July 2014).
- Engagement between the trust and the public and patients was being developed further.
- The trust had a clear strategy for the EOC to provide clinical coordination of care across a range of health and social care settings. However, most staff were not aware of this strategy in relation to their service. Governance arrangements needed to improve to support staff to share learning, raise concerns, manage risk and act on performance information. Staff worked well in their teams but some wanted better support from managers, particularly in the northern EOC.

Emergency and Urgent Care

- Front-line 999 services provided an emergency response to people with life threatening emergency or urgent conditions. Overall, during 2013/14, the trust was meeting national emergency response targets for 75% of calls to be responded to within 8 minutes. The national categories are for Red 1 calls (for patients who have suffered cardiac arrest or stopped breathing) and for Red 2 calls (for all other life threatening emergencies). Red 1 and Red 2 calls added together and are referred to as Category A calls. The category A target is to have a vehicle that could convey a patients to hospital arrive at the scene within 19 minutes for 95% of cases. This target was also met.
- The trust had the highest percentage of 'see and treat' in the country (that is, managing patients at the scene without the need for ambulance transfer to hospital). The re-contact rate within 24 hours of this treatment was higher than the national average in 2013-14 but was decreasing.
- The trust used a Resource Escalation Action Plan (REAP) as a way of forecasting performance and service delivery. There was moderate to high pressure on the service during our inspection and the trust was communicating effectively with hospitals to align conveyancing decisions against waiting times and the capacity to receive patients. This included having hospital ambulance liaison officers (HALOs) to support

Summary of findings

the timely handover and safety of patients in A&E departments, and to monitor and respond to situations particularly at times of increased demand for services. There was effective planning and preparation for major incidents and the trust had worked effectively with partner organisations.

- The trust was monitoring long waiting times and had introduced measures to ensure that people were monitored while waiting and that high-priority calls took precedence. There was an impact however on people who may be in a healthcare setting but awaiting transfer to another hospital for acute care and for people at a distance from an ambulance station. The trust was taking action to reduce these waiting times and projects were planned in different areas.
- The service followed safety procedures overall, but needed to improve infection control practice and the management of medicines. Staff had a good understanding of the Mental Capacity Act 2005 and of safeguarding procedures although the timeliness of reporting concerns and referrals needed to improve. The performance of the external contractor to 'make ready' ambulances (that is, to prepare ambulances, for example, in terms of cleanliness and appropriate equipment) was monitored but the quality of their work required better supervision and monitoring. Ambulance crews had allocated time to check vehicles but told us they spent more time rechecking vehicles to ensure they were ready for use.
- The trust was affected by the national shortage of paramedics and there were a high number of vacancies. The allocation and skill mix of staff were appropriate but staff worked long hours and some reported stress and fatigue. There was a rising demand for services that was above predicted levels. The trust had introduced shift changes to help manage resources to meet demand in emergency services and new rotas were being introduced to further improve the work life balance of staff. The trust used private providers to ensure service cover and these providers were appropriately monitored.
- National evidence-based guidelines were used to assess and treat patients. Patients experiencing a heart attack did receive pain relief although this was not always the pain relief that was nationally recommended. Patients experiencing a heart attack were transported quickly to hospital. Patients that had had a stroke had appropriate care but there could be delays in their transport to hospital. Some hospital staff identified the need for better pain relief for children in certain circumstances.
- The coordination of emergency care with hospitals and GPs was good overall, but needed to improve for heart and stroke care in Buckinghamshire and for mental health patients in crisis across the four counties. The trust was working with its partners and had action plans to improve care in these areas.
- The trust was ranked the best in the country for patients who had had a cardiac arrest and stopped breathing, who then after resuscitation, had a pulse/heartbeat on arrival to hospital. This is called return of spontaneous circulation (ROSC). The trust had improved its effectiveness of action taken when staff witnessed a cardiac arrest and was fourth best in the country this year (April to August 2014) a change from eighth best in 2013-14.
- The trust was ranked the best in the country for patients who had had a cardiac arrest and survived to be discharged from hospital.
- Staff explained treatment options to patients in a way that they, or their relatives, could understand. Patients, and relatives or carers, received good emotional support if they were in distress. There was support for vulnerable patients, such as those with a learning disability, bariatric patients and people whose first language was not English.
- Engagement between the trust and the public and patients was well developed through a variety of channels, such as social media, surveys, newsletters and liaison work.
- The trust had a clear vision and strategy for the service to provide mobile healthcare and to coordinate care in hospital, the community and people's homes. Staff were supportive of the strategy and worked well together in teams and with their managers. There were good governance arrangements to monitor performance and quality and to manage risks although more action was needed on ongoing risks.

Patient Transport Services

- Patient transport services (PTS) provided non-emergency transport for patients who attend, for example, outpatient clinics or day hospitals, or were

discharged from hospital. Commissioners had identified eligibility criteria for the service and the trust was working with 12 clinical commissioning groups to monitor performance and compliance.

- Staff followed the eligibility criteria designed by commissioners and were also working to improve the signposting of people to other services if they did not meet the criteria.
- Procedures to ensure the safety of services needed to improve, specifically around incident reporting, equipment checks and safeguarding procedures. Most vehicles were visibly clean. 'Do not attempt cardio-pulmonary resuscitation' (DNA CPR) orders were understood and used appropriately, but staff had limited awareness of the Mental Capacity Act 2005.
- There were staffing vacancies and staff felt stretched, particularly in the dispatch team where this had an impact on the planning and scheduling of transport. The trust was using volunteers and private providers to cover driving shifts. There needed to be better governance arrangements for private providers and for driving and employment checks for volunteers.
- The trust had made significant changes to the IT system in the PTS on the day of our inspection. Anticipated resource and capacity risks needed to be better managed, for example, problems with the new IT system had caused a serious disruption to transport arrangements for many patients during our inspection
- Dispatch staff did not always have appropriate assessment information, from hospitals or patients or from their own records. Patients sometimes did not have an appropriate vehicle or equipment, and transport sometimes had to be reorganised. The system to plan journeys was manual and often reactive based on a lack of timely and coordinated information and this had caused delays to patient transport.
- The trust was not meeting performance targets and this was having an impact on patients' care and treatment. Patients were experiencing delayed and missed appointments for outpatient consultations and diagnostic scans, and renal dialysis, and some were choosing to curtail their treatment in order not to risk missing their transport home for fears of excessive delay. Some hospitals had reorganised clinics, for example, to finish early to accommodate the vagaries of the PTS. There were good examples of multi-disciplinary working with GPs and health professionals in hospitals. The trust had been working with other providers to improve the coordination of care and some progress had been made.
- Patient surveys were regularly undertaken; these were positive about the service but identified delays. Patients we spoke with were positive about the care and compassion of staff. However, they were concerned that the service was not effective and that they were not given enough information about delays, missed appointments and the eligibility criteria.
- Many patients told us they had been distressed and anxious waiting for transport, but did not know whom to contact within the service. Call handlers were overwhelmed with calls about service delays and only half of all calls were answered.
- There was good support for vulnerable patients (for example, those with dementia or a learning disability), and carers and escorts could travel in the ambulances too. A policy for the transport of children needed to be developed.
- The trust had a clear strategy for the development of PTS to support safe non-emergency travel between people's homes and healthcare settings, but most staff were unaware of this strategy. Governance arrangements needed to improve in order to assess and manage risks. Although staff worked effectively in teams, many wanted the management and leadership of the service to improve and for the trust to prioritise PTS alongside the emergency 999 service.

We saw several areas of outstanding practice:

- We observed many examples where staff demonstrated outstanding care and compassion to patients despite sometimes working in very difficult and pressured environments. Staff "lived" the values of the trust "Towards excellence – Saving lives and enabling you to get the care you need".
- Representatives of the trust attended local youth organisation meetings, village fetes and school assemblies. The trust had developed a child-friendly first-aid book printed specially for schools and the wider local community.
- The trust provided an innovative learning resource to their frontline staff using the educational resource

centre and film centre at Bracknell. The staff were involved in making films which supported learning around new guidelines from the Joint Royal Colleges Ambulance Liaison Committee (JRCALC).

- The trust had introduced a lifesaving automatic external defibrillator (AED) locator mobile phone application. By using GPS, this app locates the nearest AED in the event of a cardiac arrest. In total, the app identified over 800 AEDs across four counties.
- A new initiative was the introduction of a 'Simbulance': a large command vehicle fully equipped with simulation learning activities. It was an innovative virtual classroom facility in that it gave ambulance staff the opportunity to experience realistic medical situations inside an ambulance saloon.
- Operation centres had direct access to electronic information held by community services, including GPs. This meant that the staff could access up-to-date information about patients (for example, details of their current medication).
- Trauma risk management (TRiM) was in place to provide confidential support to staff who may have been affected by traumatic incidents or conditions. Staff were assessed 3 days after a traumatic event and again after 28 days. Thirty-two TRiM practitioners gave peer support and advice, and there was also an external counselling service. The early intervention had both reduced sickness absence and improved the welfare of staff.
- The Helicopter Emergency Medical Services (HEMS) showed innovative practices and learning taken from combat zones. The team now had the equipment and skills to give blood transfusions and perform ultrasound and blood gas tests. In some circumstances, this bypassed or reduced the time a patient had to spend in the accident and emergency (A&E) department, and meant they could receive treatment immediately on arrival at the hospital. HEMS was also planning to introduce a night service, so it would operate 24 hours every day.
- The introduction of a midwife to the clinical support desk (CSD) in the Southern House emergency operation centre had improved the outcomes for expectant mothers and their new babies. The 24-hour labour line started as a pilot in May 2014. It gave women in labour access to advice and support, whereas the 'professional's line' enabled medical professionals to speak to a midwife 24/7 during a woman's labour and birth. The service had over 1,600 calls in the first eight weeks.
- The trust provided a service on Friday and Saturday nights in the city centres of Portsmouth (Safe Place) and Southampton (ICE Bus) to provide support, first aid and transfer to hospital if required for the public enjoying a night out. This had been set up in partnership with other organisations such as the Hampshire Police, the local council, volunteers and the local street pastors
- The trust had a clinical lead in mental health and learning disability. This role was unique among ambulance trusts. The lead had established a national mental health group for ambulance trusts, and worked with partner agencies such as the Royal College of Psychiatrists and the College of Policing. The introduction of mental health practitioners into the EOC was supporting operational practice and care to mental health patients.
- The trust had worked in partnership with Oxford Brookes University to provide staff with extra opportunities to develop their careers by becoming a paramedic, and to counter the national shortage of paramedics. A foundation degree course was to start in January 2015. The training covered an 18-month period and included in-hours training. The trust's investment had been significant in terms of the time taken to negotiate the resources and facilities for the programme and the release of staff from work duties.

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

Importantly, the trust must ensure that:

- Staff uptake of statutory and mandatory training meets trust targets
- Staff in EOC and PTS understand the Mental Capacity Act 2005
- All EOC and PTS staff receive safeguarding training to the required level so that they are able to recognise signs of abuse and ensure there are robust arrangement in place for staff to report concerns within the agreed timescale.
- Emergency call takers answer calls, and the emergency medical dispatchers dispatch an ambulance within target times

Summary of findings

In addition the trust should ensure that:

- Procedures for incident reporting continue to improve and staff in EOC and PTS have appropriate training and are able to report incidents directly. There must be timely investigation of incidents, staff must receive feedback and learning must be shared.
- The risks around IT vulnerability in the EOC and PTS are appropriately managed.
- Infection control practices are followed and ambulance stations (resource centres) and vehicles are effectively cleaned and deep cleaned.
- There are suitable arrangements to ensure that equipment is regularly checked and fit for purpose.
- Staff are aware of the appropriate steps to take to reduce the risks to patients left unattended in PTS ambulances because of staff working alone.
- Appropriate equipment is available in all areas for the transport of children in PTS and this continues to be rolled out for emergency transport.
- Volunteer drivers in PTS have the appropriate safety and employment checks before working within the service.
- The trust to continue to work with partners and ensure the planning and scheduling of PTS improve to prevent delays and missed appointments, and to reduce the impact on the clinical care, treatment and welfare of patients.
- The governance and security arrangements for the management of controlled drugs need to be improved in Hampshire.
- Recruitment of staff in all areas continues and there are specific staff retention plans in response to identified reasons as to why staff leave.
- Staff in PTS receive appropriate training on dementia care, learning disabilities and all staff continue to received training in mental health conditions.
- Anticipated resource and capacity risks in PTS continue to be appropriately identified, assessed and managed.
- Pain relief continues to be appropriately administered for patients with ST segment elevation myocardial infarction (STEMI) and pain relief for children is effectively monitored.
- Continue to work with acute trusts to review protocols for the non- critical transfer of hospital patients.
- There is better coordination of care between providers, in particular for cardiac and stroke services in Buckinghamshire and mental health services.
- Complaints are responded to within the trust's target of 25 days. All staff in EOC and PTS receive feedback from complaints and learning is shared.
- Operations staff in PTS are appropriately resourced to be able to answer telephone calls.
- Patients (or people acting on their behalf) using the PTS are made of aware of how to complain or send compliments about the service.
- Staff in PTS have regular supervision and the trust should raise awareness amongst staff about the professional and career development opportunities within the trust.
- The formal structure of team meetings is in place for all staff groups and staff are given the opportunity to attend, share information and raise issues or concerns.
- Staff have a better understanding of the trust's vision and strategy as it applies to their service in EOC and PTS and staff communication continues around service changes and development.
- Leadership in the northern EOC and PTS supports staff and action is taken to improve staff morale where this is low.
- Staff in PTS receive feedback from the completed patient satisfaction surveys.
- There are better governance arrangements within EOC and PTS to share information with staff, so that staff can raise concerns and risks are appropriately identified, assessed and managed.
- There are better governance arrangements for private providers in PTS and make ready services.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to South Central Ambulance Service NHS FT

South Central Ambulance Service NHS Foundation Trust (SCAS) was formed on 1 July 2006, after the merger of the Royal Berkshire Ambulance Service NHS Trust, the Hampshire Ambulance Service NHS Trust, the Oxfordshire Ambulance Service NHS Trust and part of the Two Shires Ambulance Service NHS Trust. It provides NHS ambulance services in Berkshire, Buckinghamshire, Hampshire and Oxfordshire in the South Central region. This area covers approximately 3,554 square miles with a residential population of over 4 million. On 1 March 2012, the trust achieved foundation trust status.

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 logistics and commercial services. There is also a Hazardous Area Response Team (HART) based in Hampshire. Services are delivered from the trust's main headquarters in Bicester, Oxfordshire, and a regional office in Otterbourne, Hampshire. Each of these sites includes an emergency operations centre (EOC) where 999 and NHS 111 calls are received, clinical advice is provided and from where emergency vehicles are dispatched if needed.

The trust currently owns or leases 27 ambulance stations (resource centres), two HQ/operation centres plus additional standby points, aerial sites and support buildings, as well as 312 front-line ambulances spread across Berkshire (Berkshire consists of the following unitary authorities: West Berkshire, Reading, Wokingham, Bracknell Forest, Windsor and Maidenhead, and Slough), Buckinghamshire, Hampshire and Oxfordshire. South Central Ambulance Service NHS Foundation Trust operates a fleet of front-line emergency ambulances, a fleet of rapid response vehicles and supports the operation of two air ambulance helicopters.

The inspection included the emergency service and PTS. The 111 service provided by the trust was not inspected on this occasion. The logistical and commercial training services were also not inspected as these do not form part of the trust's registration with the Care Quality Commission (CQC).

Our inspection team

Our inspection team was led by:

Chair: Leslie Hamilton, Consultant Cardiac Surgeon, The Newcastle upon Tyne Hospitals NHS Foundation Trust

Head of Hospital Inspections: Joyce Frederick, Care Quality Commission

The team of 48 included CQC inspectors and inspection managers, an analyst and inspection planners and a variety of specialists: The team of specialist was comprised of a consultant physician in intensive care, two nurses working in accident and emergency departments, four paramedic staff, one emergency care practitioner, a paramedic clinical supervisor and development manager, three managers with an operations role, a head of governance, a director of service delivery, two chief executives, a pharmacist, a safe guarding lead, two people with a role in an operations centre and three experts by experience

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?

Summary of findings

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

The inspection took place on 10 and 11 September 2014 with unannounced visits on 30 September and 1 October.

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about the South Central Ambulance Service. These included local clinical commissioning groups (CCGs); local quality surveillance groups; the health regulator, Monitor; NHS England; Health Education England (HEE); College of Emergency Medicine; General Dental Council; General Medical Council; Health & Safety Executive; Health and Care Professions Council; Nursing and Midwifery Council; National Peer Review Programme; NHS Litigation Authority; Parliamentary and Health Service Ombudsman; Public Health England; the medical royal colleges; local authorities, local NHS Complaints Advocacy Service; local Healthwatch groups; and local health overview and scrutiny committees. We also reviewed information collected by Speak Out who hosted a listening event.

During our inspection, we spoke with a range of staff in the organisation including call handlers, dispatchers, paramedics, ambulance technicians, emergency care assistants, emergency care practitioners, community first responders, patient transport services (PTS) staff, the lead pharmacist, the safeguarding lead, the infection prevention and control lead, the mental health lead, operational managers, emergency operation centre managers, resilience staff and staff at director level.

We visited 10 ambulance stations, the northern and southern EOC (where we listened in to calls and observed dispatchers for the emergency service and PTS. We also visited 10 acute hospitals and one community hospital: John Radcliffe, Oxford; Churchill, Oxford; Wexham Park, Slough; Bicester Community, Bicester; Stoke Mandeville, Aylesbury; Wycombe; Royal Berkshire, Reading; Milton Keynes; Southampton General; Basingstoke and North Hampshire, Basingstoke; Queen Alexandra, Portsmouth. At these hospitals, we observed the interaction between ambulance staff and hospital staff in the accident and emergency (A&E) areas, direct admission wards, outpatient areas and discharge lounges. We noted how people were being cared for and spoke with patients using the emergency ambulance service and PTS. We spoke with staff from the hospitals we visited about the ambulance service. We rode and observed on three emergency ambulances and two patient transport vehicles.

We would like to thank all staff, patients and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment provided by the South Central Ambulance Service.

Facts and data about this trust

South Central Ambulance Service NHS Foundation Trust: Key facts and data

1. Context

- Service covers - Berkshire, Buckinghamshire, Hampshire, Oxfordshire and Milton Keynes and the resident population approximately £4million (Significant rural areas).
- Health Summary: Health of population generally better than England average; Deprivation is lower than average; life expectancy is higher than the England average.
- The services has 40 sites; 27 ambulance stations; 489 vehicles of which 312 are frontline ambulances; and supports the operation of two Air Ambulance helicopters.
- The services covers 10 acute hospital sites, 2 Major Trauma Centres, 7 specialist site, 5 mental health trusts.
- Staff: 3,000.
- Community First Responders: 946
- Co-responders: 359
- The total income for the service was £162,4million in 2013/14 (£118m spent on emergency services)
- Cost improvement challenge £6.2m (2013/14): Trust achieved this target.

Summary of findings

2. Activity

- Calls to 999: 416,000 (2013/14)
- Calls to 111: 873,000 (2013/14)
- Patient Transport service Journeys: 678,000 (2013/14)

3. Safe

- **National Reporting and Learning System (NRLS reporting):** Between April 2013 and March 2014, 15 serious incidents were reported by the trust. No Never Events. Summer 2013 had significantly more incidents reported to NRLS than any other four month period.
- **Staff survey**: Worse than average for three questions relating to % of staff witnessing potentially harmful errors, reporting of errors and near misses and availability of hand washing materials.
- **Staff survey**: Better than average for % of staff felt satisfied with the quality of work and patient care they are able to deliver
- **Central Alert System:** Worse than expected for acknowledging with 2 days; similar to expected for completion according to deadline.

4. Effective

DH ambulance quality indicators

- **Better than expected:** proportion of suspected Stroke patients who receive an appropriate care bundle.
- **Similar to expected:**
  - STEMI patients being transferred to centre capable of delivering PPCI and receive angioplasty within 150 minutes of the call.
  - Ambulance calls closed with advice (where clinical appropriate)
  - Ambulance calls managed without transport to A&E (where clinically appropriate)
- **Tending towards worse than expected:**
  - Re-contact rate <24 hours following discharge of care by telephone
  - Re-contact rate <24 hours following discharge of care at the scene
- **Much worse than expected:**
- Proportion of STEMI patients receiving appropriate care bundles.

Ambulance clinical performance indicators (comparison between trusts) 2013/14*

- ROSC at time of arrival at hospital (Overall) (%) : **Rank 1 (best of all 11 ambulance trusts)**
- ROSC at time of arrival at hospital (Utstein Comparator Group *) (%) **Rank 8**
- Cardiac - survival to discharge - overall survival rate (%): **Rank 1**
- Cardiac - survival to discharge –(Utstein comparator group *) survival rate (%): **Rank 1**
- % of patients suffering a STEMI who are directly transferred to a centre capable of delivering PPCI and receive angioplasty within 150 minutes of call. **Rank 6**
- % of patients suffering a STEMI who receive an appropriate care bundle. **Rank 11 (worse)**
- % of FAST positive stroke patients who arrive at a stroke unit within 60 minutes of call. **Rank 11**
- % of suspected stroke patients who receive an appropriate care bundle. **Rank 3**

Category Red calls (2103/14; April to June 2014)

- **Emergency response**
- Red 1: 75% of calls within 8 minutes - Target met overall
- Red 2: 75% of calls within 8 minutes - Target met overall
- **Vehicle capable of transporting a patient at the scene**

Category A calls (Red 1 and Red 2) - 95% in 19 minutes - Target met overall.

5. Caring

Hear and Treat survey 2013/14 national NHS survey programme.

25 questions on call handling, clinical advice, outcome and overall service.

- 23 questions - same as average
- 1 question - Best trust in explaining why an ambulance would not be sent
- 1 question - Worst trust in not mentioning the caller would receive a call back

6. Responsive

- **Conveyancing:** Above England average for emergency calls – proportion of incidents managed without the need for transport to A&E

Summary of findings

- **Telephone Advice:** Below the England average for emergency calls dealt with by telephone advice only.

7. Well led

- **NHSLA Risk Management Standard**. Level 1 achieved October 2012 (worse than expected)
- **Department of Health, Information Governance Toolkit -** attained either levels 2 (similar to expected) or level 3 (better than expected) on the indicators when compared to other trusts. .
- **Complaints:** 86% of complaints are being resolved within 25 days against a target of 95%.
- **NHS Staff Survey (2013).** The trust scored significantly better than average on 63 out of 91 questions; the trust was similar to average for 25 questions; the trust was rated as worse than average on 3 of the 91 questions.

8. CQC inspection history

- Four inspections had taken place at the trust since its registration in April 2010.

Compliant at last inspection in October 2013.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? Patients were appropriately triaged for emergency services and there were welfare checks for patients when an ambulance might be delayed. The use of special notes ensured that patient's receive safe and appropriate care. These detailed clinical information for patients with complex needs or risk information if there was a safety concern. Patient records were maintained to a high standard and patients were appropriately identified and escalated for treatment if their condition deteriorated. 'Do not attempt cardio-pulmonary resuscitation' (DNA CPR) orders were used appropriately and staff had training and understanding about end of life care across all services. Vehicles were well maintained and serviced, and most were visibly clean. Infection control procedures were followed but needed to improve in a few areas. Appropriate equipment was available and well maintained and this was standardised across the trust. Some automated external defibrillators (AEDs), for use in patient transport services (PTS), needed to be more accessible or regularly checked. Medicines were appropriately stored and tagged for ease of use in an emergency and PTS crews were able to administer oxygen when this was required. There needed to be better arrangements to check the safe storage of medicines in some areas. Driving standards were monitored and action taken was taken to improve performance. Safeguarding procedures were followed but the timeliness of reporting and documentation needed to improve. Incident reporting was improving following the introduction of a new electronic reporting system and learning was effectively shared in emergency services, although this needed to improve in EOC and PTS. Staff in EOC and PTS needed a better understanding of the Mental Capacity Act 2005, and of dementia care and all staff wanted to improve their knowledge of mental health conditions. The trust had introduced mental health practitioners into the EOC and was working with local mental health trusts to better coordinate and support care patient care. The trust had a high number of staff vacancies and was feeling the impact of a national shortage of paramedics. Staff worked agreed roster patterns, but many worked long hours, some without breaks, and those in emergency services were reporting stress and fatigue. There was a rising demand for services that was above predicted levels. The trust had introduced shift changes to help manage resources to meet demand in emergency services and new rotas	

were being introduced to further improve the work life balance of staff. There was moderate to high pressure on the service during our inspection and the trust was communicating effectively with hospitals to align conveyancing decisions against waiting times and the capacity to receive patients. Planning and preparation to respond to a major incident were effective, and done in conjunction with partner organisations.

Are services at this trust effective?

The trust used national evidenced-based guidelines to prioritise and categorise emergency calls based on the clinical needs of patients. The service needed to improve for mental health patients in crisis and/or in need of place of safety (Section 136 of the Mental Health Act 1983). The answering of emergency calls was not within the trust target of 5 seconds and the trust had average time of 40 seconds. Rapid response vehicles (RRVs) or ambulance crews were dispatched in just over 1 minute, but this was above the trust targets of 30 and 60 seconds, respectively. Overall, national response times for emergency and urgent care were being met and most treatment and care was meeting national standards. Patients who had had a heart attack received pain relief, although not always the pain relief that was nationally recommended. This was improving following a campaign by the trust to reiterate and train staff to use the appropriate pain relief. Patients who had a heart attack did have a timely arrival at hospital. Those who had had a stroke had appropriate care, but there were delays in their arrival at hospital. The trust had good outcomes overall for the survival of patients who had had a cardiac arrest, but needed to improve the effectiveness of action taken when staff witnessed a cardiac arrest.

The trust was below average for the number of 'hear and treat' calls, which is the proportion of calls dealt with based on telephone advice only; but it had the highest percentage (the best in the country) for treating patients without the need for transport to hospital ('see and treat'). Re-contact rates following these interventions were higher than national average in 2013-14 but was now below national average for 'hear and treat' this year (April to July 2014) and was decreasing for 'see and treat'.

Emergency care for A&E and maternity services was well coordinated with the acute hospitals across Oxfordshire, Buckinghamshire, Berkshire and Hampshire, and there was effective multidisciplinary working with acute hospitals, community organisations and GP teams. There was also coordination of care along specialist pathways, for example, for critical care, and the care

of children with diabetes. However, care pathways for cardiac and stroke patients in Buckinghamshire and for mental health patients across the county needed better coordination. The trust had action plans to improve the coordination of care in these areas.

The service followed eligibility criteria from clinical commissioning groups to ensure patients were appropriate for patient transport services (PTS). National clinical guidelines were used in the event of any patient needing urgent medical care. Overall, the service was not meeting performance criteria and many patients experienced delayed or missed appointments; this in turn had an impact on the timeliness (and length) of outpatient consultations, diagnostic scans and renal dialysis treatment. The service needed to be better coordinated with hospitals, but staff worked well in multidisciplinary teams to share information with GPs, hospital and community staff.

Not all staff had dedicated time to complete training and consequently, the uptake of some mandatory and statutory training was low. Staff could apply for funding to support their continuing professional development and career aspirations. The trust had worked in partnership with Oxford Brookes University to provide staff with extra opportunities to develop their careers by becoming a paramedic, and to counter the national shortage of paramedics. A foundation degree course was to start in January 2015. The training covered an 18-month period and included in-hours training. The trust's investment had been significant in terms of the time taken to negotiate the resources and facilities for the programme and the release of staff from work duties. There was access to specialist training, which included learning disabilities, dementia care, end of life care, infection control and mental health awareness. However, staff in PTS and EOC needed a better knowledge of the Mental Capacity Act 2005, and of dementia care and mental health conditions.

Are services at this trust caring?

Staff were caring and compassionate when delivering services, and they treated patients with dignity and respect. Patients were involved in discussion about their treatment and care, including why they may not need to be taken to hospital. Staff listened carefully to what patients said, and they explained procedures and treatments in a way that the patients, or their relatives or carers, could understand. In patient transport services (PTS), patients needed more information about whom to contact in the event of a delayed or missed appointment.

Patients spoke positively about the kindness of staff. The staff were extremely sensitive, supportive and reassuring to vulnerable patients. Patients, their relatives and others received emotional

support when experiencing distressing events, including when someone had died. Patients were supported to manage their own health by using non-emergency services when it was appropriate to do so.

Are services at this trust responsive?

Emergency calls were allocated and triaged to appropriate patient pathways. These could be an ambulance, a GP appointment, or care in their own home or another community setting. Patients who were critically unwell and needed the air ambulance or specialist services had a separate triage process. GPs and staff in community hospitals had a direct line to call. The trust was monitoring long waiting times and had introduced measures to ensure that people were monitored while waiting and that high-priority calls took precedence. There was an impact however on people who may be in a healthcare setting but awaiting transfer to another hospital for acute care, and for people at a distance from a resource centre. The trust was taking action on these issues

Patient transport services (PTS) provided non-emergency transport for patients who attended hospital outpatient clinics, or who were admitted to or discharged from hospital. The services across Oxfordshire, Buckinghamshire, Berkshire and Hampshire had different eligibility criteria from clinical commissioning groups. The trust was compiling a directory of services to signpost people appropriately if they did not meet the criteria. There needed to be a policy for transporting children in PTS.

There was support for people who could not speak English, or who had hearing difficulties or speech impairment, to access the 999 emergency call services. Information was available to meet the needs of patients who had a complex or chronic clinical condition. The trust had begun to analyse the needs of frequent callers to better coordinate services with GPs and other healthcare professionals to manage demand. There was support for bariatric patients and those with a learning disability or dementia. Ambulance staff had less training and experience to deal effectively with people with a mental health condition. Care pathways to coordinate responsive services for people in crisis were not well developed. People whose first language was not English were supported with advice and language aids where available in the ambulance.

The trust was not meeting 'pick up' and 'drop off' times for PTS and patients did not know where to send complaints or compliments. Complaints, when received, were handled appropriately but the

investigation and response sometimes took longer than the trust target time of 25 days. There was evidence of action as a result of complaints, but some staff had not received feedback and learning was not consistently shared.

Are services at this trust well-led?

The trust had a vision and clinical strategy to provide excellent, sustainable services. These included coordinating mobile responsive healthcare services so that people received the right care at the right time and in the right place; this could be care closer to home. Governance arrangements were clear and there was an integrated performance report to benchmark quality, operational and financial information. The trust identified quality priorities and could demonstrate progress. However, much of the data on risk and quality was at a high level and some risk issues, such as safeguarding and significant delays in PTS, needed a better focus. The leadership team of the service showed commitment, enthusiasm and passion to develop and continuously improve services. Most staff reported that the trust culture reflected an effective and responsive service rather than a target-driven organisation. Leadership at team level varied and the trust needed to improve this area to develop its strategic priorities.

Public engagement took place through a variety of means, such as liaison work, use of social media and trust membership. Patient feedback through surveys, interviews and liaison work, was being used to improve the service. Staff were positive about working for the trust. They said it was a friendly and positive place to work but not without its challenges: namely, managing tight resources against an increasing demand for services. Staff engagement was well developed although staff indicated the need for more ongoing dialogue about service changes. The trust had a highly innovative culture and staff were encouraged to suggest new ideas to improve service delivery. This was seen as important against a background of tightening resources, but also essential to develop services in response to the needs of patients. There were many examples of service improvements developed by the trust and the staff. The trust could demonstrate proactive and effective financial management to invest in new technology and service developments, and to ensure the sustainability of services. Cost improvement programmes were demonstrating savings and were monitored. Mitigating actions were identified to reduce the potential impact but the action taken on some of these needed to improve.

Vision and strategy for this service

Summary of findings

- The trust had a five-year strategy that would develop the service into more than a traditional one providing transport. The strategy intended for the trust to lead on the coordination of mobile healthcare services that would ensure that people would receive the right care at the right time and in the right place. The service would aim to guide patients around emergency and urgent care services, and improve the range and availability of services offered in each local area. This would include clinical assessment, signposting people to appropriate services, treating them in their own homes and, locally, improving pre-hospital care and taking people to an appropriate healthcare setting.
- The trust had identified the key challenges to improving patient care and supporting local systems to manage the rise in demand, within the context of tightening finances and increased competition. The strategy was developed in February 2014 and was quality driven. There were clear objectives that were regularly reviewed.
- Current developments to improve services included
  - better monitoring and refinement of staff rotas to more accurately and flexibly align capacity with overall demand;
  - implementing the electronic patient records system to personalise care and link 'special notes' (which detailed clinical information for patients with complex needs or risk information if there was a safety concern)from GPs and other health professionals to the electronic records;
  - modernising PTS with a single virtual computer-aided dispatch system, scheduling and electronic communication with road staff;
  - establishing a team to analyse the needs of frequent callers;
  - and implementing a tool to accurately predict emergencies in each dispatch area, based on modelling historical data and adding in factors such as weather or unforeseen events.
- The trusts' organisational values for 2014/15 aimed at delivering high performance through teamwork, innovation, professionalism (setting high standards) and caring. Its vision was encompassed in the strapline "Towards excellence – Saving lives and enabling you to get the care you need".
- Most staff we spoke with were not aware of the trust's overall vision and strategy but were aware of changes that were happening in their services, and all staff were aware of the values of the organisation. Some staff knew that there was information on the intranet that they could access. Staff in PTS, however had the least knowledge,
- Most staff were aware of, and showed, that they 'lived' the values of the organisation.

Summary of findings

Governance, risk management and quality measurement

- The trust governance structure was managed through the quality and safety committee, which reported to the board on clinical effectiveness , patient safety and patient experience. There were sub- committees to manage specific areas of governance, such as medicines management or serious incidents requiring investigation.
- The trust used internal quality indicators, mandated quality metrics and external reports, such as the Francis Inquiry, the Berwick Report and the Keogh review on Urgent care, to develop its strategy and quality account. An action plan had been produced. It focused on three priority areas based on clinical quality, patient safety and patient experience.
- The trust quality account 2013/14 showed a focus on priority areas around clinical quality, patient safety and patient experience. Improvements were noted for most areas, with work ongoing to achieve compliance where priorities had not been met (that is, promoting a patient safety culture and using the care bundle for patients who had had a heart attack).
- Many areas had team meetings and monthly operational performance meetings to review quality and operational issues. These reported to the trust's Level 2 meetings (operational leadership level) and then senior management meetings. This structure was not replicated in all areas and documented minutes of discussion and actions from these meetings did not consistently identify the action taken in response to risks and performance issues.
- Quality, operational and financial data was monitored through an integrated performance report. This included information on areas that could be benchmarked with other ambulance services and performance against national targets. The report was being developed so that the trust could focus on localities and use a predictive model of risk based on local information. It was not always clear what specific action was being taken in an area identified as a risk but not included as an indicator for example, under safeguarding or significant delays in PTS.
- The corporate risk register included clinical, organisational and financial risks, and used likelihood and severity criteria for risks to develop a rating score. There were mitigating actions and controls. The register identified high-level risks for an ambulance trust and contributed to the board's assurance framework, which was used as a strategic predictive tool. Some risks, however, based on the trust's actual delivery of services (such as safeguarding issues, medicines management, incident reporting or infection control issues) had not been identified or assessed.

- The trust worked in a complex environment and there was an array of data collected. Action was being taken to ensure that the data was being centralised for use, but data was not always used effectively when it was collected.
- Contracts were monitored effectively for private providers in emergency care but this was inconsistent in PTS and some security and employment checks had not been done for volunteers.
- The trust monitored progress against the trust's strategy and quality account every two months and a risks summit was held once a year to review progress. The board assurance framework was monitored at every board meeting.

Leadership of service

- The trust leadership was relatively stable. The Chief Executive and key directors had been in post for a number of years. The Director of Patient Care joined the trust in June 2013 and the Chief Operating Officer in July 2013. There was a new non-executive director in January 2014.
- The leadership team showed commitment, enthusiasm and passion to develop services. They were rising to the challenge of continuous quality improvement alongside a rising demand for services and tightening budgets and resources. Governors of the trust were invited to sit on specific groups (for example, the patient experience and clinical review groups). The board and governors had had strategy sessions so that the board could obtain the views of governors about the strategic direction of the trust. The trust undertook annual effectiveness reviews to ensure that the governors were delivering their statutory duties
- Leaders were supported to develop their roles, for example, the Medical Director told us that he was taking part in a national leadership training programme and non-executive directors told us they were supported with specific learning and development opportunities to fulfil their role. The governors told us they were well supported by the trust leadership and had received relevant training to fulfil their roles.
- The trust had a team structure to make 'leadership' visible and clear at locality level, and to lead the service changes identified in the strategy. There had been three leadership days in the trust to support team leaders, area managers and operational leads.
- The NHS Staff Survey 2013 identified that the trust was similar to other trusts for the percentage of staff reporting good communication between senior management and staff. It was understood that the diverse nature and spread of the workforce

made visibility difficult. Staff reported that they knew who their team leaders were; they also knew the senior management team and the leadership team of the trust although. Many staff said the Chief Executive was visible.

- The leadership team was clear about the strategic direction of the trust, but messages were being diluted through the operational tiers of the organisation. Staff were not always aware of the reasons for some changes, or the opportunities available to them as employees. When the reasons were clearer (such as when resources were diverted to meet demand), staff asked for engagement and communication to be more of a dialogue, rather than messages sent down from the top.
- Team leaders were supported with specific training and development opportunities. The trust acknowledged that there was variation in the leadership skills of some team leaders. This was particularly evident in PTS where many team leaders needed more support. The capacity of leaders to deal with specific areas (safeguarding, medicines management and infection control) also varied.
- The trust had a clinical lead in mental health and learning disability. This role was unique among ambulance trusts. The lead had established a national mental health group for ambulance trusts, and worked with partner agencies such as the Royal College of Psychiatrists and the College of Policing.

Culture within the service

- We held focus groups for staff but these were not well attended. We spent time seeking out staff on duty, so as to be able to talk to as many as possible. Some staff reflected that they were too busy to attend the focus groups; others were unaware that they were being held. A few told us that it might have been more helpful to have held them in non-trust locations.
- Most staff were very positive about the service they provided. They wore their uniforms with pride, acknowledging that their service was held in high esteem by the public. Many were concerned about the challenges of meeting the rising demand for services, and the impact these were having on their working hours, terms and conditions, and roles. Staff indicated, and we observed, that morale was low in some areas. However, many were positive and resilient because of the critical nature of the service they provided. They 'lived' their values, which was "Towards excellence – Saving lives and enabling you to get the care you need".

- The trust had identified a number of services to support staff, for example, a confidential counselling service and trauma risk management [TRiM] service to support staff that had dealt with a distressing or traumatic incident, and to assess their need for further intervention.
- The leadership team was clear that the service it provided was not target driven but about the effectiveness of response. Many staff at all levels identified that the culture was driven first by quality, which was not sacrificed for targets or finance. There was some concern, however, about the pressure to meet targets in the northern operations centres.
- Staff had a sense of collective responsibility and were focused on care pathways for patients. As an organisation, however, there was a north/south divide in management culture with staff reporting more support and understanding from managers in the south, particularly in the emergency control centres. There was also a distinct difference within PTS, where staff considered they were the 'Cinderella' service of the trust.
- The trust did a staff survey in 2013/14 using the Manchester Patient Safety Framework (MaPSaf). This is a system where an organisation can have its current patient safety culture evaluated by its employees, and responses are categorised along a scale from 'pathological' (such as blame and denial of risk) to 'generative', where there is anticipation, response and learning from risk. The trust was still analysing this information. Most staff told us they would raise concerns about patient safety, but many also commented that they did not have formal opportunities (such as in regular team meetings) to do this.
- As an ambulance trust, there was a wealth of stakeholders from commissioners, acute hospitals, local authorities and local Healthwatch groups. These stakeholders identified that the trust was an open and transparent organisation, worked well in partnership and was increasingly responsive to concerns. It was acknowledged that the trust managed difficult circumstances well.

Staff engagement

- The leadership team undertook walkarounds to engage with staff and promote the culture of safety. The team discussed issues with staff and did environmental checks. Areas for action were reported to the trust's quality and safety committee for monitoring. Operational and clinical leads undertook walkarounds focusing on environmental standards and health and safety.
- The trust had produced two documents with the input and direction of staff. These were called 'Room for Improvement'

and 'What SCAS Does Well'. The documents identified where the trust needed to improve, and the innovation and improvement work undertaken by the staff and leadership team over the past year. The documents were produced in preparation of the Care Quality Commission inspection, but the process and outcome had proved popular with staff and the trust intended to continue to produce them.

- The trust was above average in 14 (50%) of the 28 questions in the NHS Staff Survey 2013. It was in the top 20% of trusts for staff engagement overall and for questions on support from immediate managers; appraisal; lower levels of physical violence from staff; and bullying and abuse from the public. It was in the bottom 20% of trusts for the availability of hand-washing materials; job training; reporting errors, near misses and incidents; effective teamworking; and equal opportunities to career progression. The trust scores had deteriorated compared to 2012 on work related stress, equal opportunities to progress, staff appraisal and motivation at work. Trust scores had improved compared to 2012 on equality and diversity training and health and safety training.
- The trust used a variety of means to support good staff communication (for example, the Chief Executive's blogs, newsletters, screens at control centres and electronic communications). Many staff told us communication was good considering the logistical difficulties. However, the reliance on electronic communication was a concern for those who had little access to computers.
- All policies and procedures were signed off with the joint consultative committee and staff groups, and the trust had good relationships with its staff. Staff told us that there had been effective engagement around key changes, such as those to shifts and rotas, and working unsociable hours, and the decision that the new emergency care assistant should work alongside paramedics rather than technicians. However, as the changes had progressed and their impact was clearer, the staff wanted ongoing engagement and dialogue on these issues.
- The team structure was valued by staff. They identified that it was improving effective teamworking, and that clinical mentoring was now embedded within teams.
- The trust required a vehicle capacity of 135% to take account of repairs and maintenance, but it was running at 128%. It was replacing 32 dual crew ambulances in 2014, 22 were replaced routinely (which happened every 7 years); 4 were replaced due to an increase in demand; 6 were replacing damaged vehicles. Sixty-three new PTS vehicles were to be purchased as part of the new contract for the PTS in Hampshire starting on 1 October

2014. Staff were engaged in the procurement, selection and layout of vehicles, as well as the selection of equipment, through the equipment and vehicle working group and the recently established vehicle planning and procurement group.

- There was an annual award ceremony called the 'AMBIES'. Staff had the opportunity to nominate individuals who showed dedication and commitment in their work every day. There was a judging panel and staff were considered against the core values of the organisation, which were professionalism, caring and compassion, teamwork, innovation, taking responsibility, a 'can do' attitude and demonstrating pride. The AMBIES covered all staff groups although there was no defined category for staff working in PTS

Public engagement

- The trust board heard patients' stories and concerns at alternate board meetings. These helped the board to identify where changes could be made to improve services.
- The Chief Executive was the chair of the trust's patient experience group and the governors of the trust identified that they had a major public engagement role and lead on these issues. The trust had over 12,000 foundation trust members gathered through a sustained campaign to increase support and awareness about the trust.
- The trust had increased its number of community first responders and co-responders (with medical students, fire services personnel, the military and the police), recognising that it needed to maintain the level of services (and increase exposure to patients) through co-production. The trust had approximately 946 community first responders and 349 co-responders and was working towards 10 to 15,000 people based on the 'Seattle Model', in which everyone was trained in cardio-pulmonary resuscitation as a community.
- The trust had identified effective public engagement as an important way to improve patient care and had undertaken a number of initiatives and public education work. These included roadshows, patient forums and meetings with local community groups; health events with private companies; a 'Name the Bear' competition in schools to improve children's awareness of 999; a fall prevention scheme in residential homes and day centres; and educational talks to secondary schools, colleges and universities. Twitter and other social media were also used.
- The trust provided a service on Friday and Saturday nights in the city centres of Portsmouth (Safe Place) and Southampton (ICE Bus). This offered support, first aid and transfer to hospital

(if needed) for the public enjoying a night out. The service had been set up in partnership with other organisations, such as the Hampshire Police, the local councils, volunteers and local street pastors.

- The trust had started a campaign to minimise the misuse of 999. To directly combat hoax and inappropriate calls, it was asking members of the public to only call 999 for emergencies and life-threatening situations. The campaign provided information and a hard-hitting video to the public that illustrated how lives can be put at risk when 999 is called inappropriately.
- Patient feedback through surveys, interviews and liaison work, was being used to improve the service. The PTS in particular undertook regular surveys and there were good examples to demonstrate service improvement in response to concerns. For example, the new fleet of vehicles and renal patient's project to improve drop off and pick up times.

Innovation, improvement and sustainability

- The trust had a highly innovative culture and staff were encouraged to suggest new ideas to improve service delivery. This was seen as important against a background of tightening resources, but also essential to develop services in response to the needs of patients. There were many examples of service improvements developed by the trust and the staff.
- The trust had produced a report on its innovation in the past year or so. This was called 'What We Do Well' and gave many examples of where its action and those of its staff had improved services. This included the automatic external defibrillator (AED) locator mobile phone application, a trauma triage tool, the 24-hour labour line and blood transfusions on the air ambulance.
- The trust had analysed the factors that affected its clinical, operational and financial sustainability, such as recruitment, reconfiguration of acute services, a growth in demand for services and competition from other providers. Mitigating actions were introduced and monitored.
- The trust, as a foundation trust, is regulated by Monitor. As part of its regulatory regime, Monitor assigns risk ratings to each foundation trust. In 2013/14, the trust had a four-risk rating (no evidence of concerns) for continuity of service, and a green-risk rating (no evidence of concerns) for governance. Its annual business plans were rated amber/green.
- The trust could demonstrate proactive and effective financial management to invest in new technology and service developments, and ensure the sustainability of services.

Budgets were pre-planned and resources identified on a monthly basis. Data was being used to identify where resources may need to be diverted, for example, to areas of low performance.

- The trust identified that any financial surplus should be used to bolster performance, and that being a foundation trust and providing a quality service had helped it to win tenders. There was a large exit fee if contracts were lost, so the trust was working to maintain and increase the number of contracts won for services. A surplus of £0.5 million in 2012/13 had been used to improve quality. The trust had also secured a £7 million capital loan over 5 years to secure its financial position and make the necessary investments. In 2013/14, the trust had invested in its development and change programme, which included investment in IT, the electronic patient record system and a university programme to train future paramedics.
- The trust was financially stable in its current configuration. It had a surplus of £1.5 million in 2013/14 and a year end cash balance of £8.3 million, which it used to pay off £1 million of the capital loan.
- The trust was investing to improve effectiveness (for example, with private providers to improve response times due to the shortage of paramedics, by supporting 30 university paramedic places and by replacing the vehicle fleet with high-quality vehicles that would last longer). Some investments were still being rolled out but were produced some inequalities in the interim (for example, staff in the south had protected learning time but this had yet to happen in the north).
- The trust had cost improvement programme targets of £6.2 million in 2013/14 and these were achieved. Quality impact assessments were undertaken, and the Director of Patient Care and the Medical Director approved planned projects to ensure that there was no detrimental impact on quality. The trust had forecasted a £0.5 million surplus this year. Each cost improvement programme was monitored in an integrated performance report and given a risk rating according to its potential impact on service quality and delivery; mitigating actions were identified to reduce the potential impact but the action taken on some of these needed to improve. For example, arrangements for deep clean had changed from 8 to 12 weeks but some vehicles were not being cleaned at 12 weeks; and in PTS there was recruitment of band 2 assistants instead of band 3 but monitoring of complaints and incidents needed to improve.

Responsibilities under the Civil Contingencies Act 2004

Summary of findings

- The ambulance service was classified as a Category 1 responder under the Civil Contingencies Act 2004. **Category 1 responders** are the organisations at the core of an emergency response. The trust would need to assess the risk of emergencies occurring and use this to inform contingency planning. The service had arrangements in place to inform the public about civil protection matters and to warn, inform and advise the public in the event of an emergency.
- The trust had a command and control policy whereby a bronze, silver or gold command structure would carry out an authoritative command in the event of a major incident or emergency as described in Civil Contingencies Act 2004. Senior staff were aware of the categories of response (bronze, silver or gold) and the actions entailed within this in the event of a major incident.
- The trust is a member of local resilience forums (LRFs) across South Central area. Within the Thames Valley region, for example, the LRF is chaired by Thames Valley Police. There are a series of working groups that deliver the LRF's strategic goals and discharge the duties specified in the Act.
- The trust had worked with the Joint Emergency Service Interoperability Programme (JESIP). This was a partnership set up to improve the ways in which police, fire and ambulance services worked together at major and complex incidents. Staff received joint training with these other services at varying levels, depending on their role within the trust.
- The trust participated in emergency plans and rehearsals in 2014 relating to a Chemical, Biological, Radioactivity and Nuclear (CBRN) incident scenario.

Outstanding practice and areas for improvement

Outstanding practice

- We observed many examples where staff demonstrated outstanding care and compassion to patients despite sometimes working in very difficult and pressured environments. Staff "lived" the values of the trust "Towards excellence – Saving lives and enabling you to get the care you need".
- Representatives of the trust attended local youth organisation meetings, village fetes and school assemblies. The trust had developed a child-friendly first-aid book printed specially for schools and the wider local community.
- The trust provided an innovative learning resource to their frontline staff using the educational resource centre and film centre at Bracknell. The staff were involved in making films which supported learning around new guidelines from the Joint Royal Colleges Ambulance Liaison Committee (JRCALC).
- The trust had introduced a lifesaving automatic external defibrillator (AED) locator mobile phone application. By using GPS, this app locates the nearest AED in the event of a cardiac arrest. In total, the app identified over 800 AEDs across four counties.
- A new initiative was the introduction of a 'Simbulance': a large command vehicle fully equipped with simulation learning activities. It was an innovative virtual classroom facility in that it gave ambulance staff the opportunity to experience realistic medical situations inside an ambulance saloon.
- Operation centres had direct access to electronic information held by community services, including GPs. This meant that the staff could access up-to-date information about patients (for example, details of their current medication).
- Trauma risk management (TRiM) was in place to provide confidential support to staff who may have been affected by traumatic incidents or conditions. Staff were assessed 3 days after a traumatic event and again after 28 days. Thirty-two TRiM practitioners gave peer support and advice, and there was also an external counselling service. The early intervention had both reduced sickness absence and improved the welfare of staff.
- The Helicopter Emergency Medical Services (HEMS) showed innovative practices and learning taken from combat zones. The team now had the equipment and skills to give blood transfusions and perform ultrasound and blood gas tests. In some circumstances, this bypassed or reduced the time a patient had to spend in the accident and emergency (A&E) department, and meant they could receive treatment immediately on arrival at the hospital. HEMS was also planning to introduce a night service, so it would operate 24 hours every day.
- The introduction of a midwife to the clinical support desk (CSD) in the Southern House emergency operation centre had improved the outcomes for expectant mothers and their new babies. The 24-hour labour line started as a pilot in May 2014. It gave women in labour access to advice and support, whereas the 'professional's line' enabled medical professionals to speak to a midwife 24/7 during a woman's labour and birth. The service had over 1,600 calls in the first eight weeks.
- The trust provided a service on Friday and Saturday nights in the city centres of Portsmouth (Safe Place) and Southampton (ICE Bus) to provide support, first aid and transfer to hospital if required for the public enjoying a night out. This had been set up in partnership with other organisations such as the Hampshire Police, the local council, volunteers and the local street pastors
- The trust had a clinical lead in mental health and learning disability. This role was unique among ambulance trusts. The lead had established a national mental health group for ambulance trusts, and worked with partner agencies such as the Royal College of Psychiatrists and the College of Policing. The introduction of mental health practitioners into the EOC was supporting operational practice and care to mental health patients.
- The trust had worked in partnership with Oxford Brookes University to provide staff with extra opportunities to develop their careers by becoming a paramedic, and to counter the national shortage of paramedics. A foundation degree course was to start in January 2015. The training covered an 18-month

Outstanding practice and areas for improvement

period and included in-hours training. The trust's investment had been significant in terms of the time taken to negotiate the resources and facilities for the programme and the release of staff from work duties.

Areas for improvement

Action the trust MUST take to improve

The trust must ensure that:

- Staff uptake of statutory and mandatory training meets trust targets.
- Staff in EOC and PTS understand the Mental Capacity Act 2005.
- All EOC and PTS staff receive safeguarding training to the required level so that they are able to recognise signs of abuse and ensure there are robust arrangement in place for staff to report concerns within the agreed timescale.
- Emergency call takers answer calls, and the emergency medical dispatchers dispatch an ambulance within target times.

Action the location SHOULD take to improve

The trust should ensure that:

- Procedures for incident reporting continue to improve and staff in EOC and PTS have appropriate training and are able to report incidents directly. There must be timely investigation of incidents, staff must receive feedback and learning must be shared.
- The risks around IT vulnerability in the EOC and PTS are appropriately managed.
- Infection control practices are followed and ambulance stations (resource centres) and vehicles are effectively cleaned and deep cleaned.
- There are suitable arrangements to ensure that equipment is regularly checked and fit for purpose.
- Staff are aware of the appropriate steps to take to reduce the risks to patients left unattended in PTS ambulances because of staff working alone.
- Appropriate equipment is available in all areas for the transport of children in PTS and this continues to be rolled out for emergency transport.
- Volunteer drivers in PTS have the appropriate safety and employment checks before working within the service.
- The trust to continue to work with partners and ensure the planning and scheduling of PTS improve to prevent delays and missed appointments, and to reduce the impact on the clinical care, treatment and welfare of patients.
- The governance and security arrangements for the management of controlled drugs need to be improved in Hampshire.
- Recruitment of staff in all areas continues and there are specific staff retention plans in response to identified reasons as to why staff leave.
- Staff in PTS receive appropriate training on dementia care, learning disabilities and all staff continue to received training in mental health conditions.
- Anticipated resource and capacity risks in PTS continue to be appropriately identified, assessed and managed.
- Pain relief continues to be appropriately administered for patients with ST segment elevation myocardial infarction (STEMI) and pain relief for children is effectively monitored.
- Continue to work with acute trusts to review protocols for the non- critical transfer of hospital patients.
- There is better coordination of care between providers, in particular for cardiac and stroke services in Buckinghamshire and mental health services.
- Complaints are responded to within the trust's target of 25 days. All staff in EOC and PTS receive feedback from complaints and learning is shared.
- Operations staff in PTS are appropriately resourced to be able to answer telephone calls.
- Patients (or people acting on their behalf) using the PTS are made of aware of how to complain or send compliments about the service.
- Staff in PTS have regular supervision and the trust should raise awareness amongst staff about the professional and career development opportunities within the trust.

Outstanding practice and areas for improvement

- The formal structure of team meetings is in place for all staff groups and staff are given the opportunity to attend, share information and raise issues or concerns.
- Staff have a better understanding of the trust's vision and strategy as it applies to their service in EOC and PTS and staff communication continues around service changes and development.
- Leadership in the northern EOC and PTS supports staff and action is taken to improve staff morale where this is low.
- Staff in PTS receive feedback from the completed patient satisfaction surveys.
- There are better governance arrangements within EOC and PTS to share information with staff, so that staff can raise concerns and risks are appropriately identified, assessed and managed.
- There are better governance arrangements for private providers in PTS and make ready services.