East of England Ambulance Service NHS Trust

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

The East of England Ambulance Service NHS Trust (EEAST) is one of 10 ambulance trusts in England providing emergency medical services to Bedfordshire, Cambridgeshire, Essex, Hertfordshire, Norfolk and Suffolk; an area which has a population of around 6 million people over 7500 square miles. The trust employs around 4000 staff and 1500 volunteers who are based at more than 130 sites including ambulance stations, emergency operations centres (EOCS) and support offices across the East of England.

The main role of EEAST is to respond to emergency 999 calls, 24 hours a day, 365 days a year. 999 calls are received by the emergency operation centres (EOC), where clinical advice is provided and emergency vehicles are dispatched if required. Other services provided by EEAST include patient transport services (PTS) for non-emergency patients between community provider locations or their home address and resilience services which includes the Hazardous Area Response Team (HART).

Every day EEAST receives around 2600 calls from members of the public dialling 999. The service provided by EEAST is commissioned by 19 separate Clinical Commissioning Groups with one of these taking the role as co-ordinating commissioner.

Our announced inspection of EEAST took place between 4th and 8th April 2016 with unannounced inspections on 19th April 2016. We carried out this inspection as part of the CQC's comprehensive inspection programme.

We inspected three core services:

• Emergency Operations Centres

• Urgent and Emergency Care including the Hazardous Area Response Team (HART).

• Patient Transport Services

Our key findings were as follows:

- The trust was under significant pressure and was failing to meet performance standards and targets for response to emergency calls.
- The chief executive had been in post for approximately 6 months and was developing new models of care and new strategies to address performance and recruitment concerns. These were yet to reach fruition.
- Resources were frequently unavailable as they were unable to hand over patients to acute providers in a timely way. This occurred throughout or inspection.
- There was ongoing significant issues in recruitment of paramedics across the trust with particular 'hotspots' in certain areas including Norfolk and Cambridgeshire.
- The trust had identified new models of workforce development and new roles to support the service. This was in the process of consultation and implementation during our inspection.
- There was variation across the trust in many areas including governance, medicines management and infection control.
- The emergency operations centres were recruiting clinical staff into 'clinical hubs' to dramatically improve the number of patients treated over the telephone or signposted to more appropriate services.
- All staff were passionate about providing the best possible service to patients. We consistently observed staff to be caring and compassionate and concerned for the welfare of patients.
- There were low levels of mandatory training and many staff were not equipped with the skills to care for people living with dementia and mental health problems and a poor knowledge of the Mental Capacity Act 2005.

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

Importantly, the trust must:

- Improve performance and response times for emergency calls.
- Ensure that there are adequate numbers of suitable skilled and qualified staff to provide safe care and treatment
- Ensure staff are appropriately mentored and supported to carry out their role including appraisals.
- Ensure staff complete mandatory training (professional updates).

Summary of findings

- Ensure that incidents are reported consistently and learning fed back to staff.
- Ensure that all staff are aware of safeguarding procedures and there is a consistent approach to reporting safeguarding.
- Ensure that medicines management is consistent across the trust and that controlled medicines are stored and managed according to regulation and legislation.
- Ensure that all vehicles and equipment are appropriately cleaned and maintained.
- Ensure all staff are aware of their responsibilities under legislation including the Mental Capacity Act 2005.
- Ensure all staff are aware of their responsibility under Duty of Candour requirements.
- Ensure records are stored securely on vehicles.

In addition the trust should:

- The trust should consider how all risks associated with PTS can be captured and reviewed on the risk register.
- The trust should improve the numbers of patients offered hear and treat services.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to East of England Ambulance Service NHS Trust

East of England Ambulance Service NHS Trust (EEAST) covers the six counties of Bedfordshire, Cambridgeshire, Essex, Hertfordshire, Norfolk and Suffolk. This is an area which has a population of around 6 million people and covers approximately 7, 500 square miles. The trust employs around 4000 staff and 1500 volunteers. The trust was formed in 2006 following the amalgamation of 3 ambulance services.

EEAST provides an emergency service to respond to 999 calls; patient transport service (PTS) in various locations across the trust for non-emergency patients between community provider locations or their home address and emergency operation centres (EOC), where 999 calls were received, clinical advice is provided and emergency vehicles dispatched if needed. There is also a Hazardous Area Response Team (HART).

The trust serves an ethnically and geographically diverse population including rural, coastal and urban environments. There are areas of high deprivation in Essex, Bedfordshire and Norfolk.

We inspected EEAST as part of our announced comprehensive inspection programme. The trust is not a Foundation Trust and this inspection has not considered any application for Foundation Trust status.

As part of our inspection we visited trust premises including offices, training areas, fleet workshops, specialist units such as Hazardous Area Response Team (HART), ambulance stations and emergency operations centres. We also visited hospital and other health care locations to speak with patients and staff about their experiences of the ambulance service.

Our inspection team

Our inspection team was led by:

Chair: Daren Mochrie, Director of Service Delivery, Scottish Ambulance Service

Head of Hospital Inspections: Fiona Allinson, Care Quality Commission

East of England Ambulance Service was inspected by a team of 42 people including specialist advisors with a variety of backgrounds including at director level, paramedics, and consultant paramedics, emergency operations centre team leaders as well as CQC inspectors, inspection managers, a national professional advisor, two pharmacist inspectors, and inspection planner.

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 including Hazardous Area Response Team (HART).
- Patient Transport Services

Prior to the announced inspection, we reviewed a range of information that we held and asked other organisations to share what they knew about the trust.

These included the 19 clinical commissioning groups (CCGs), the Trust Development Authority/ NHS Improvement, NHS England and local Healthwatch

Summary of findings

organisations through the lead Healthwatch in Suffolk as well as the local branch of Unison at their request. We held a week of focus groups for staff ahead of the inspection which was attended by more than 150 staff.

We held interviews with a range of staff in the service and spoke with staff individually as requested. We talked with staff from acute hospitals who used the service provided by the trust. We spoke with patients and observed how they were being cared for. We also talked with carers and/or family members and reviewed patients' treatment records. We carried out the announced inspection visit between 4th and 8th April 2016 with unannounced inspections on 19th April 2016.

What people who use the trust's services say

The CQC 'Hear and Treat' Survey for 2013-2014 which looked at the experiences of over 2,900 people who called an ambulance service in December 2013 or January 2014. Responses were received from 234 patients at East of England Ambulance Service NHS Trust. This survey demonstrated that the trust was performing about the same as other trusts in England. The trust scored 9/10 which is better than the national average when arranging and delivering a call back to patients waiting for an ambulance or other assistance.

Local Healthwatch groups told us that generally the feedback from patients and relatives who used the service were positive.

Patients' views during inspection

During the inspection we spoke with a number of patients across all services. Patients and their loved ones also contact the CQC by telephone and wrote to us before, during and after our inspection. The comments we received were mostly positive. The main concerns raised with us were about delayed vehicle responses to emergency patients.

Facts and data about this trust

Revenue (Apr 15 to Mar 16)

Income £246m

Surplus £998k

Demographics:

The area is made up of:

- more than 5.9 million people
- 7,500 square miles
- 19 CCGs
- 17 acute trusts
- one health authority.

In 2014/15 the Trust:

- received 964,917 emergency calls
- handled 464,194 non-emergency patient journeys
- delivered primary care services to more than 450,000 patients

Resources and teams include:

- 357 frontline ambulances
- 201 marked response cars
- 164 non-emergency ambulances (Patient transport service vehicles)
- 52 HART/major incident/resilience vehicles
- more than 130 sites
- three emergency operations centres (EOCs)
- more than 4,000 staff and 1,500 volunteers.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? We rated safe as Requires Improvement because: • Incident reporting methods were inconsistent and not all staff received feedback about incidents. • Mandatory training attendance did not meet the trusts target, including basic life support and safeguarding. • Staff did not manage medication in line with the trust policy and medicines were not always stored safely or audited effectively. • Although processes were in place for responding to major incidents, many staff had not received training. • Staff experienced excessive hand-over times at some acute hospitals which drained the trusts resources and reduced the ability to meet the service demand. However we also found that: • Staff knew safeguarding processes and reported concerns appropriately. • The environments were visibly clean and well maintained and were conducive to a good working environment. • There were appropriate methods and processes to respond and manage risks to patients. **Duty of Candour** • 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. Serious Incident investigations showed that the duty was considered as part of the investigation and most managers were aware of the duty. • However not all staff were unaware of the duty of candour responsibilities but were able to describe an open and honest culture. • The senior team were aware of the duty of candour requirements and described meetings with patients and their relatives who had made a complaint. **Safeguarding**	**Requires improvement** 

Summary of findings

- There were comprehensive policies for safeguarding children, young people and adults at risk and staff were aware of these policies and knew how to raise safeguarding concerns through a single point of contact (SPOC) dedicated phone line.
- The trust has a safeguarding committee that meets on a quarterly basis. Representatives from across the trust staff team are present at the meeting and they discuss key issues, for example, resources, training, and the outcomes of serious incident reviews.
- All staff had received safeguarding level 2 training as part of their induction. All staff we spoke with told us they had had no refresher training for safeguarding as part of professional updates.
- There were multiple arrangements in place to manage safeguarding referrals based on the six counties in which East of England Ambulance Service (EEAST) provides a service.
- There was a lack of consistency regarding how staff reported safeguarding incidents.

Incidents

- Treatment delays meeting the SI criteria accounted for 34% of serious incidents and 31% of SI related to the suboptimal care of deteriorating patients.
- Where serious incidents occurred a root cause analysis (RCA) was completed, lessons learned, and appropriate future actions identified, including improving information governance training.
- Incident reporting methods were inconsistent and not all staff received feedback about incidents.
- Some staff we spoke with told us they felt there was a reluctance to report incidents amongst PTS staff due to being frightened of repercussions and that they would be questioned over the reported incident in an accusatory way. This was not replicated across the rest of the service.

Staffing

- The trust was experiencing difficulties recruiting to paramedic vacancies. The CEO was exploring new models of care to provide appropriate resources to meet the needs of patients.
- During our inspection of the trust in April 2016, we found the trust had recruited 400 new student paramedics to its service. This meant that in the majority of cases ambulance crews had a student member as part of their team.

Summary of findings

- The vacancy rate was 6.3% at Norwich EOC, 2.4% at Bedford EOC and -1.3% at Chelmsford meaning Chelmsford EOC had more staff than they were planned for in December 2015.The highest vacancies were for clinical staff for the clinical support desk and administrative staff.
- The overall vacancy rate across PTS was 15.4% (57 whole time equivalent). The staff group with the highest vacancy rate was managers and administrative (58.8%) and the lowest vacancy rate was ACAs (5.9%).
- For the Emergency Care Operations Norfolk, Suffolk, and Cambridgeshire had a vacancy rate of 3.24%. Essex had the highest vacancy rate across the trust of 14.1%.
- Staff were dedicated to their roles however, staff reported regularly working more hours than their shift allocation. This was having an impact on morale and some staff told us they were looking to leave the service due to frustrations over workloads and working hours.
- Staff essential education or mandatory training, was not always undertaken because of operational pressures and rates of completion did not meet trust targets.

Are services at this trust effective?

Requires improvement

We rated effective as Requires Improvement because:

- Emergency calls to East of England Ambulance Service (EEAST), which were immediately life threatening such as cardiac arrest and termed Red 1 were below the national target of 75%. Data for April 2016 showed the trust as the fifth of ten performing ambulance services in NHS with responses within target at 73%.
- For Red 2 calls, the trust failed to reach the national target of 75% five times between July 2014 and January 2016. Data for April 2016 showed the trust as the eighth of ten performing ambulance services in the NHS with responses within target at 63%.
- Prolonged delays at some acute hospital emergency departments reduced the capacity of front line staff to respond to patient's needs.
- We were not assured sufficient training was in place to support staff or that supervision and appraisals were undertaken in order to provide staff effective guidance and training opportunities.
- Most staff we spoke with did not fully understand their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS).

Summary of findings

- There were no methods in place to monitor staff performance within the PTS service.
- There were some delays in sharing information relating to patients and their transport needs due to communication devices being unreliable.

However we also found:

- EEAST followed both National Institute for Health and Care Excellence (NICE) and Joint Royal Colleges Ambulance Liaison Committee (JRCALC) clinical practice guidelines and had access to a clinical advice team when necessary although this was sometimes not available in a timely manner.
- Front line staff worked effectively and professionally with other healthcare providers to comprehensively meet patient's needs.
- There was an ongoing programme of local and national clinical audit within the EOC's.
- Calls were answered promptly for almost all patients (greater than 99%).
- Good relationships were in place with local healthcare providers.

Evidence based care and treatment

- Staff carried a copy of the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidance and referred to it in their assessment and documentation of patient care. We carried out vehicle checks on 12 emergency vehicles. Care-bundle or pathway information was available in all the vehicles outlining the accepted steps required for patients who were experiencing for example, a stroke, heart attack, or asthma.
- Notice boards in most ambulance stations had specific areas dedicated to providing staff with clinical updates, these included care pathways, latest audit results and ambulance care quality indicators (ACQI).
- The EOC's used AMPDS to assess and prioritise emergency calls. The system was regularly updated including changes to national guidance or protocols and procedures in their management of emergency medical conditions. EEAST were using the most up-to-date version (12.2) of the protocols.
- Eligibility for patient transport reflected Department of Health guidelines and was monitored by the control centre staff at point of booking.

Patient outcomes

- Information about peoples care and treatment that used this service was routinely collected and monitored to establish if intended outcomes were being achieved in line with commissioners' requirements.
- Key performance indicators (KPIs) were used to establish whether intended outcomes were being achieved. KPIs were set by the various local commissioners in line with national guidelines and in agreement with the trust; this did mean that there were some variations in requirements by contract. Data suggested that the PTS service met their KPI's.
- Trust outcomes for patients having a return of spontaneous circulation (ROSC) at the time of arrival at a hospital following cardiac arrest were improving.
- Between April 2015 and November 2015, patient outcomes for acute ST-elevation myocardial infarction (STEMI) and proportion of stroke patients receiving thrombolysis in East Suffolk generally met the targets set. However, there was a downward trend with October and November 2015.

Multidisciplinary working

- We observed that handovers between EEAST ambulance staff and hospitals staff were extremely professional. Information shared regarding the patients' needs was comprehensive. Written records used for the handover were of a very good quality, reflected the patient's initial diagnosis, and enabled the staff to agree the most appropriate care pathway on handover. Hospital staff told us that EEAST staff were extremely professional and easy to work with when bringing patients into their department.
- Staff who "see and treat" patients were referring them to appropriate alternative providers of health or social care as required.
- There was positive engagement between staff in the clinical hub and call handlers and dispatchers. Each recognised the skills of the other and worked together to provide positive patient engagement.
- There were clear processes in place for dealing with other emergency services and agencies. We observed an incidence of this and that EOC staff worked well with the fire service to manage an appropriate response to a complex emergency.
- PTS staff were in regular contact with clinics and telephoned ahead if a patients was going to be late for an appointment.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

Summary of findings

- Patients were supported to make decision. We observed staff asking for patients' verbal consent for all interventions, including use of the winch to load wheelchairs and the use of restraints such as seatbelts and chair fixing equipment. Ambulance crews were aware of the importance of obtaining consent from patients who were conscious and able to do so before giving any form of care and treatment to them.
- The trust provided staff training performance data on the Mental Capacity Act 2005 (MCA) across Cambridgeshire, which showed the number of staff who had received training between 2015 and 2016, was low.
- The majority of staff we spoke with lacked a knowledge or understanding of the Mental Capacity Act (MCA) or Deprivation of Liberty Safeguards (DoLS). Staff told us they received very brief training in this area but did not feel it was sufficient to ensure they were fully confident in this topic.
- A knowledge booklet was on the majority of PTS vehicles that contained information relating to MCA
- Ambulance crews that attended a patient with mental health needs in Cambridge carried out a risk assessment of the situation and if necessary could request the police for assistance at the scene if a patient was or may become aggressive or likely to cause themselves or others harm.

Are services at this trust caring?

Outstanding ☆

We rated caring as Outstanding because:

- All staff treated patients with compassion and respect whilst promoting their dignity and respecting their individual needs.
- We observed patients being involved in their care and treatment throughout our inspection. Ambulance crews explained what they were going to do and why, before treatment was given and ensured the patient understood fully what was going to happen.
- We saw several examples of staff acting with the utmost professionalism and supporting patients and the public in the most trying of circumstances to provide positive outcomes for patients.
- EOC staff always ensured that patients or the public understood what they were being told and kept communication open throughout calls.
- PTS staff showed an awareness of the importance of providing emotional support to patients during difficult times, including developing positive relationships with regular patients who were undergoing major healthcare treatments.

Summary of findings

- Feedback from people, who use the service, and those close to them, was largely positive about the way staff treat people.
- Patients told us they felt supported and encouraged to be independent and make choices in relation to their care.

Compassionate care

- We observed positive interactions between staff and patients as they prepared for their journey. Staff ensured patients had with them all that was required for the appointment as well as keys to get back into their home on return and snacks if necessary.
- We observed some exceptionally caring practice from patient facing crews, including stopping the vehicle to allow a patient to have a drink just before their allocated nil by mouth time began, and also a patient who was extremely anxious about her legs being on show and staff remembering this from previous journeys and taking the time prior to leave their address to ensure they were covered appropriately.
- During each patient contact crews introduced themselves by name and asked patient what they would like to be called.
- We observed patients being involved in their care and treatment throughout our inspection. Ambulance crews explained what they were going to do and why, before treatment was given and ensured the patient understood fully what was going to happen. If the patient or family members required further explanations, the ambulance crew gave these in a timely and appropriate manner.
- In all of the 32 calls we listened to in the EOC, staff were unfalteringly polite and respectful, even when on occasion they were verbally challenged by members of the public for delays in getting resources to the call.
- Healthwatch Suffolk provided feedback to us before the inspection. Almost all feedback about staff working for the ambulance service was extremely positive and remarked how kind and caring staff were from call through to the team who responded.

Understanding and involvement of patients and those close to them

- We observed many occasions when staff ensured the person they were talking to understood what was being said, they reported ley information and let the person ask questions. They understood that people calling in an emergency don't like 'quiet calls' and as such, call handlers kept talking to people, giving them information and asking them if they were ok.

- For some conditions such as cardiac arrest, the call handlers could give information to the person making the call so they could commence treatment before paramedics arrived.
- We observed patients being involved in their care and treatment throughout our inspection. Ambulance crews explained what they were going to do and why, before treatment was given and ensured the patient understood fully what was going to happen. If the patient or family members required further explanations, the ambulance crew gave these in a timely and appropriate manner. Patient and relative's opinions and preferences regarding treatment were taken into account by staff and adhered to where possible.
- Feedback from care homes and families was wholly positive in relation to the care that the PTS crews provide to their residents.

Emotional support

- PTS staff showed a respectful understanding of the impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff we spoke with and observed showed an excellent knowledge of using communication to support patients if they became distressed or upset.
- We observed that ambulance crews consistently reassured patients and providing emotional support whilst they were in their care. Routinely ambulance crewmembers crouched down to the eye level of patients on trolleys to talk to them and give reassurance.
- We observed an ambulance crew arranging for a friend of a patient to stay with the patient when they were leaving, as the crew were mindful of the patient's emotional wellbeing due to their mental health condition. Staff offered calm supportive treatment and non-confrontational advice in a non-judgemental way to the patient who was experiencing alcohol addiction.
- Crews showed empathy and compassion to patients and relatives. This was seen in the manner in which people were spoken to and treated. A hug for an emotionally distressed mother, handholding for nervous patients and contacting loved ones for support in the event of a sudden death.
- We observed and heard numerous examples of EOC staff providing emotional support to patients, relatives and members of the public phoning on their behalf. We also heard two outstanding examples of emotional support during our inspection.

Summary of findings

- On one occasion a member of the public called into to report a patient choking in the street who subsequently had a respiratory arrest. The call handlers system 'froze' and they reverted to a backup card system to support the member of the public. They delivered cardiopulmonary resuscitation advice in a calm and assertive manner whilst providing ongoing emotional support to the member of the public carrying out a difficult task. The resuscitation was successful and the call handler continued to provide emotional support to the member of the public until an ambulance arrived telling them they had done an excellent job and should be proud.

Are services at this trust responsive?

Requires improvement

We rated effective as Requires Improvement because:

- There was no coordinated training for staff in dementia awareness or mental health.
- The trust did not provide any training to staff to raise awareness and education for learning disabilities. Staff were unable to give any examples of meeting the needs of people with learning or physical disabilities.
- Staff were consistently concerned that they were not meeting needs of patients with mental health issues and we saw no care pathways or specific training or support for staff in this area.
- Frontline staff said that sometimes no vehicles were available to attend a 'red' call in a specific area, especially rural areas. This happened when ambulance crews were responding to other calls and delayed in handing over patients to accident and emergency department staff in acute hospitals. In such circumstances, a call would go out to all available ambulance crews in the area to assist.
- There were shortfalls in assisting communication with people who did not speak English.
- There were not documented procedures in place to advise staff what to do if there would be a delay in someone's care.

However we also found:

- There were examples of service planning to meet local needs including the increase in provision of hear and treat services and the strategic placement of hazardous area response teams.
- The EOC's met individual needs including using a variety of communication tools for callers, having processes in place for frequent callers and silent calls and providing welfare calls to patients who had waited longer than target time for resource.

- There were systems in place to try and manage the access and flow of calls and patients including 'intelligent conveying' which highlighted demand in local hospitals and transferred patients to areas with lower demand.
- The trust comprehensively managed complaints and ensure staff had opportunities to learn from when things went wrong without fear of retribution. Although learning from complaints was not well shared amongst PTS staff.
- The trust had developed a strong volunteer team to support the local community and staff had opportunities to pursue roles in the Eastern Anglian Air Ambulance (EAAA) and local community volunteer emergency response activities.

Service planning and delivery to meet the needs of local people

- At Chelmsford EOC the clinical hub managed to hear and treat approximately 40% of the calls they received though the trust only managed to transfer 6% of calls to hear and treat. The trust's ambition was to double this number by the end of 2016.
- Emergency and urgent care services were planned to meet the needs of individuals. This included falls cars, Medical First Responders, a 'see and treat' service and hazardous area response teams (HART) that provide 24-hour cover.
- Plans were in place to respond to any large influx of people into the region for special events such as festivals or motor racing events.
- The SOS bus operated in Colchester on Friday and Saturday nights to help with the night time economy, and managing those people who may be at risk or intoxicated.
- PTS provided non-emergency transport for patients who were unable to use public or other transport due to their medical condition. This included those attending hospital, outpatient clinics, being discharged from hospital wards or requiring treatment such as chemotherapy or renal dialysis. The service was meeting the demand for patient transport locally as reflected in the commissioning requirements.

Meeting people's individual needs

- Translation services were available for patients requiring this assistance with communication. We observed two occasions then this was required and found the translation service to be easily accessible.
- There was no coordinated training for staff in dementia awareness or mental health. This meant services delivered

might not take account of the needs of patients and callers living with dementia or mental health although some staff gave us examples of how they would communicate with patients living with dementia or mental health.

- A draft Dementia strategy was produced in December 2015, which set out the trust's aims for the next three years, but this has not yet been ratified. Only the more senior members of staff (Band 7 and above) were aware of this.
- The trust did not provide any training to staff to raise awareness and education for learning disabilities. Staff were unable to give any examples of meeting the needs of people with learning or physical disabilities.
- There were specific care plans for patients with complex needs. These were either built into the software or where person specific where the service knew of patients, particularly children, who had complex health and care, needs. For example, we saw one care plan in place for a child who required ventilation at home and who was prone to respiratory infections.
- East of England Ambulance Service (EEAST) staff routinely informed us that support for patients with mental health symptoms was poor and they had limited training to meet individual needs.

Access and flow

- The symptoms described by a caller in the call made to the emergency operations centre (EOC) determined how quickly an ambulance was sent to meet the patient's needs. Large areas of the county covered by East of England Ambulance Service (EEAST) were rural and the roads difficult to navigate due to farm traffic and the general road layouts.
- Frontline staff said that sometimes no vehicles were available to attend a 'red' call in a specific area, especially rural areas. This happened when ambulance crews were responding to other calls and were delayed in handing over patients to accident and emergency department staff in acute hospitals. In such circumstances, a call would go out to all available ambulance crews in the area to assist. The HALO's employed by the trust had made a difference in terms of improving flow rates; however, these had been removed in some areas of the trust as part of cost saving activities. Managers told us that the transient posts were instrumental in improving performance in access and flow and they were starting to see a negative impact on the service since their removal.
- Where possible people could access care and PTS transport at a time to suit them, in line with an appointment or clinic. Patients

or their representatives booked the service by telephone through the control centre. Those asked about the booking process said that they found it easy but that they were asked the same questions every time.
- Some crews would contact patients prior to their pick up to make sure they still required transport, this ensured only correct journeys were completed, however this was not common practice across the PTS and no SOP in place to support this.

Learning from complaints and concerns

- All staff was aware of the complaints process at the trust. Staff were able to describe the process of making a complaint and how to get information for patients if they should wish to complain. However, we found no details of the complaints process on any emergency vehicles. Staff told us that patients and families did not complain to them but would wait until later and then contact the Patient Advice and Liaison Service (PALS). However, staff informed us they would always give people who wanted to complain the correct phone numbers for EEAST complaints services.
- Complaints investigations held locally showed that complaints were properly investigated and learnings identified. Audit staff played a role in the investigation process and reviewed the calls which the complaint related to.
- The trust board meets bi-monthly and the board report contains an extensive section on both patient experience and complaints to include themes and patient stories. The trust board also receives anonymised case studies on a bi-monthly basis, which are published on the trust website.
- There is extensive guidance and literature on the trusts website on how to contact the ambulance service, how to raise a complaint, concern, comment, or compliment (including access to the Trusts Complaints Policy), and how to request advice or information. The information detailed on the website is available in a variety of formats including multiple languages and easy read formats. The website itself also has the 'Read Aloud' function, which enables members of the public to listen to the information contained on the trust website.
- Learning from complaints is shared through a mix of local and regional professional updates, trust wide bulletins are sent out by the internal communications team via the intranet / internet 'Need-to-Know' site, e-mail and targeted campaigns such as notice board posters / notices.

Summary of findings

- Most patient facing PTS staff we spoke with were unsure what to do if a patient wished to make a complaint. There were no patient advice liaison service (PALS) leaflets available to give patients and only a small number of vehicles contained a sheet containing a contact number for the PALS service. Staff told us they would try to resolve the complaint immediately if possible, but if a patient, family member or care staff were unhappy they would contact their manager for advice on what to advise them.

Are services at this trust well-led?

Requires improvement 

We rated this key question as requiring improvement. This was because:

- Governance systems were not robust due to a mixture of paper based and electronic systems used to collect data.
- At the time of the inspection the the trust lacked a formal strategic for plan for the service as a whole though we were aware the trusdt were working towards this.
- Lessons were not always learnt from incident and there was a lack of oversight in action taken following incidents.

However we also saw:

- Proactive engagement of the senior team and local stakeholders.
- Improving relationships and challenge from board members.
- A wealth of new initiatives to improve capacity issues.
- Staff that were proud to work at the organisation.
- Increasing quality and clinical focus within the trust.

Vision and strategy

- The trust lacked a formal strategic plan as the new chief executive had only been in post for seven months and was creating a stable senior leadership team. The development of a strategy had been slow due to not having a director of strategy or PMO office and due to new planning guidance from NHS England. The trust has an action plan/vision for 2016 - 2017 with three strategic themes and 10 objectives. The strategy will then be developed. The new chief executive was to address the vision through increasing engagement and commitment from commissioners and stakeholders.
- The chief executive outlined a vision of a new clinical operating model. This included a single clinical HUB, increased see and treat, increased non conveyed, CAB based/ tele health technology, intermediate tier, 18 make ready substations etc.

Summary of findings

- The trust was in financial balance and this was not an issue for the trust. However recruitment of the appropriately qualified staff was a challenge for the trust.
- The trust acknowledged that it currently lacked an up to date strategy in a number of areas such as a fleet strategy and an estates strategy, though we were aware that a staregy for these areas had been signed off three years ago. However following the commitment of commissioners a new clinical education model had been implemented costing £5.4m
- The trust was focused on performance improvement, capacity, strategic planning and culture within the service. The senior team were aware that these issues were their main priorities.
- The trust had recently launched a quality strategy. They had held road shows at a number of bases throughout the six counties in which they had staff. Information gained through these roadshows were fed back to the board.

Governance, risk management and quality measurement

- The trust uses the DATIX system of capturing incidents. The trust acknowledged that there was a time delay and a backlog in investigating incidents on the system. This was due to the increased workload and the capacity of staff in operations. Themes from the incidents included, handover delays, medication issues and staff being late off duty. The trust were aware of these issues and actively putting plans in place to address these issues.
- Despite the delay in reporting we heard examples of triangulation of incidents with complaints and involvement of commissioners in this process. Staff were able to provide evidence of learning occurring from incidents. We reviewed 2 sets of notes from serious incidents and found that not all identified issues were included in the action plan. There was no multiagency review of the incident. There was also a lack of apparent progress against the actions taken.
- The trust used the standard governance model for NHS trusts. This included operational staff who had input into the quality and patient safety group which reported to the quality governance committee which in turn reported to the board.
- The previous leadership team had stripped back the “back room” staff and this was seen to have a negative impact on the way in which governance functioned. Having less staff to ensure that audits were robust impacted on the information provided to the board. However the trust had clinical leads working out in operations which had begun to improve information flows.

Summary of findings

- The serious incident panel met twice weekly to discuss any serious incidents occurring and to allocate an investigator to ensure that these were robustly addressed.
- The trust planned to have an electronic patient record system. However at present the patient's records were mostly paper based. These were taken from the stations and scanned onto the electronic system. This meant a delay in recording electronically patient records. It was noted by some staff that records went missing through this system. Most staff at the trust told us that internet connection around the counties in which they worked was very patchy and this led to the use of paper based systems.
- Due to the use of paper based systems auditing of incidents and patient record completion was difficult and often not robust. However the trust had plans in place to move to a fully electronic system.
- The trust provided staff with monthly bulletins to highlight areas of learning and to provide focus on specific areas. There were quarterly bulletins to supplement these. These bulletins contained information from the complaints and patient experience group.
- Complaints were disseminated to the local managers for investigation and resolution. Performance dashboards which contained this information were share with the board.
- Due to capacity issues mandatory training had been suspended. However the trust had actions plans in place to increase attendance at these sessions.
- The safeguarding team had low capacity to train and support staff. Whilst there were bimonthly safeguarding meetings held and a single point of access for safeguarding alerts training across the trust was poor. However the team were supported by the senior team and were sending letters to remind staff that they required DBS checks prior to commencing work. This letter stated that those volunteers who did not have this in place would not be able to continue working for the trust until they had a valid certificate in place.

Leadership of the trust

- The trust had not had a stable leadership base for approximately 5 years. However a new chief executive had been in place for seven months at the time of our inspection and substantive appointments had been made to the senior leadership team. However the medical director was currently part time in his role but supported by a full time deputy medical director.

- The new chief executive had visited a significant proportion of the operational bases. There are 92 operational bases in the six counties which the trust covers. However due to the nature of work he had not managed to meet a significant proportion of the workforce.
- Non-executive members spoken to commented on the increasingly positive relationship with the new senior team. The trust had held a board development workshop which had enhanced relationships. There was positive challenge from the non-executive members of the board and they were well sighted on the risks and challenges for the trust. The non-executives were aligned to key committees which reported to the board and in geographical areas.
- The senior team were proactive in developing positive relationships with key stakeholders and commissioners. They met with these groups regularly to discuss the longer term vision and strategy and to secure commitment to this from stakeholders. The chief executive had also met with chief executives of the hospitals with which they worked to address issues such as ambulance handover times.
- Divisional directors were engaged with staff through divisional forums. Each director was able to highlight individual issues within their area.

Culture within the trust

- The trust senior team recognised that there were some significant issues with culture within the organisation. The trust had been a merger of a number of smaller ambulance services. This meant that in each county there was a different culture. We saw that even within counties different bases had different cultures. This led to differing practices within the bases. The senior team were working to produce a standardised set of procedures and a single culture. However we recognise that this takes time to engender into the workforce.
- The trust had used an external company to move away from the traditional command and control structure and move towards leadership and development for managers. They were aware that some areas of the workforce felt devalued. This and the significant numbers of workers who were late off duty meant that retention was an issue for the trust.
- We held focus groups with staff prior to our inspection taking place. These were attended by union representatives. We found that the feedback from these focus groups was quite negative. However, when we spoke to staff during the inspection staff were generally more positive about working for the organisation.

Summary of findings

- The NHS Staff survey results were improving year on year. Staff engagement scores had increased year on year and were better than he national average at 3.44 as opposed to the national average of 3.39. The areas where the trust score better than he national average included; quality of appraisals, quality of training, staff reporting good communication with senior managers, staff motivation and staff seeing equal opportunities for career progression. However, the lowest ranking questions included; percentage of staff working extra hours, number of staff appraised in the past 12 months, staff experiencing violence, staff not reporting incidents, and perception of management interest in health and well-being. The trust had recently introduced a new well-being policy.
- There were allegations of bullying in some parts of the trust. Where we inspected we saw that these were being approprialtey investigated and managed. The staff survey had shown concerns as to bullying and harassment in some areas of the trust. Work on culture had been started in many areas to begin to address these concerns and staff where aware this was a large, ongoing piece of work.
- At the time of inspection it was apparent that Union consultation arrangements under the previous Executive had led to strained relationships between managers and officials. The new Executive have moved to formalise partnership working arrangements and apply appropriate governance processes but conflict still remains. This has led to challenges for managers and staff representatives and had a significant impact on senior leaders both personally and professionally. The new chief executive was working with full time officials to address these issues.
- The trust had an equality and diversity strategy. There were local equality and diversity ambassadors throughout the organisation.
- There were high levels of sickness within the operations staff which the trust were aware of. The trust had introduced a number of initiatives to mitigate this including a Trauma Risk Management facility which provided counselling and occupational health services including physio and a variety of other support services.

Fit and Proper Persons

- The fit and persons requirement (FPPR) for directors was introduced in November 2014. It is a new regulation that intends to make sure senior directors are of good character and have the right qualifications and experience.

Summary of findings

- The trust had appropriate systems and processes in place to ensure that all new and existing directors were and continued to be fit and proper persons. The trust has a policy on ensuring that they employ fit and proper people only.
- The executive directors were able to demonstrate an understanding of the regulation.
- We reviewed four files where we found that the staff had signed declarations as to them being fit and proper people. All files had relevant employment checks however interview notes were only seen in one file.

Public and staff engagement

- The trust engage patients in reviewing the quality of the service they provide.
- Patient feedback is received and utilised by the trust to improve services.
- Social media sites were used as a method of communicating with staff.

Innovation, improvement and sustainability

- The trust working with staff had produced a clinical manual for staff in operations. This manual gave clinical information for all levels of staff employed in operations. This manual was to be produced as an app for smart phones so that staff could quickly access information in the field.
- The trust was developing many projects to prevent patients being transported to hospital. These included mental health street cars, having a GP in the emergency care hub and emergency care practitioners who visited care homes rather than these patients being transported to hospital. The trust was proactive in financing roles which would prevent patients having to attend hospitals. These roles dealt with people having falls or reviewing a patient's condition and providing support.

Overview of ratings

Our ratings for East of England Ambulance Service

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Patient transport services (PTS)	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Emergency operations centre (EOC)	Requires improvement	Good	Outstanding	Good	Good	Good
Overall	Requires improvement	Requires improvement	Outstanding	Requires improvement	Requires improvement	Requires improvement

Our ratings for East of England Ambulance Service NHS Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Requires improvement	Requires improvement	Outstanding	Requires improvement	Requires improvement	Requires improvement

Notes

Outstanding practice and areas for improvement

Areas for improvement

Action the trust MUST take to improve

Action the trust MUST take to improve

- Improve performance and response times for emergency calls.
- Ensure that there are adequate numbers of suitable skilled and qualified staff to provide safe care and treatment
- Ensure staff are appropriately mentored and supported to carry out their role including appraisals.
- Ensure staff complete mandatory training (professional updates).
- Ensure that incidents are reported consistently and learning fed back to staff.
- Ensure that all staff are aware of safeguarding procedures and there is a consistent approach to reporting safeguarding.
- Ensure that medicines management is consistent across the trust and that controlled medicines are stored and managed according to regulation and legislation.
- Ensure that all vehicles and equipment are appropriately cleaned and maintained.
- Ensure all staff are aware of their responsibilities under legislation including the Mental Capacity Act 2005.
- Ensure all staff are aware of their responsibility under Duty of Candour requirements.
- Ensure records are stored securely on vehicles.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider was not ensuring the use of effective audit to assess, monitor and improve the quality of the service. Care records were not always stored securely.

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider was failing to ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced persons to meet the needs of people using the service. The provider was failing to ensure all staff received annual appraisals. The provider was failing to ensure that all staff received mandatory training (professional updates).

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider was failing to ensure that all staff were aware of their responsibilities and acted in accordance with the Mental Capacity Act 2005.

This section is primarily information for the provider

Requirement notices

The provider was not ensuring medicines were always stored safely and securely and audited effectively nor ensuring staff followed trust policy relating to controlled drugs.

The provider did not consistently report safety incidents or feedback actions and learning to staff.

The provider was failing to meet the needs of all patients by ensuring a timely emergency response.

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The provider was failing to ensure that all staff were aware of their responsibilities and acted in accordance with safeguarding procedures.**

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **The provider was failing to ensure that patient transport service vehicles were properly cleaned.**