North West 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.

Summary of findings

Letter from the Chief Inspector of Hospitals

North West Ambulance Service NHS Trust has been selected as the first ambulance trust to be inspected under the Care Quality Commission's revised inspection approach.

It is one of 10 ambulance trusts, five of which are foundation trusts. It is in the process of applying to become a foundation trust.

The announced inspection took place between 19 and 22 August 2014, and the unannounced inspection visits took place on 26 and 27 September 2014.

As the first ambulance trust inspected under the new model, we did not provide ratings for this trust.

The trust operates a 111 service. This was not looked at as a part of this inspection.

Our key findings were as follows:

The service was clinically led and focused on patients and outcomes.

The trust was only achieving one of the three key response time targets in 2014/15; although it did achieve all key national ambulance targets 2013/14.

Systems, processes and practices were used to keep people safe from harm.

The ambulance service used evidence-based computer systems to support decision making when the public called 999. Special patient notes were held on the system to support and inform decisions.

The trust had clinicians based in its three emergency operations centre however they were used effectively in Manchester.

Paramedics used a Paramedic Pathfinder tool (Pathfinder allowed staff to transfer patients to the correct pathways using known clinical guidance to determine the correct treatment) to ensure that patients received care in the most appropriate setting.

The patient transport services provided transport for people who met the eligibility criteria. These were people who needed to be taken to hospital for a planned appointment and who were unable to make their own way to hospital because of clinical or medical needs.

The trust's leadership team had a clear vision that was freely quoted by many staff. It was underpinned by a strategy to make the trust one that provides not just a good service but a great one. The trust had a system to communicate its messages via different media such as notice boards, bulletins and emails. However some staff cited lack of time, lack of face to face meetings and lack of access to emails to be able receive those messages.

Overall, staff felt supported and well equipped to carry out their duties. It was compulsory for advanced paramedics to have a Master's qualification; operational managers were encouraged to partake in Chartered Management Institute schemes. Some staff expressed concerns that they had not received the training they needed to manage obstetric emergencies, although mandatory training included an obstetric update.

There was a procedure for staff to report this colleagues' poor practice and staff were encouraged not to tolerate this.

There were challenges in the delivery of the patient transport services. However, there was a commitment to this service and recognition that it was part of the future plans for the trust.

Staff treated patients and their families and carers in a caring manner with dignity and respect, and valued them as individuals. We observed exemplary care being given across the whole trust.

We saw several areas of outstanding practice including:

Numerous examples where staff showed a caring, committed and compassionate manner, despite the situation or the environment they were in, or the challenges they faced.

Patients who called more than twice in 7 days or 4 times in 28 days were recognised as 'frequent callers'. The trust had a 'frequent callers' team that liaised with the caller, their GP and other social care providers to ensure that the person's health and social care needs would be met by the right provider.

Clinical staff performance was monitored and all paramedics' results were published within the team. Each

Summary of findings

paramedic had a unique identifying number so only they would know which results related to their performance. This meant they could compare their performance against their colleagues without knowing which results related to whom.

'Prevent' is part of the UK government's counter-terrorism strategy known as CONTEST, which aims to reduce the risk to the UK and its interests overseas from terrorism. At the time of our inspection, 55% of staff had completed their training.

Emergency Medical technicians in order to progress to paramedics they've had to apply to a University to undertaken the Paramedic Diploma which meant that they had to leave the trust. Recently, a trial had been undertaken for them to enhance their level of education to the point where they can apply to the trust's own internally sponsored Paramedic course.

The trust showed commitment to ongoing education and development of their staff at all levels. It appointed one of the first consultant paramedics back in 2008 and was focused on ensuring that staff were equipped to carry out their roles.

The commitment and enthusiasm for the use of volunteer community first responders and their support was evident. They received a comprehensive 6-month package of training, and then continuing training and support.

The trust had developed a process for responding to calls when a patient had already been seen by ambulance staff within the previous 24 hours. These calls were automatically flagged and referred to the clinical governance team who then immediately reviewed these incidents to understand and share any learning from these incidents.

The purpose-built emergency operations centre at Parkway in Manchester provided a good working environment and a positive atmosphere to work within.

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

Getting the most appropriate vehicle to the patient (a key objective for ambulance services) is known as 'best allocation' and the trust aimed to achieve this target 60% of the time. However, this had only been achieved in 40% of cases from July to September 2014. It varied but was around 40% for the trust.

The service took a high number of patients to hospital when alternative services may have been more appropriate in meeting their needs. The trust was the worst performing nationally in this area. Less than 4% of calls to the trust were closed with telephone advice.

Some staff raised concerns that they did not have access to pain relief medication for children experiencing significant pain. The issue had been raised with senior staff who were in the process of addressing it.

Pulse oximeters (which check the oxygen levels in blood streams) with probes suitable for children were not available to all staff at all times.

There were some areas within the trust where staff had not had appraisals and regular communication was not taking place.

Importantly, the trust must:

Review the process for pre-alerting hospital accident and emergency (A&E) departments to make sure that communication is sufficient for the receiving department to be made fully aware of the patient's condition.

Make sure that emergency operations centre staff across all three EOCs are consistently identifying and recording incidents as appropriate.

Make sure dosimeters (that measure exposure to radiation) on vehicles are in working order.

Improve access to clinical supervision for all clinical staff.

Review medicines formulary guidance issued to front-line staff to make sure it is current.

Ensure that all staff are receiving the mandatory training necessary for their role.

Ensure that all staff across all divisions are consistently receiving appraisals.

The trust should:

Assess the impact and mitigate of any identified risks by call-handling staff not accessing clinical advice, in contrast to regular clinical advice being sought by Manchester Parkway call-handling staff.

Summary of findings

Assess the impact and mitigate associated risks of non-clinical staff re-triaging calls.

Ensure measures in action plans are SMART (specific, measurable, achievable, realistic and timed), in the Broughton emergency operations centre.

Audit and assess individual call-handling performance at all emergency operations centres.

Assess and implement measures to improve performance for the proportion of calls closed with telephone advice when clinically appropriate.

Review the adoption of the urgent disconnect policy at all emergency operations centres.

Assess and implement measures to improve performance against the national target for the percentage of calls abandoned before being answered.

Share learning and good practice across emergency operations centres.

Review the system for managing controlled drugs at ambulance stations to ensure that they are managed appropriately.

Review systems to assess if access to new stocks of controlled drugs in rural areas can be improved.

Evaluate the availability of training and opportunities for career progression for emergency medical technicians across the trust.

Assess and implement measures to improve performance against the 40-minute transfer target for transport services patients having haemodialysis or cancer treatment.

Ensure that the public know how to complain should they wish to.

Improve complaint response times.

Ensure that the various communication media that the trust employs be supported to be effective by the ability of staff to access them in both time and physical access, recognising the geographical spread of the trust.

Consider bringing forward the programme to provide a new Emergency Operations Centre (EOC) at Elm House Liverpool or consider renting purpose built accommodation

Re-examine and improve basic cleaning processes for ambulances such as standards for replacement of mop heads and processes for replenishing buckets containing cleaning fluids

Instigate team meetings or training in specialist subjects, such as the Mental Capacity Act 2005 or deprivation of liberty safeguards for Liverpool Elm House EOC staff.

Develop a system for EOC staff to deal with requests for information from the police.

Call-taking and dispatch staff arranged call-backs to Green 3 and 4 calls (non-life threatening) that had passed the expected response time, in order to explain delays and check for any deterioration in the patient. This was organised in an ad hoc way and sometimes overlapped with call-backs undertaken by staff at the urgent care desk. Set up a process to undertake this is a systematic way.

Improve the frequency of face-to-face interactions between managers and staff ensure that team meetings take place on a regular basis.

Professor Sir Mike Richards
Chief Inspector of Hospitals

November 2014

Summary of findings

Background to North West Ambulance Service NHS Trust

The North West Ambulance Service NHS Trust was established on 1 July 2006 by the merger of ambulance trusts from Greater Manchester, Cheshire and Merseyside, and Cumbria and Lancashire.

The trust headquarters is in Bolton, and there are four area offices serving Cheshire and Merseyside (Liverpool), Cumbria (Salkeld Hall, Carlisle), Lancashire (Broughton near Preston) and Greater Manchester (Whitefield).

The trust serves a population of seven million over 14,000 square kilometres. Services to this area are commissioned by 33 clinical commissioning groups; the lead commissioner is Blackpool Clinical Commissioning Group. The trust works with 39 NHS trusts, 46 local authorities, five police forces and five fire and rescue services.

At the time of our inspection, there were 108 ambulance stations, three emergency operations centres, one support centre, three patient transport services control centres and two Hazardous Area Response Team buildings – one shared with Merseyside fire and rescue. The trust operates around 1,000 vehicles on both emergency and non-emergency operations.

The trust receives over 1.2 million emergency calls per year, with emergency crews attending more than 952,000 incidents each year; around 800,000 of these need emergency transport. The trust undertakes over 1.1 million non-emergency patient transport journeys each year. It currently employs over 4,900 staff.

Our inspection team

Our inspection team was led by:

Chair: Mr Leslie Hamilton, Consultant Cardiac Surgeon, Newcastle Upon Tyne NHS Foundation Trust

Head of Hospital Inspections: Siobhan Jordan, Care Quality Commission.

Inspection Lead for Cheshire and Merseyside: Robert Throw, Inspection Manager, Care Quality Commission.

Inspection Lead for Cumbria and Lancashire: Damian Cooper, Inspection Manager, Care Quality Commission.

Inspection Lead for Greater Manchester: Hayley Marle, Inspection Manager, Care Quality Commission.

The team included CQC inspectors, analysts, paramedics, emergency medical technicians, doctors, nurses, midwives, mental health specialists, call centre specialists, patients and public representatives, experts by experience and senior NHS managers.

How we carried out this inspection

- In planning for this inspection, we reviewed a range of information we held about the trust and asked other organisations to share what they knew about the ambulance service. This information included information from the lead Commissioner.
- We held meetings with staff on 5 and 6 August in advance of the inspection. We visited Salkeld Hall, Carlisle, Penrith, Formby, Birkenhead, Burnley, Northwich, Chester, Central Manchester and Salford ambulance stations, as well as Elm House and Broughton emergency operations centres.
- We carried out our announced visit from 19 to 22 August 2014 when we talked with staff and patients in all areas of the trust, as well as key stakeholders.
- We observed how people were being cared for, talked with carers or family members, and reviewed patients' personal care and treatment records.

Summary of findings

- We visited all three emergency operations centres and we visited over 50 ambulance stations.
- We held listening events before the inspection, in partnership with local community groups, in Penrith (23 June), Salford (17 July), Manchester (21 July) and Preston (8, 22 and 24 July) where patients and members of the public shared their views and experiences.
- On 12 August, we met with community first responders in Cumbria. We carried out further unannounced inspections on 26 and 27 September 2014 in Greater Manchester.

The inspection team inspected the following core services:

- Access to the Service
- Emergency and Urgent Care
- Patient Transport Services

What people who use the trust's services say

National Friends and Family Pilot

The FFT will be introduced in all NHS ambulance services from 1 April 2015. The trust had undertaken a case study to pilot the use of text messaging for patient transport services patients as part of the national development of the FFT programme. The pilot was to assess how a predominantly older patient group would embrace text messaging as a way of providing feedback on their experience of the service. The study found that it was extremely quick, easy and cost effective to set up the process and a response rate of over 35% was received, with over 70% of those responding leaving detailed feedback.

NHS Staff Survey 2013

The latest results for the NHS Staff Survey 2013 were published in February 2014. Twenty-nine per cent of the trust's staff who were sent the survey responded, which was one of the lowest response rates nationally for all ambulance trusts.

Results from this latest survey are organised into 28 key findings. For 10 of the key findings, the trust was better than average for the ambulance sector.

The top five findings where the trust compared most favourably were as follows:

- Staff recommending the trust as a place to work or receive treatment scored 3.31 out of 5 compared with 3.08 nationally.
- For the percentage of the trust's staff experiencing harassment, bullying or abuse from staff in the past 12 months: 22% compared with 28% nationally.
- Work pressure felt by staff scored 3.14 out of 5, compared with 3.22 nationally.
- Eighty per cent of staff said they felt satisfied with the quality of work and patient care they were able to deliver, compared with 75% nationally.
- The trust's score of 3.66 out of 5 for staff motivation at work, compared with 3.53 nationally.

The trust was worse than the ambulance sector average for 8 of the key findings, the five where the trust compared least favourably were as follows:

- Percentage of staff working extra hours: 90% of the trust's respondents said they did this, compared with 85% nationally.
- Thirteen per cent of the trust's staff said they had had a well-structured appraisal in the past 12 months, compared with 19% nationally.
- The percentage of the staff who agreed that their role made a difference to patients was 84%, compared with 86% for staff nationally;
- Sixty-one per cent of staff said that they had had an appraisal in the past 12 months, compared with 67% nationally.
- Forty-three per cent of staff said they had received health and safety training in the past 12 months, compared with 52% nationally.

2013/14 'Hear and Treat' Survey

The 2013/14 'Hear and Treat' Survey was the first telephone survey carried out under the national NHS Survey programme. It surveyed callers aged 18 years or older who would have received telephone triage and advice from trained clinical support advisers when calling '999' in December 2013 or January 2014.

Summary of findings

The survey asked 25 questions and its results were published in July 2014.

Nationally, the experiences of over 2,900 people were captured; responses were received from 263 patients from the trust.

The trust performed better than other trusts when patients were asked 'Were you told when you would be called back?' (for those who spoke to a second person), with a score of 9.1 out of 10. The trust also performed better than other trusts when patients were asked whether the clinical adviser they spoke with listened to what they had to say, with a score of 9.3 out of 10.

The trust performed worse than other trusts when patients were asked overall whether, if they had questions, they had the opportunity to ask them. Here, the trust's score was 7.3 out of 10. For all the other 22 questions in the survey, the trust's scores were similar to those for the other ambulance trusts.

Comment cards

We received feedback from service users on comment cards placed in hospitals in the North West.

Service users in Tameside told us that ambulance staff were understanding and that they provided good care. Service users in South Manchester told us that they thought the service provided was of a high standard and that ambulance staff were caring and professional. People recognised the demands on ambulance staff and commented that they felt that staff were responsive and sensitive to patients' needs, regardless of the pressure that they were under day to day.

In Liverpool, we received feedback that ambulance staff were kind and caring towards older patients and that staff made patients feel safe and relatives reassured.

Patients in Liverpool and other areas told us they had experienced delays when calling for an emergency ambulance and waiting for patient transport to take them to and from appointments.

Across Lancashire, patients told us that they felt that the ambulance environment was safe and hygienic. They told us that what would happen next had been explained to them when they had needed care and treatment.

Nearly all patient groups fed back that trust staff were friendly and courteous.

Facts and data about this trust

Context

- Established on 1 July 2006
- Not a foundation trust but is seeking to become one
- 108 ambulance stations
- Three emergency operations centres
- One support centre
- Three Patient Transport Services control centres
- Two Hazardous Area Response Team buildings - one co located with Merseyside fire and rescue
- Circa 1,000 vehicles
- Serves seven million people and covers 14,000 square kilometres
- Employs 4,932 staff
- Annual turnover of £261.3 million
- Surplus of £2.7 million (2012/13)

Activity (2013/14)

- 1,240,645 emergency calls received
- 728,809 emergency journeys
- 75.86% Red 1 calls responded to within 8 minutes (target = 75%)
- 77.43% Red 2 calls responded to within 8 minutes (target = 75%)
- 95.79% of all category A calls resulting in an ambulance arriving within 19 minutes against a national target of 95%

Safety

- No Never Events reported between July 2012 and March 2014
- 26 serious incidents reported between April 2013 and March 2014
- Reported to the National Reporting and Learning System between July 2012 and March 2014; 10 deaths, six incidences of severe harm and 30 incidences of moderate harm.

Effective

For national ambulance quality indicators:

Summary of findings

- Performance much better than expected for one indicator - proportion of suspected stroke patients assessed face to face who received an appropriate care bundle
- Performance worse than expected for one indicator - proportion of calls managed without transport to A&E, where clinically appropriate
- Performance much worse than expected for proportion of calls closed with telephone advice, where clinically appropriate
- Performance for four other indicators similar to expected

Caring

For Hear and Treat Survey:

- Better than other trusts for two questions - were you told when you would be called back, for those that spoke to a second person and whether the clinical adviser that they spoke to listened to what they had to say
- Worse than other trusts for one question - when asked overall, if they had questions, did patients have the opportunity to ask them?
- Scores were similar to those for the other ambulance trusts for remaining 22 questions

Responsive

- Target for Red 1 calls met in 8 out of 12 months in 2013/14
- Target for Red 2 calls met in 11 out of 12 months in 2013/14
- Between 2011 and 2014 the trust has been below the average for resolving calls via telephone advice
- Calls managed without transport to A&E were higher in last three years compared to the national average
- Re -contact rates following discharge after telephone advice was more than double the national average in 2011/12 and 2012/13 but changed in June 2013 to be more in line with other services
- Re-contact rates following discharge at the scene were higher in the last three years compared to national average

Well-led

NHS Staff Survey – 28 questions:

- Better than average for 10 questions
- Worse than average for eight questions
- Within expectations for 10 questions
- Sickness rate 1% above the national average of 5.82% between April and June 2014.

Summary of findings

Our judgements about each of our five key questions

Are services at this trust safe?

Incidents

We observed established patient safety systems being used, and a move from reporting incidents on paper to electronic reporting. However, this varied across the area and some areas were better established than others. In 2008/09, the staff reported 3,517 incidents on the incident reporting system, and in 2013/14 this had increased to 8,945.

There were 768 incidents reported by the trust to the National Reporting and Learning System between July 2012 and March 2014. There was no reported death, severe or moderate harm incidents in 8 of the 21 months.

We reviewed 26 serious incidents that occurred between April 2013 and March 2014. Serious incidents are those that require an investigation and meet the national criteria to be reported on the national Strategic Executive Information System as a serious incident. The investigations were thorough and action plans achievable. However, it was not clear what communication had taken place with patients for the trust to be assured of compliance with the duty of candour requirements. A number of incidents were directly associated with the receiving hospital and there was no evidence that communication had taken place with partner organisations.

We saw bulletins displayed at ambulance stations and evidence that emails were sent to update staff and inform them of actions and learning from incidents. However, this information was not accessed by all staff, and some said they did not see updates or learning. Front-line staff were only able to access computers at the end their shift. Most shifts were 12 hours long and there was no allocated time for staff to access computers at the beginning of their shifts.

Organisations should be committed to protecting patients through systems that ensure that notices, alerts and other communications concerning patient safety are acted on within the required timescales – such as alerts from the Medicines and Healthcare products Regulatory Agency (MHRA) central alerting system. Organisations should acknowledge any alert issued within two days of the issue date. The trust has acted within the expected time frame for MHRA alerts.

Staffing

We reviewed staffing across the whole trust. The trust recognised that there were shortages and that staff in all areas were working overtime to address this. Staff told us that many of them worked extra hours and in the Department of Health NHS Staff Survey 2013 reported that they felt pressure but were able to cope. Ninety per cent of those who responded to the survey said they worked extra hours. Executives confirmed that they were recruiting to full establishment.

Paramedics are a graduate workforce and the trust was aware of when students would be graduating and took account of this as part of their workforce planning.

The trust was proactive in supporting existing staff to develop their professional skills.

Cleanliness, infection control and hygiene

We visited more than 50 ambulance stations and inspected many vehicles. The trust used clinical safety indicators to measure compliance with infection prevention and control standards.

We noted that dedicated staff at different seniority levels led on infection prevention and control. Staff were aware of whom to contact if they needed advice or to raise infection control issues.

Most of the ambulance stations we visited were visibly clean and well maintained. All the vehicles we inspected, including their equipment, were found to be clean. The monthly audit results for cleanliness of vehicles mostly met or exceeded the target of 95%.

Summary of findings

Deep cleans were undertaken by a dedicated team. All vehicles used for transporting patients were included in this rota. When cleaned, we saw discs were placed in a vehicle's window indicating when the last deep clean had taken place and when the next was due.

All staff involved in clinical activity were observed adhering to the trust's 'bare below the elbow' policy.

Environment and equipment

There was a contrast in the emergency operations centre environments. This was particularly obvious between Parkway, Greater Manchester, and Elm House, Liverpool.

There were originally four separate ambulance services (the trust was formed in 2006), they work from three very different call centres. One has been purpose built recently Parkway in Greater Manchester, and the plans had been developed with significant input from staff. It now provided a good working environment and a positive atmosphere to work within. The trust had plans to redevelop its other emergency operations centres. However, staff were not fully aware of the time scale.

Elm house was providing the service on a ground and first level floor which presented immediate challenges, particularly when the IT system went down.

Overall, sufficient equipment was available to front line staff to enable them to carry out patient care with some limited concerns about promptness of replacement in a few cases. The team in Broughton worked with procurement and operations leads to make sure that the equipment was appropriate, and also considered cost effectiveness.

There had been a recent change in the provision of children's basic life support equipment, which had been merged with adult kit. This meant that only one bag was needed to be carried to a scene.

Equipment for vehicles, such as suction units and personal protective equipment, was held at ambulance stations so that staff were able to access it. There were issues with equipment not always being returned on inter-hospital transfers in Cheshire and Merseyside.

Medicines

The trust monitored medicines management through clinical safety indicators that were regularly audited.

The trust stored controlled medications in emergency and rapid response vehicles in a locked cabinet, accessible only by paramedics. We observed that on-duty paramedics called the dispatch team to request controlled medications when stocks were low; these medications were ordered promptly and the paramedics experienced minimal delay in re-stocking the medication while on the road. However, in Cumbria, access to medicines from pharmacies was an issue because of the long distances sometimes involved when stocks ran low.

We identified issues with the secure storage of controlled drugs in ambulance stations while on inspection in Cumbria and Lancashire. We raised these with the trust's senior management team who responded to resolve the issues immediately.

Records

We observed that records and record keeping were consistently appropriate and completed in full. Staff filled in a patient report form for each patient. This was a detailed form and staff at organisations receiving patients from the trust commented that it was comprehensive and effective.

Hospital staff reported that the patient report forms were clear and covered all aspects of care; information recorded was concise, and covered both key positive and relevant negative findings.

Summary of findings

Safeguarding

All staff we spoke with were aware of the safeguarding policies and procedures. These were available on the intranet and were up to date. Some staff told us about safeguarding 'champions' whose role was to advise, communicate and disseminate information to colleagues about safeguarding issues. Most staff had received training in safeguarding children and vulnerable adults.

Staff reported any child or adult safeguarding concerns to a central reporting team based in Carlisle. This team then liaised with the appropriate authorities within agreed timescales.

The trust had recently developed an online system to deliver specific safeguarding training. However, it could not audit which staff had completed it.

Mandatory training

The format of mandatory training varied across the trust, delivering three different programmes to meet the specific needs of the services delivered. The three areas were paramedic emergency service (PES) mandatory training, patient transport services (PTS) mandatory training and corporate and support staff mandatory training. Mandatory training for PES staff had been delivered bi-annually; however, this was becoming annual. Performance across the three geographical areas for PES mandatory training was 83.34% and for PTS was 85.45%. Sixty of the 78 members of the Hazardous Area Response Team had completed the bi-annual mandatory training.

The trust target was 80% for 2013/14 with a target of 85% for 2014/15. This was to take account of the transition from bi-annual training to annual training.

The development of trauma centres across the North West region meant that extra training was needed for PES staff in trauma equipment and procedures related to this change. Ninety per cent of all staff had completed this trauma equipment and procedures training at the time of our inspection.

Are services at this trust effective?

Evidence-based care and treatment

The service used an internationally approved call triage system called the 'advanced medical priority dispatch system' (AMPDS). Staff followed evidence-based care guidance in assessing callers' symptoms and ensuring that they were referred to the appropriate healthcare professional. Also, once on site with a patient, paramedics used the Paramedic Pathfinder tool to ensure that they received care in the most appropriate setting.

Staff were issued with trust clinical guidelines, and guidance for the doses of medicines to be administered to adults and children were detailed in 'Clear Vision' booklets that were carried by paramedic staff. The Joint Royal Colleges Ambulance Liaison Committee (JRCALC) develops and reviews national clinical practice guidelines for NHS paramedics. Staff had been given a handbook on JRCALC guidelines dated 2013.

The patient transport services provided vital access for many patients with planned healthcare appointments, thereby complying with the National Institute for Health and Care Excellence (NICE) transport standards. The Trust aimed to drop off and pick up patients within 1 hour of their clinical treatment (30 minutes before / 30 minutes after) for Enhanced Priority patients (renal / oncology) and 1 hour for other planned appointments e.g. Outpatients (45 minutes before / 15 minutes after). These are the standards set out in the contracts with the Commissioners.

Patient outcomes

All ambulance services in England are measuring and reporting against 11 clinical quality indicators. The trust's performance and position against national performance are as follows:

Summary of findings

Outcome from acute ST segment elevation myocardial infarction (STEMI), which is a type of heart attack: the trust's position on this indicator was that 86.1% of STEMI patients seen by the trust received the correct treatment (appropriate care bundle) in line with ambulance guidelines for the current year to date (April to May 2014); this performance was the fourth best of all ambulance trusts. For the year to date, the national average was 81.7% (with a range of 69.1%–96.2%). For the previous full year, April 2013 to March 2014, the percentage for the trust was 85.3% (which the third best nationally); for 2013/14, the national average was 80.1% with a range of 68%–89.6%.

Outcome from cardiac arrest, return of spontaneous circulation: this indicator measures how many patients, in cardiac arrest and after resuscitation, have a pulse/heartbeat on arrival at hospital. Twenty-six per cent of the trust's patients who, having suffered a cardiac arrest and stopped breathing, were recorded as having had a return of spontaneous circulation (a pulse/heartbeat) at the time of their arrival at hospital for the current year to date (April to May 2014); this performance was the sixth best of all ambulance trusts. For the year to date, the national average was 25.5% (and the range was 15.8%–38%). For the previous full year, April 2013 to March 2014, the percentage for the trust was 28.6%, which was the fourth best nationally. For 2013/14, the national average was 26.1% with a range of 16.2%–37.8%.

Outcome from cardiac arrest, survival to discharge: this one measures the percentage of those who recover from cardiac arrest and are later discharged from hospital. Of the trust's patients who had suffered a cardiac arrest and stopped breathing, 7.8% were successfully resuscitated and survived to be discharged from hospital for the current year to date (April to May 2014); this performance was the sixth best of all ambulance trusts. For the year to date, the national average was 7.7% (with a range of 3.1%–15.4%). For the previous full year, April 2013 to March 2014, the percentage for the trust was 8.8%, which was the fifth best nationally. For 2013/14, the national average was 8.7% with a range of 4.9%–19.4%.

Outcome after stroke for ambulance patients: this indicator required ambulance services to measure the time it took from the 999 call to the time FAST positive (face, arm, speech, time, acronym) stroke patients arrived at a specialist stroke centre so that they could be rapidly assessed for treatment called thrombolysis. For the current year to date (April to May 2014), 71.9% of the trust's patients who had suffered a stroke, as confirmed by FAST, and were potentially eligible for thrombolysis, arrived at a hyper acute stroke centre within 60 minutes of the original 999 call; this performance was the second best of all ambulance trusts. For the year to date, the national average was 62.7% (with a range of 54.9%–78.5%). For the previous full year, April 2013 to March 2014, the percentage for the trust was 75.3%, which was the second best nationally. For 2013/14, the national average was 63% with a range of 43.6%–76.5%.

Proportion of calls closed with telephone advice or managed without transport to accident and emergency (A&E) departments (when clinically appropriate): this indicator should reflect how the whole urgent care system is working, rather than simply the ambulance service or A&E, because it will reflect the availability of alternative urgent care destinations (for example, walk-in centres) and the providing of treatment to patients in their home. The proportion of 999 calls that were resolved by the trust providing telephone advice only, with no ambulance response, was 3.6% for the period April–August 2014; this performance was the worst of all ambulance trusts. For the same period, the national average was 7.2% with a range of 3.6%–11%.

Recontact rate following discharge of care (that is, closure with telephone advice or after treatment at the scene): if patients have to call 999 a second time, it is usually because they are anxious about receiving an ambulance response or their condition has not improved as expected. Sometimes it may be due to an unexpected or new problem. To ensure that ambulance trusts are providing safe and effective care the first time, every time, this indicator measures how many callers or patients call back within 24 hours of the initial call being made. Between April and August 2014, 11% of patients contacted the trust again within 24 hours of having called 999 and been offered clinical advice over the phone; this performance was the seventh best nationally. For the same period, the national average was 8% with a range of 1.9%–13.6%.

Summary of findings

A similar indicator measured recontact within 24 hours by patients who had called 999 and were then discharged at the scene after face-to-face ambulance assessment. The trust's performance for this indicator for the same time period, April–August 2014, was 5.8%, which was the eighth best nationally; the national average was 5.3% with a range of 3.8%–7%.

Then there is the call abandonment rate: this indicator ensures that the trust and other ambulance services are not having problems with people phoning 999 and being unable to get through. Of 999 callers between April and August 2014, 4.5% hung up before their call was answered in an emergency control room. This performance was the worst for all ambulance trusts; for the same period, the national average was 1.5% with a range of 0.3%–4.5%.

Time to answer calls is equally important to ensure that people dialling 999 get their calls answered quickly. This indicator therefore measures how quickly all 999 calls that are received get answered. For the period April –August 2014, the trust answered 50% of calls within 1 second, 95% of calls within 24 seconds and 99% of calls within 1 minute and 7 seconds. Compared with the other trusts on these measures, its performance was second, eighth and sixth best respectively.

All ambulance services need to show how they find out what people think of the service they offer and how they are acting on that information to continuously improve patient care. We refer to patient feedback earlier in this report.

The category A, 8-minute response time indicator measures the speed of all ambulance responses to the scene of potentially life-threatening incidents, and the extent to which those patients most in need of an emergency ambulance get one quickly. For the period April–August 2014, the trust reached 72.3% of category A (Red 1) calls within 8 minutes (the national target for this measure is 75%); this performance was eighth best of all the ambulance trusts. For the same period, the national average was 73% with a range of 67.2%–82%.

Time to treatment by an ambulance-dispatched health professional is also measured. It is important that, if a patient needs an emergency ambulance response and possibly urgent treatment, the wait from when the 999 call is made to when an ambulance-trained healthcare professional arrives is as short as possible. Between April and August 2014, the average time taken for a health professional working for the trust to arrive at 50% of the scenes of Category A (immediately life-threatening) calls was 6 minutes and 15 seconds; this time extended to 18 minutes and 20 seconds for 95% of the scenes, and to 32 minutes and 36 seconds for 99% of the scenes. The trust's performance on this indicator was seventh best compared with other ambulance trusts for the time to treatment for both the 50% and 95% measures, and tenth best for the 99% measure.

Response times

NHS England collect data on three key performance indicators for England's ambulance services; these are specifically around response times.

Category A (Red 1) calls, which are in response to patients whose conditions are immediately life threatening: the national target is for attendance at 75% of all incidents within 8 minutes. The trust achieved this target 8 months out of 12 in 2013/14 and achieved an overall performance for the year of 75.9%, compared with an England average performance of 75.6%.

Category A (Red 2) incidents, which related to conditions that may be life threatening, but are less time critical: the national target was again for attendance at 75% of all incidents within 8 minutes. The trust achieved this target in 11 months out of 12 in 2013/14 and achieved an overall performance for the year of 77.4%, compared with an England average performance of 74.8%.

Summary of findings

A third key performance indicator is for both Category A calls (Red 1 and Red 2), which require that a vehicle capable of transporting a patient should arrive at the scene of the incident within 19 minutes. The national target is 95%. The trust achieved this target in 10 out of 12 months in 2013/14 and achieved an overall performance for the year of 95.8%, compared with an England average performance of 96.1%.

The trust had not met Category A (Red 1) or Category A (Red 2) incidents from May 2014 until August 2014, they had seen signs of improvement in August performance to date. The 75% for Category A (Red 1) was 8 minutes 10 seconds in May, 8 minutes 25 seconds in June and 8 minutes 45seconds in July. The 75% for Category A (Red 2) was 8 minutes 5 seconds in May, 8 minutes 20 seconds in June and 8 minutes 55 seconds in July.

During the period between June 2013 and May 2014, response times accounted for almost half (47.9%) of complaints made to the trust about the emergency service provided. However, data in January 2014 showed that, out of the 10 trusts, the trust ranked fourth on Red 1 response times, third on Red 2 response times and fifth on the 19-minute target. This equated to an average wait for an ambulance of 13 minutes, 51 seconds.

The patient transport services had performance targets that had been agreed as part of the service contract with commissioners. One performance target was that patients arrived no more than 45 minutes before or 15 minutes after their appointment time on 90% of occasions. For haemodialysis or cancer patients, the target was to arrive within 30 minutes of the appointment time on 90% of occasions. Trust performance data between July 2013 and June 2014 showed that the local teams achieved or were slightly below the expected targets. When arrival targets were not achieved, most patients arrived earlier than their expected time rather than after their appointment time, which meant that they were still able to attend their appointments.

Are services at this trust caring?

Compassionate care

We noted numerous examples of staff showing a caring, committed and compassionate manner despite the situation or the environment they were in, or the challenges they faced.

We observed many compassionate conversations between staff and callers. Staff took their time, were clear and informative. Callers were often distressed and anxious, and staff in the operations centre responded to them patiently, assuredly and compassionately. Call handlers adapted their tone with consideration for the caller and the circumstances. Patients and family members described the call centre staff positively. For example, they said they were “very caring”, “helpful” and “reassuring”.

Some examples of compassionate care included the following:

A patient in South Manchester told us, “I was extremely satisfied with the service I received; the ambulance crew were extra sensitive to my needs.”

A relative of a patient in Liverpool told us, “The care my mother received was exceptional; I think staff should wear name badges so we can give feedback to the right people.”

And in Lancashire we were told, “The ambulance staff were so considerate and friendly; they asked about how my husband felt about pain relief and respected his wishes.”

Throughout our inspection, we witnessed staff treating patients and their families and carers in a caring manner with dignity and respect, and valuing them as individuals. We observed exemplary care being given across the whole trust.

Summary of findings

Providing emotional care and support

We witnessed, and listened to patients and relatives telling us, that staff provided them with emotional care and support. Patients near the end of their life were treated with dignity and respect. We saw relatives being supported, kept informed and looked after.

Staff told us how they had experienced some difficult calls and how they had learned from them to ensure that they offered appropriate emotional support to callers in the future. A member of staff gave us an example of how they had recently stayed with a relative in a distressing situation until the police arrived. They said this would be usual practice. During the inspection, we observed staff giving emotional support to patients, offering reassurance and comfort as necessary.

We observed staff being sensitive to patients' mental health needs and supporting them appropriately. Accident and emergency (A&E) staff told us that in their opinion the ambulance crews were very caring towards patients and their relatives.

It was clear that the staff we observed and spoke with were dedicated to providing the best care possible.

Patient understanding and involvement

Treatment was explained before it was carried out and, whenever possible, with the patient's consent. Patients had suggested treatment options explained to them that took into consideration their cultural needs.

Patients told us they were involved in their care and treatment.

We observed positive interactions between staff, patients and their relatives when staff were handing over the patients in their care to another healthcare professional; the patients were included in these conversations whenever possible. We discussed communication with people whose first language was not English. Staff told us they had the use of multilingual phrase books and visual communication aids. We were given an example of when staff had used a large-print questionnaire to establish a person's pain score.

While observing in ambulances, we saw staff discussing with patients the next steps to take and whether or not to take them to the A&E department. In each case, staff took the time to explain their reasoning and involved the patient in the final decision. When a person declined to go to the A&E department, this was respected. The correct procedure was followed, including an assessment of their capacity to make the decision.

Throughout our inspection, we were told by patients and their relatives how caring staff had been towards them, and how staff had "gone the extra mile" to support them and involve them during their transfer to hospital.

Patients who regularly used the patient transport services said they felt well looked after and safe.

Are services at this trust responsive?

Service planning to meet local needs

The trust recognised the diverse population it served in terms of demography, ethnicity and geography. It provided services in 4 of the 10 most deprived areas in England, including dense urban areas and large remote rural areas.

The trust had been active in engaging with the community to understand local needs and had developed services in response. In Cumbria and Lancashire, it had an extensive community first responder and community defibrillator programme, and it was also one of the first 20 Cardiac Smart communities with the British Heart Foundation. In Manchester, staff worked in the Manchester gay village with the 'street angels', teaching them basic first aid, what to do if someone was unwell and when to call an ambulance.

Summary of findings

The trust recognised the key role it played in delivering The End of Life Care Strategy, Department of Health (2008), and the essential role it played in transporting patients to their preferred place to die.

To demonstrate its commitment and ensure it met its objective, the trust had a policy for the rapid transfer of the dying. The trust recognised the need for an appropriate vehicle that could not only transport the patient but also the family or carers who wished to accompany them; the target was to transfer a patient within 2 hours.

The trust also identified on the system patients who were dying at home, so that any calls from that address could be appropriately managed. End of life care was part of its mandatory training.

Patients who called more than twice in 7 days or 4 times in 28 days were recognised as 'frequent callers'. The trust had a 'frequent callers' team that liaised with the caller, their GP and other social care providers to ensure that the person's health and social care needs would be met by the right provider.

Staff had immediate access to a language line for people who made 999 calls and could not understand English.

Call handlers were trained in 'Type talk', which is a national telephone relay service for deaf, deafened, hard of hearing, deaf blind and speech-impaired people.

Call centre staff had a protocol to follow if they identified during the call that the caller may have a learning disability. Staff on ambulances had access to communication books that included easy-to-follow visual prompts. These were used when staff identified a patient who could not speak English or was unable to communicate for other reasons.

Complaints

The 'Making experiences count' team supported the trust to seek and act on feedback from people who used the service.

We reviewed recent complaints across the trust. We noted that the time to response and closure was on average 47 days, one complaint was still ongoing and the longest time to respond was 86 days. The trust's complaints policy did not state a mandatory time frame in which to respond to complaints, and this was not a statutory requirement. It was a requirement that services must bring the complaints system to the attention of users in a suitable format, such as on the internet or by distributing leaflets. The procedure for making a complaint was clear on the trust's website; however, throughout our inspection, we did not see complaints leaflets readily available either in the vehicles or at the receiving hospitals.

In most cases, we noted examples that the message had been received and appropriate action had been taken, we noted that in some cases the action had been reflection by the individuals concerned and this had been captured in writing, also detailed action plans to address the issues identified in the complaint. In two cases, we noted responses to patients advising them actions would be taken; however, we did not see the action plans so could not be sure that the actions had been taken. We also noted information on lessons learned in staff bulletins and updates as a direct response to the complaints we read.

None of the front-line ambulance staff we spoke with had any information about how to make a complaint that they could give to patients or relatives. In Cheshire and Mersey, they told us they would advise people to contact the emergency operations centre, or the trust's Patient Advice and Liaison Service (PALS). Staff were not familiar with the contact details and did not always have paper on which to write them down. They told us they felt the trust culture was not to encourage complaints, and that the general consensus was to try and discourage people from complaining formally. However, the trust had produced 'Making experiences count' leaflets that gave information on how to make complaints and we found that some of the PTS ambulance vehicles we inspected held stocks of these.

Complaints were recorded on a centralised trust-wide system. There was a centralised team that managed all complaints. Trust data showed that there had been 289 complaints across the whole PTS, and that 231 of these (79.9%) had been categorised as relating to arrival and collection times.

Summary of findings

The trust's performance targets were to acknowledge 95% of complaints within 1 working day and to resolve 80% of them within 40 working days. Trust data between July 2013 and June 2014 showed that responses to complaints did not always achieve this 40-day target.

The trust's patient experience annual report 2013/14 included an analysis of complaints about the PTS and listed actions to address the key concerns identified. In 2013/14, the PTS generated 47.3% of the complaints against the trust.

The trust's 'Making experiences count' team also reviewed and managed concerns raised by healthcare professionals about trust staff. We observed staff engaging with other providers in a positive way.

Public engagement

The service was using a variety of methods to engage with patients and the public. The trust's website contained detailed information about the services provided and actively encouraged people to submit their views and feedback. A community strategy had also been developed to widen public engagement and identify ways to improve the quality of the services provided. There was public consultation on a variety of trust policies, including the community strategy, communication and engagement, and equality and diversity.

An example of how the trust worked with local communities in 2012/13 included 300 members of the public attending an open day to hear about the service and its future plans. Trust staff attended many events, such as a local mosque open day and 'Fresher's' week' for the new university students, to encourage students to register with a GP, and to educate them on healthcare issues and when to call an ambulance.

The trust was active in using social media to engage the public and it had more than 9,000 Twitter followers at the time of our inspection. It had an award-winning patient experience board game that it used with community groups to identify gaps in public perception, service quality and information, as well as to involve them in service redesign.

The trust had achieved its target to reach a membership of 8,000 people and had elected shadow council of governors as part of the application for foundation trust status. It was actively engaging with the shadow governors.

The trust had also produced 'YouTube' videos to educate the public about the work it did.

Are services at this trust well-led?

Vision & strategy

The trust had a vision as well as a 5-year business plan to take it from 'Good to Great'. Staff freely quoted the vision: 'to deliver the right care, at the right time and in the right place', and it was visible in all the ambulance stations we inspected.

The trust had a quality strategy for 2011 to 2015. The purpose of this strategy was to set out how it planned to build on what it had achieved and to continue to improve the quality of the services it provided. This strategy included key objectives: for example, to ensure that the Patient Transport Services (PTS) was able to deliver the right care at the right time. These objectives had been applied across the service and measurable performance targets were set for each one, for example, patient arrival and collection times as part of the 'right time' objective.

The trust had an aspiration to be the safest ambulance service in the country. Executives described the three key aims of the trust as being to: deliver safe care closer to home; to be a great place to work; and to cause no harm to patients, public or staff.

The executives showed commitment and enthusiasm when they spoke of the trust and the Board's commitment. The longstanding Chair had recently appointed a number of new non-executive directors who had brought a variety of skills and expertise to the trust.

Summary of findings

Governance, risk management and quality measurement

The trust was using systems, processes and practices to keep people safe. Staff learned when things went wrong and took steps to improve safety standards. Safety was monitored in real time, reacting to changes in risk levels for individuals. Staff anticipated potential risks and planned for them in advance whenever possible. There were structured committees that fed into the trust Board and the Board received assurance through well-established routes.

The trust had developed a process for responding to calls when a patient had already been seen by ambulance staff within the previous 24 hours. These calls were automatically flagged and alerted the clinical governance department alerted. After they had been triaged, the calls were passed to a local advanced paramedic to investigate and identify any potential care planning needs or learning that would be of benefit to the person using the service.

However, we found inconsistent practices in the management of local risks including risks associated with the reporting of and learning from incidents, the storage and management of medicines, maintenance of trust premises and the availability of clinical advice for non-clinical staff. Where we found good practice, this had not always been shared with staff and managers performing the same roles across the trust.

Within the call centres, there was a medically approved call triage system. Staff followed evidence-based care guidance in assessing callers' symptoms and ensuring they were referred to the appropriate healthcare professional. The senior managers monitored each team's performance and the results were displayed in the emergency operations centre.

Performance was monitored and reported at station level and also at sector level, via the clinical quality improvement forum.

However, the service was unable to give us audit data for the performance of individual staff members in some locations; so local managers were unable to identify when staff were not performing or to benchmark staff against targets.

The quality of the service was monitored by auditing clinical pathways through the clinical performance indicators; this information was displayed across the trust's premises and in local accident and emergency departments. The trust was leading the way for ambulance trusts in the development of the clinical performance indicators.

Senior paramedics assessed ambulance crews' performance through audits of completed patient report forms, as well as by regularly accompanying paramedics on shift.

We were told there were no risk registers held at a local level to identify issues or concerns relating to their location. However, operational managers monitored their risks through incident reporting and real-time data about demands on the service, the Quality Committee meeting had oversight of risks on the risks register and the Director of Quality presented detailed papers as a standing item.

The trust used care bundles as a way of measuring the quality of care being delivered to patients. A 'care bundle' is a group of interventions related to a condition that, when delivered together, result in better outcomes than when implemented individually.

The initial care bundles developed in 2008 were for asthma, cardiac arrest, hypoglycaemia, pain management, patient report form completion and stroke. We noted year-on-year improvement across the trust on all six bundles. The trust introduced two new ones in 2013: one for patients who had an isolated limb fracture, and the other for children who had had a febrile convulsion.

While on inspection, we noted that in 2014/15 a further three care bundles were being piloted. These were for patients who had had a transient loss of consciousness (TLOC), those who had intended to self-harm and those who had fallen. The Medical Director at the trust was the Chair of the National Ambulance Service Clinical Quality Group (NASCQG), and the trust had led the way in implementing and rolling out clinical quality indicators and care bundles.

Summary of findings

We saw many examples of the trust's commitment to continuous improvement. Targets for improvement were not set with a fixed percentage increase they took account of previous achievements and consider how to improve performance still further, in some cases apply stretch targets.

Leadership of service

The trust's executive team showed commitment to high-quality care, while recognising the challenges of providing a service in a large and diverse geographical area. The population the trust served had the worst health indices in England, thereby placing an increasing demand on the service that outweighed its capacity. During peak period of activity resources did not always meet demand.

The Board was made up of individuals whose skills and expertise complemented each other. The Chief Executive was one of the first paramedics in the country, the Medical Director chaired the committee that led the way in developing quality indicators for ambulance services, and they all showed commitment to the service and its aims and objectives. The Director of Organisational Development was enthusiastic and eager to improve the working environment for staff within the trust and the trust had received numerous accolades in evidence of this. Most recently these included an Investors in People Champions award in September 2013 and a National Management & Leadership Awards - Team of the Year award in October 2013.

The trust was focused on the quality of care being delivered and on achieving performance targets, and had recognised the need to strengthen the representation of its non-executive directors on the Board. Most of the non-executive directors were new to the organisation. They brought a wide range of experience and expertise, this included individuals with financial, business, public sector and medical backgrounds. The individuals we spoke with were committed and enthusiastic; despite their limited time in the trust they appeared to understand both the vison and the challenges.

The Chief Executive's passion and commitment to getting it right, not only for patients but also for his staff and the organisation as a whole, came over in every conversation we had with him. This trust was the first ambulance service to achieve Centre of Excellence status for leadership development.

Local leadership was again inconsistent with low appraisal rates for some staff in the trust, inconsistency of access to key information for staff and a failure to deliver agreed improvements to the environment in a timely manner in one of the trust's operations centres.

The trust Board received detailed papers that had been through a comprehensive committee structure.

Culture of Service

The NHS staff survey 2013 showed that, over the past 3 years, there had been continual improvement in how motivated and satisfied staff felt about their roles; how they felt they could use their skills in their roles and the level of support they experienced from colleagues. However, the health and wellbeing of staff continued to be areas in which staff reported more attention was needed.

Local staff survey data for the service was not available but the trust's overall performance was rated as better than average, or tending towards better than average, for 10 of the 28 key findings in the NHS Staff Survey 2013. The trust was rated as worse than average, or tending towards worse than average, for 8 of the 28 key findings. These included working extra hours, staff appraisals within the past 12 months and staff experiencing harassment, bullying or abuse from patients, relatives or the public in the past 12 months.

The trust had reviewed the findings from the survey and started two projects: one focused on staff health and wellbeing and the other on violence and aggression experienced by staff.

Summary of findings

The overall aim of the health and wellbeing project was to identify the positive actions the organisation took both operationally and corporately, and to establish appropriate systems and procedures for continued and regular reviews of worker and workplace health and wellbeing.

An independent organisation was undertaking the survey, which also incorporated the review of violence and aggression experienced by staff. The survey was developed in partnership with staff representatives to understand how work influences the health and wellbeing of staff, and to understand the prevalence, nature and consequence of violence and aggression experienced by staff. The intention was that the results would help to develop an action plan so that the trust could make identified improvements.

The trust had recently reviewed its sickness policy and had an encouraging relationship with occupational health workers, whom staff could go to for support.

The call centre environments we visited varied. We heard from some staff that they had regular breaks from the computer screens during their shifts and that they worked no more than 3 night shifts in a row; this was because it was recognised that doing more could compromise wellbeing, safety and decision making. However, some call handling and dispatch staff raised that they felt unsupported in their role and not listened to.

Across the whole organisation, staff were dedicated and regularly worked longer than contracted hours, supporting the service and each other. Many staff groups had worked together for a number of years and socialised together.

We were told by some that that the working environment was supportive and that there was a 'no blame culture'. Staff were encouraged not to tolerate colleagues' poor practice and there was a procedure for them to report this. However, the view of 'no blame' culture was not universal with many clinical staff in one area sharing the view, the only time they received clinical supervision was when something had gone wrong.

The trust had also renamed the Whistleblowing policy, as Raising Concern at Work policy to enable the purpose of the policy to be clear to all.

Staff engagement

Staff gave us examples of being involved in the development of work systems, such as working hours and the development of the urgent care desk modules.

Staff were given information relevant to their role through one-to-one contact, team meetings, briefings or circulars. All staff had access to a staff suggestion scheme on the intranet; however, not all suggestions were acted on. Staff could access the Chief Executive directly through the intranet or email.

There were clear management structures to ensure that staff were supported to carry out their duties. However, access to clinical leadership was varied across the trust and this is detailed in the location reports. Staff on the front line and most other staff knew whom to contact if they needed to raise clinical concerns or operational issues. The culture of the teams differed across the sectors. Staff we spoke with were honest and committed to providing the best care for people who accessed the service. They all recognised the increasing demand on the service and many were involved in trying to reduce this demand and improve the service.

The trust had become the first ambulance service in the UK to be awarded the Investors in People Gold standard. Investors in People are a nationally recognised standard that both private and public sector organisations can obtain when they show high standards in business and people management. The award is categorised as Standard, Bronze, Silver and Gold, with Gold being the highest accolade. Only 2% of Investors in People award holders have achieved this.

Summary of findings

The trust achieved the Gold standard following an intense assessment process by Investors in People, which included visiting various trust sites, shadowing training events and interviewing more than 160 employees, union representatives, non-executive directors and community first responders. The trust will be re assessed in October 2015. Following the Gold award the trust received Investors in People Health & Wellbeing Award in June 2013 and Investors in People Champions, September 2013.

In the past financial year alone, over 900 members of the service's workforce benefited from a range of in-house workshops and training, and over 220 participated in external activities such as undergraduate degree and Master's courses in public health, healthcare practice, and personnel and development.

Innovation, improvement and sustainability

The trust had used Commissioning for Quality and Innovation (CQuIN) funding to support innovative projects to improve quality of care. The lead commissioners were positive about the leadership of the trust and the commitment shown to address the challenges faced. They recognised the large demographical area, and the variety of expectations from numerous clinical commissioning groups. However, they noted the trust's commitment to improve the quality of care and performance of the service to a large and diverse population.

Through CQuIN funding the following developments have progressed: the establishment of the 'frequent callers' project, the patient stories, patient diaries, mental health project and the Electronic Referral Information Sharing System. The trust and the commissioners recognised that the initiatives not only improve the quality of service: they also contribute to the sustainability of a service in which demand continues to exceed capacity at pace.

There were clear and separate management and clinical leadership structures in place. Most staff were aware of who their line manager was. Due to shift patterns emergency staff did not always see their line manager but they knew there were managers on shift at the larger stations if they needed them.

Visibility of managers varied across the area. Some staff at the smaller ambulance stations said they rarely saw them but could speak to them on the phone if necessary. PTS staff told us they had limited communication with any managers above team leader level, and limited contact and little direct communication with senior managers or trust executives.

Senior staff held 'hot debriefs' for staff immediately after a serious or difficult incident. This enabled staff to discuss their thoughts and feelings, and any outcomes that worked well or could have worked better.

Innovation, improvement and sustainability

The trust had introduced new technologies and we were told that crews were now using mobile devices for the management of information. The trust had piloted the use of text reminders for appointments and was looking to develop the use of mobile phone technology for seeking patients' views and improving service delivery.

Outstanding practice and areas for improvement

Outstanding practice

- Numerous examples where staff showed a caring, committed and compassionate manner, despite the situation or the environment they were in, or the challenges they faced.
- Patients who called more than twice in 7 days or 4 times in 28 days were recognised as 'frequent callers'. The trust had a 'frequent callers' team that liaised with the caller, their GP and other social care providers to ensure that the person's health and social care needs would be met by the right provider.
- Clinical staff performance was monitored and all paramedics' results were published within the team. Each paramedic had a unique identifying number so only they would know which results related to their performance. This meant they could compare their performance against their colleagues without knowing which results related to whom.
- 'Prevent' is part of the UK government's counter-terrorism strategy known as CONTEST, which aims to reduce the risk to the UK and its interests overseas from terrorism. At the time of our inspection, 55% of staff had completed their training.
- Emergency medical technicians had completed basic training to undertake their role. Until recently, there had been little support for them to further their career. However, a trial was taking place to offer a course that would enable them to raise their level of education in order to gain access to further opportunities.
- The trust showed commitment to ongoing education and development of their staff at all levels. It appointed one of the first consultant paramedics back in 2008 and was focused on ensuring that staff were equipped to carry out their roles.
- The commitment and enthusiasm for the use of 'volunteer community first responders and their support was evident. They received a comprehensive 6-month package of training, and then continuing training and support.
- The trust had developed a process for responding to calls when a patient had already been seen by ambulance staff within the previous 24 hours. These calls were automatically flagged and referred to the clinical governance team who then immediately reviewed these incidents to understand and share any learning from these incidents.
- The purpose-built emergency operations centre at Parkway in Manchester provided a good working environment and a positive atmosphere to work within.

Areas for improvement

Action the trust MUST take to improve

Importantly, the trust must:

- Review the process for pre-alerting hospital accident and emergency (A&E) departments to make sure that communication is sufficient for the receiving department to be made fully aware of the patient's condition.
- Make sure that emergency operations centre staff across all three EOCs are consistently identifying and recording incidents as appropriate.
- Make sure dosimeters (that measure exposure to radiation) on vehicles are in working order.
- Improve access to clinical supervision for all clinical staff.
- Review medicines formulary guidance issued to front-line staff to make sure it is current.
- Ensure that all staff are receiving the mandatory training necessary for their role ..Ensure that all staff across all divisions are consistently receiving appraisals

The trust should:

- Assess the impact and mitigate of any identified risks by call-handling staff not having access to clinical advice, in contrast to regular clinical advice being sought by Manchester Parkway call-handling staff.
- Assess the impact and mitigate associated risks of non-clinical staff re-triaging calls.

Outstanding practice and areas for improvement

- Make identified measures specific, measurable, achievable, realistic and timed, in action plans relating to the Broughton emergency operations centre call-handling and dispatch team and their working environment,
- Audit and assess individual call-handling performance at all emergency operations centre.
- Assess and implement measures to improve performance for the proportion of calls closed with telephone advice when clinically appropriate.
- Review the adoption of the urgent disconnect policy at all emergency operations centres.
- Assess and implement measures to improve performance against the national target for the percentage of calls abandoned before being answered.
- Share learning and good practice across emergency operations centres.
- Review the system for managing controlled drugs at ambulance stations to ensure that they are managed appropriately.
- Review systems to assess if access to new stocks of controlled drugs in rural areas can be improved.
- Evaluate the availability of training and opportunities for career progression for emergency medical technicians across the trust.
- Assess and implement measures to improve performance against the 40-minute transfer target for transport services patients having haemodialysis or cancer treatment.
- Ensure that the public know how to complain should they wish to.
- Improve complaint response times.
- Ensure that the various communication media that the trust employs be supported to be effective by the ability of staff to access them in both time and physical access.
- Consider bringing forward the programme to provide a new Emergency Operations Centre (EOC) at Elm House Liverpool or consider renting purpose built accommodation
- Re-examine and improve basic cleaning processes for ambulances such as standards for replacement of mop heads and processes for replenishing buckets containing cleaning fluids
- Re-examine processes for access to drugs to prevent long round trips for ambulances in certain locations
- Instigate team meetings or training in specialist subjects, such as the Mental Capacity Act 2005 or deprivation of liberty safeguards for Liverpool Elm House EOC staff.
- Develop a system for EOC staff to deal with requests for information from the police.
- Call-taking and dispatch staff arranged call-backs to Green 3 and 4 calls (non-life threatening) that had passed the expected response time, in order to explain delays and check for any deterioration in the patient. This was organised in an ad hoc way and sometimes overlapped with call-backs undertaken by staff at the urgent care desk. Set up a process to undertake this is a systematic way.
- Improve the frequency of face-to-face interactions between managers and staff ensure that team meetings take place on a regular basis.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff 23. (1) The registered person must have suitable arrangements in place in order to ensure that persons employed for the purposes of carrying on the regulated activity are appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard, including by — (a) receiving appropriate training, professional development, supervision and appraisal.