East of England Ambulance Service NHS Trust

Inspection report

Unit 3, Whiting Way
Melbourn
Royston
SG8 6NA
Tel: 08456013733
www.eastamb.nhs.uk

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Ratings

Overall trust quality rating	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Good**
Are services responsive?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Overall summary

What we found

Overall trust

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

We rated well led (leadership) from our inspection of trust management, taking into account what we found in relation to leadership within the individual core services. We rated other key questions by combining the service ratings and using our professional judgement.

We conducted this comprehensive short notice announced inspection of the emergency and urgent care and emergency operations centre core services between 5 April and 6 April 2022. We also inspected the well-led key question for the trust overall between 4 May and 5 May 2022.

We did not inspect the core services of resilience or patient transport services because this inspection was focused on services where we had concerns. However, we continue to monitor the progress of improvements to these services and will re-inspect them as appropriate.

Our rating of this trust improved. We rated it as requires improvement, however the chief inspector of hospitals has recommended to NHS England and NHS Improvement (NHSEI) that it remain in the Recovery Support Programme to ensure the trust continues to receive relevant support to continue to make the changes required.

- The trust has made marked improvement on those issues that led to it being placed in the Recovery Support Programme (which was then called Special Measures).
- We rated caring as good, safe, effective and responsive as requires improvement. Well-led is the overall trust-wide rating, not an aggregation of services ratings.
- We rated both services we inspected as requires improvement overall. In rating the trust, we took into account the current ratings of the two services we did not inspect this time.
- Mandatory training, including safeguarding compliance was consistently low throughout the organisation.

Our findings

- Staff did not routinely appraise staff's work performance or hold supervision meetings with them to provide support and development.
- Leaders did not always understand or manage the priorities and issues the service faced. They were not always visible and approachable in the service for staff.
- Staff did not always feel respected, supported or valued and there was a lack of professional standards being adhered to and a lack of urgency and ownership of responsibilities within the service.
- For concerns requiring action from senior leaders in the organisation there were often delays in getting a response impacting on the ability of local leaders to deal with issues and concerns at a local level in a timely way.

However:

- Staff provided care and treatment based on national guidance and evidence-based practice. The trust monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved outcomes for patients.
- Staff treated patients with compassion and kindness, they provided emotional support to patients, families and carers to minimise their distress. Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.
- All those responsible for delivering clinical care worked together as a team to benefit patients and staff gave patients practical support and advice to access appropriate services. Staff kept detailed records of patients' care and treatment. Records were clear, stored securely and easily available to all staff providing care.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.
- Leaders operated effective governance processes, throughout the trust and with partner organisations.

East of England Ambulance Service NHS Trust (EEAST) provides an emergency ambulance service 24 hours, 365 days a year across Bedfordshire, Hertfordshire, Essex, Norfolk, Suffolk, Cambridgeshire and Peterborough. This area is made up of:

- More than 6.2 million people
- 7,500 square miles
- 15 Clinical Commissioning Groups
- Six integrated care systems
- 17 acute hospital trusts

The trust also provides hear and treat and see and treat services. In some areas, the trust provides non-urgent patient transport for patients requiring non-emergency transport to and from hospital and treatment centres.

In 2020/21 the trust:

- received 1,195,670 emergency 999 calls
- treated 82,015 people through their Emergency Clinical Advice and Triage Centre
- made 426,500 non-emergency (patient transport service) journeys

Our findings

The trust's resources and teams include:

- more than 4,000 staff and more than 800 volunteers
- three ambulance operations centres (AOCs) located in Bedford, Chelmsford and Norwich
- 387 front line ambulances
- 178 rapid response vehicles
- 175 non-emergency ambulances (patient transport service and health care and HCRTs vehicles)
- 46 HART/major incident/resilience vehicles
- more than 120 sites.

Total income in 2020/21 was more than £402 million.

(Source: Trust website)

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 previously inspected EEAST under our current methodology and published the report in September 2020 and rated the trust as requires improvement overall, with well led being rated as inadequate.

How we carried out the inspection

We carried out this inspection on various days throughout April and May 2022. We visited areas relevant to each of the core services. We inspected and spoke with a number of staff groups. During the inspection we visited two emergency operation centres and six ambulance stations. We spoke with 124 staff members of various speciality and profession including, emergency call handlers, emergency medical dispatchers, clinicians (including paramedics and nurses), student paramedics, emergency medical technicians, team leaders, duty managers local operations managers, and senior managers.. We spoke with 18 patients throughout the departments and observed patient care.

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Outstanding practice

All staff were focused on delivering the best level of care they could for their patients. They took the time to understand their patients individual needs to deliver high quality, personalised care. All staff we observed, did their absolute best to ensure patients were well cared for.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Our findings

Action the trust MUST take to improve:

We told the trust that it must take action to bring services into line with two legal requirements. This action related to two services.

Emergency and Urgent Care

- The service must ensure it provides mandatory training in key skills to all appropriate staff and volunteers. (Regulation 17 (1) (2) (b))
- The service must ensure that it has enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and or to provide the right care and treatment. (Regulation 18 (1) (2) (a) (b) (c))
- The service must ensure that all staff receive appraisals, one - to one support and that clinical staff receive clinical supervision. (Regulation 18 (2) (a))
- The service must ensure it continues to develop its staff engagement processes to improve staff wellbeing and respond to staff concerns within the service. (Regulation 17 (2) (a))
- The service must improve access to resources to support local managers take action to manage behaviours that do not meet the trust values. (Regulation 17 (1) (2))
- The service must ensure the application and recruitment process for internal promotion is open and transparent. (Regulation 17 (1) (2))
- The service must ensure people can access the service when they needed it, and that response times for calls are in line with national standards. (Regulation 17 (1) (2) (a))

Emergency Operations Centre

- The service must ensure it provides mandatory training in key skills to all appropriate staff and volunteers. (Regulation 17 (1) (2) (b))
- The service must ensure that it has enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and or to provide the right care and treatment. (Regulation 18 (1) (2) (a) (b) (c))
- The service must ensure that all staff receive appraisals, one - to one support and that clinical staff receive clinical supervision. (Regulation 18 (2) (a))
- The service must ensure the design, maintenance and use of facilities and premises always keep people safe. (Regulation 15 (1))
- The service must ensure staff complete risk assessments for each patient comprehensively to remove or minimise risks and update the assessments. (Regulation 17 (1) (2) (b) (c))
- The service must ensure people can access the service when they need it, and that waiting times for calls and dispatch of resources are in line with national standards. (Regulation 17 (1) (2) (a))
- The service must ensure it continues to develop its staff engagement processes to improve staff wellbeing and respond to staff concerns within the service. (Regulation 17 (2) (a))

Action the trust SHOULD take to improve:

Trust wide

Our findings

- The trust should ensure all staff are informed and engaged with in relation to the Fit for the Future programme. Regulation 17
- The trust should ensure there is a policy in place to support women, including those who are breast feeding back into the workplace following maternity leave. Regulation 17
- The trust should ensure they engage with and act on feedback from all staff, particularly from those represented with protected characteristics. Regulation 17
- The trust should continue with the pace of addressing cultural issues.

Emergency and Urgent Care

- The service should ensure that training opportunities are available and that the application process for training places is open and transparent.
- The trust should ensure there a systems and processes in place to support staff when skill mix is adjusted due to operational demands.

Emergency Operations Centre

- The service should ensure that it introduces and uses electronic information and data systems to improve performance regarding patient waiting times and to dispatch resources in line with national standards.

Is this organisation well-led?

Our rating of well-led improved. We rated it as requires improvement.

Leadership

There had been further significant changes in the executive leadership team since our previous inspection. Where there had been many interim posts previously, efforts had been made to establish a substantive leadership team. The senior leadership team understood the priorities and issues the service faced but had not always taken action to address them.

- The trust board was made up of nine executive directors, a chair, five non-executive directors and three associate non-executive directors. Since our last inspection, the trust had appointed a new Chief Executive Officer (CEO), Director of Nursing, Director of People Services, and a new interim medical director. In addition, the trust had created and appointed to the Director of Integration, Director of Strategy, Culture and Education and Director of Corporate Affairs and Performance roles.
- Since our last inspection, the executive leadership team had not had the experience, capacity and capability to lead effectively due to the high turnover of leaders and the number of leaders that were in interim positions. However, for the first time since our last inspection, all posts apart from the medical director post had been made substantive. Following our inspection, the trust advertised for a permanent appointment to this post. Some members of the team were just weeks into their post and were settling into their new roles. It was recognised by the executive leadership team that they were starting on their journey with building and strengthening the team with the aim of becoming a unitary board.
- Throughout our core service inspection, staff told us there had been a disconnect between the senior leadership team and the local leadership teams. Staff told us there was limited visibility of the executive team and that they were not

supportive. However, we heard this was not the case for the chief executive officer who regularly visited bases and offices. The chief executive officer also told us since they had been in post, they held regular engagement with the wider workforce and visited key areas within the service to talk with staff. They also told us that each member of the executive team had an objective to undertake visits to engage with staff going forward.

- A board development programme was in place to support the development of the senior leadership team. The board had completed phase one of the board development programme and were embarking on phase two throughout 2022. Following the recruitment of the new executive board, and through their development programme, the board had undertaken 360-degree feedback and put in place a coaching framework to develop an effective leadership team.
- The style and leadership of the new executive team represented a developing open and empowering culture. They recognised the seriousness of the concerns around the culture within the organisation.
- Staff were not always supported to develop. The recent pandemic had a significant impact on the trust's ability to support staff to train and develop. Mandatory training and appraisal rates throughout the trust were low. There was a recognition that training, development and annual appraisals were important at all levels and as a result the trust were in the process of addressing how to manage this given the current demands on the service.
- Many staff had been promoted into leadership roles but were not provided with the necessary training to support them in that role. During our core service inspection, we had several contacts from staff at the trust who described poor leadership. Examples included local managers not following policies and procedures, failing to recognise requests for reasonable work adjustments, failing to follow occupational health guidance, concerns regarding discrimination on the grounds of protected characteristics, and favouritism amongst the leadership team. At our well led inspection, the senior leadership team told us they had plans to address this through a time to lead programme for managers.
- We reviewed eight personnel files in line with Fit and Proper Persons Requirement: Directors (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014 and found appropriate employment checks had been made. Executive and non-executive directors were also required to complete an annual self-declaration, to confirm they did not fall into the definition of an 'unfit person' or any other criteria set out in the guidance. We reviewed evidence to confirm this was completed.

Vision and Strategy

The trust had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress but it was not clear how plans were going to be delivered.

- The trust had a vision for what it wanted to achieve and a five-year strategy (2020 to 2025) which was aligned to the vision. The strategy had been developed with the help of staff, patient representatives, volunteers, charity and emergency service partners and sustainability and transformation (STP) representatives and integrated care system (ICS) colleagues.
- The trust's vision was 'Outstanding care, exceptional people, every hour of every day' #WeAreEEAST. The vision was underpinned by four goals, these were to: be an exceptional place to work, volunteer and learn; provide outstanding quality of care and performance; be excellent collaborators and innovators as system partners and to be an environmentally and sustainable organisation. The goals were supported by sub strategies, such as an education and learning strategy, digital strategy, and sustainability strategy.

Our findings

- There were a number of plans ongoing, however key priorities for the change programme still needed to be finalised and agreed on. In addition, it was not clear how the team would deliver the plans.
- The trust had introduced a priority programme called 'Fit for the Future'. This programme aimed to bring together several key priorities of work to focus on the longer-term improvement the trust wanted to make within the service. The programme was split into five key workstreams: culture, workforce, system partnership, capability and capacity and demonstrating impact. At the time of our core service inspection, staff we spoke with below general manager level were unaware of the fit for the future programme. Throughout our well led inspection, the senior leadership acknowledged that while engagement events had happened, staff awareness and buy in was not at the stage they would like it to be and there was more to do in relation to communicating the Fit for the Future programme with staff.

Culture

Staff did not always feel respected, supported and valued. The trust was working towards promoting an open culture where staff, patients and their families could raise concerns without fear of reprisal.

- At our last inspection, we found high levels of bullying and harassment, inappropriate sexualised behaviour and a high number of open grievances. During this inspection, staff told us that harassment and bullying had been an issue and that managers had been slow to deal with these issues. However, they felt there had been an improvement regarding bullying and harassment. We saw evidence to support this, through the responsiveness of the executive team following incidents involving potential bullying, harassment and discrimination.
- Not all staff felt respected, supported, and valued by the leadership team. The temporary and constantly changing leadership structure and interim roles had led to a culture of uncertainty amongst the staff team and a lack of trust in relation to senior managers. Staff described feeling let down because changes had not happened or been followed through. Some staff descried a toxic culture, where bullying did happen and staff were treated badly, and managers did not provide the support required for staff to do their jobs. We heard how some staff felt middle management did not always take concerns seriously. In addition, some staff told us there was a network of managers that had known each other for years and that these networks suppressed change from happening across the services.
- Throughout our core service inspection, we found low levels of staff satisfaction and high levels of stress and work overload. Much of this related to staff burn out from the pandemic and delays at emergency departments. At the Chelmsford emergency operations centre, we found staff working in unclean areas, with equipment they described as out of date and that did not match equipment in other areas. Staff told us they had become used to this and managers felt the environment was affecting staff wellbeing and not creating a professional environment for them to work in.
- Actions were being taken to address behaviour and performance that was inconsistent with the values of the organisation. However, historically capacity issues within the HR department and delays in action from the senior leadership team had meant there were delays in decision making and action to be taken. As a result of delays in decision making and taking action, the trust had introduced a pre-action review meeting (Pre-ARM) which was chaired by an executive member of the team. The Pre-ARM took place immediately following an initial fact-finding investigation, which took place and was concluded within seven calendar days. The aim of the Pre-ARM was to mitigate any risk related to a rushed judgement to enter any staff into the disciplinary process. In addition, the trust had invested in HR roles over the past 12 months and had taken action to ensure sufficient capacity to manage the increased workload and cultural challenges. At the time of our inspection, 82% of legacy cases had been closed, however the number of cases remained high due to the number of new cases that had been reported through speak up activities.
- The trust had a clear plan to address the cultural issues throughout the organisation and had taken some steps in terms of freedom to speak up, cultural ambassadors and a speak out campaign.

Our findings

- The current leadership team had made some progress to improve organisational culture and could describe the areas where culture changes still needed to be strengthened and developed. Improvement plans were in place. The senior leadership team were working with staff to promote an open and honest culture whereby people were encouraged to be brave and speak out against inappropriate behaviours.
- The trust had recently appointed a director of culture, who at the time of our inspection had been in post for approximately four weeks. This was a new role within the organisation and had been introduced to work closely with the director of people services to support new ways of working in relation to culture throughout the organisation. Both the director of culture and the director of people reported good working relationships.
- The trust did not always promote equality and diversity in daily work. For example, the trust did not have a policy to support women who were breast feeding upon their return to work following maternity leave. These women were being supported back into the workplace alongside the trust's sickness policy. In addition, there were no facilities for women who wanted to express their breast milk. However, throughout our inspection, we were told that this was being addressed and a breastfeeding policy was being developed as well as a return-to-work toolkit for managers to support women back into the workplace following maternity leave.
- Since our last inspection, the trust had launched a 'speak up, speak out, stop it' campaign to encourage staff to report their concerns internally. The trust employed more than 4,000 staff and 800 volunteers and had one freedom to speak up guardian (FTSUG). There was a plan for another 0.6 whole time equivalent FTSUG to support from the end of May 2022. The trust had just appointed 10 freedom to speak up ambassadors. The Chief Executive Officer was the executive lead for freedom to speak up and there was an identified non-executive director who was the freedom to speak up lead.
- The FTSUG reported themes of concern on a quarterly basis to the board of directors. From April 2021 to December 2021, 268 referrals had been received by the FTSUG. Themes related to bullying and harassment, application of systems and processes and behavioural and/or relationship concerns. Clear actions and objectives were in place and were being monitored through the board for the rest of the financial year.
- We found good collaborative working between the FTSUG and union representatives. There were obvious trends and themes in the concerns raised by the unions and FTSUG.
- Throughout our inspection, we reviewed five serious incident investigations and found that duty of candour had been applied. Before our inspection, we had raised concerns with the trust about the completion of their three-day investigation reports as they did not always detail the reporting of the risks and actions taken to mitigate risks in enough detail. We noted that more recent three-day reports were more detailed and comprehensive in relation to actions taken to mitigate risks. In addition, the trust had started to undertake cluster reviews to identify specific themes related to serious incidents. This was an improvement in relation to the investigation of incidents.
- At our last inspection we identified there was not enough emphasis on staff well-being. Since our last inspection, the trust had recently signed up for the blue light mental health at work commitment which requires the trust to submit an action plan by the end of October 2022. In addition, the trust had a wellbeing strategy and had recently recruited a wellbeing manager and three additional wellbeing staff.

Governance

Leaders operated effective governance processes, throughout the trust and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of services.

Our findings

- The trust had been in repeated breach of regulation 17 (good governance) of the Health and Social care Act 2008 since August 2016, and at our previous inspection, we served the trust with a section 29A warning notice in relation to this breach. At our most recent inspection, we found that leaders operated effective governance processes, through the trust and with partner organisations and that staff were clear about their roles and responsibilities.
- Governance processes in place ensured there were opportunities for the senior leadership team to discuss and learn from the performance of services, including reviewing actions taken to mitigate risk. However, both the executive and non-executive members of the board recognised that papers submitted to the Board and Committees needed to be strengthened.
- Non-executive directors were able to review performance information and scrutinise data which enabled open discussions with executive colleagues.
- The board assurance framework was aligned to the strategic objectives and links were evident to the significant risk register. There was an executive lead for each of the strategic objectives who were responsible for providing updates on the delivery of the objectives with evidence of impact, as well as mitigating actions whereby the objective was not on track to be delivered.
- In 2021, the trust commissioned an external governance review to determine priority areas to focus upon. The scope of the review included risk, governance, accountability, and frameworks. The review identified that risk and governance were areas that needed strengthening. Since the review the trust had
- Financial assurance was provided through the finance reporting routes, and the trust executive team demonstrated a high level of confidence in the Director of Finance and the supporting team.
- The trust had a strong relationship with its lead commissioner in the Suffolk & North East Essex system and had aligned both executive directors and non-executive directors across each system within the region.
- Each executive director held their own portfolio for management responsibilities, however the leadership team informed us defined portfolios for each executive director were still being finalised as new members of the team had joined.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. However, identified risks were not always acted on. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

- At our previous inspection, we identified a number of risks on our inspection that required urgent action due to posing the potential for harm to staff and patients. We placed conditions on the trust's registration requiring urgent action to be taken to identify the extent of risks and to introduce control measures. At our most recent inspection, we found arrangements were in place to identify, record and manage risk, issues and mitigating actions had been taken to reduce risk. The trust operated a Red, Amber, Green (RAG) rated corporate risk register that reflected current risks within the trust. However, risks had not always been acted on. For example, during our core service inspection we raised concerns regarding the management of the patient call and risks to patients waiting long periods in the stack, who may not receive welfare calls, or may deteriorate whilst waiting for resources to be deployed.
- We also raised a concern about the conditions that staff were working in at the Chelmsford Emergency Operations Centre, where we found staff working in unclean areas, with equipment they described as out of date and that did not match equipment in other areas. This was not identified as a risk on the trust's corporate risk register and had not been acted on by the senior leadership team, however the trust did take action once we raised concerns with them.

Our findings

- Risks were aligned to a member of the executive team who was required to review significant risks on a monthly basis, and these were reported to the board of directors.
- There was a positive incident reporting culture. Staff told us they were encouraged to report and learn from incidents which we saw within our core service inspections.
- Plans were in place to ensure the trust could cope with unexpected events.
- The most significant financial risk facing the trust was financial sustainability. The financial plan required significant efficiencies which needed to be delivered whilst simultaneously maintaining and improving operational performance.
- The relationship between finance and quality was balanced and clinical sign off was required at an executive level for all Quality Impact Assessments.

Information Management

The service collected reliable data and analysed it. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

- The trust had made improvements to their information technology infrastructure but recognised there was still work to do in this area.
- IT systems were integrated and secure, to prevent unauthorised access to information.
- All crews had access to handheld devices which were password protected and designed to capture data in real time. The devices meant staff could report incidents and safeguarding concerns in real time without having to report back to their base. Information was kept confidential and stored securely.
- The trust had recently commenced the use of statistical process controls to understand performance, make decisions and improvements. These were presented within an integrated performance report and presented to the board of directors on a bi-monthly basis.
- The Caldicott Guardian worked with the senior information risk owner (SIRO) and processes were in place to ensure data was protected.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

- The senior leadership team recognised staff engagement was an area for further development and were planning on setting up a task and finish group to address this.
- Throughout our core service inspection, staff told us that most communication was done by email, core messages and bulletins.
- The trust had developed a community engagement group with patient representatives. This related to patient engagement through the complaints process and included speciality portfolios and training and developing volunteers.
- The trust had a patient and public involvement strategy that had been co-produced with patients. This set out the trust's direction for involvement and engagement for the next two years. A workplan and implementation plan had been developed alongside this.

Our findings

- Representatives from staff networks told us the Chief Executive Officer had raised the importance of the staff network groups and supported their work. The representatives recognised further work was required to ensure the networks were fully recognised and available to all, which was also echoed by the Chief Executive Officer.
- The executive team recognised not all staff felt valued and respected. Areas of concern raised from bullying and harassment had also identified discrimination against those with protected characteristics. The executive team recognised this and acknowledged more work was required in this area.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. However, staff did not feel empowered to innovate or improve working practices.

- At our last inspection, we identified there were not robust systems in place to ensure complaints were appropriately investigated and identified as possible serious incidents; and that complaint themes were not triangulated with incident themes to address common concerns. Since our previous inspection, the trust had restructured the patient safety and patient experience teams and introduced a patient safety improvement specialist and recruited a patient experience improvement manager role.
- The trust was committed to improving services by learning from when things went well, and when they went wrong. For example, managers shared feedback from compliments, complaints and incidents.
- Leaders were aware of improvements made as a result of serious incidents and complaints. This was evident through the introduction of patient experience data and the lessons learned information that was completed to demonstrate individual, team or trust wide learning.
- Those leading on root cause analysis investigations had received relevant training to ensure incidents were appropriately investigated and actions identified.
- A weekly complaints tracking meeting took place to track complaints and concerns that were overdue a response to the complainant. This was to enable earlier escalation and discussion of any challenges or actions.
- Training had been provided to the complaints and patients advice and liaison (PALS) team which included Parliamentary Health Service Ombudsman standards of complaint handling, a journey through complaints handling with empathy, customer services and complaints letter writing and quality, service improvement and redesign (QSIR).
- Throughout our core service inspection, staff told us there were not robust mechanisms in place for providing all staff at every level with the development they needed, including high-quality appraisal and career development conversations. Staff appraisal levels were low and training opportunities and opportunities for progression were limited. This had been impacted by the pandemic. The senior leadership team were aware of this and had a plan in place to ensure staff received training going forward.
- The executive leadership team recognised that continuous improvement methodology was required, but at the time of our inspection, this was not fully present and embedded.
- The executive leadership team recognised that whilst progress had been made, there was still significant work that needed to be done to strengthen their systems and processes.

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	→←	↑	↑↑	↓	↓↓

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement →← Jul 2022	Requires Improvement →← Jul 2022	Good ↓ Jul 2022	Requires Improvement ↓ Jul 2022	Requires Improvement ↑ Jul 2022	Requires Improvement →← Jul 2022

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Ambulance	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Overall trust	Requires Improvement ➔➔ Jul 2022	Requires Improvement ➔➔ Jul 2022	Good ↓ Jul 2022	Requires Improvement ↓ Jul 2022	Requires Improvement ↑ Jul 2022	Requires Improvement ➔➔ Jul 2022

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for ambulance services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency operations centre (EOC)	Requires Improvement ↓ Jul 2022	Requires Improvement ↓ Jul 2022	Good ➔➔ Jul 2022	Requires Improvement ↓ Jul 2022	Inadequate ↓↓ Jul 2022	Requires Improvement ↓ Jul 2022
Patient transport services	Requires improvement Jul 2019	Requires improvement Jul 2019	Good Jul 2019	Good Jul 2019	Requires improvement Jul 2019	Requires improvement Jul 2019
Emergency and urgent care	Requires Improvement ➔➔ Jul 2022	Requires Improvement ➔➔ Jul 2022	Good ↓ Jul 2022	Requires Improvement ↓ Jul 2022	Requires Improvement ➔➔ Jul 2022	Requires Improvement ➔➔ Jul 2022
Resilience	Good Jul 2019	Good Jul 2019	Not rated	Good Jul 2019	Outstanding Jul 2019	Good Jul 2019
Overall	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement

Overall ratings for ambulance services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Emergency and urgent care

Requires Improvement ➔➔

Is the service safe?

Requires Improvement ➔➔

Our rating of safe stayed the same. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff however not everyone had completed it.

Staff did not always receive and keep up to date with their mandatory training.

Staff received mandatory training in both face to face and online formats. Staff accessed mandatory training through an online platform which automatically alerted them three months before their training expiring.

Staff completed Essential Care Skills (ECS) annual clinical update training. This included face to face learning and assessment as well as an online workbook. Training completion rates had been impacted by the COVID-19 pandemic with face to face training being suspended and operation pressures meaning that staff could not access training. Data provided following our inspection, showed a 50% completion rate across all sites visited against a trust target of 95% for the online statutory mandatory training. This meant the trust had not met their target for mandatory training.

Staff told us a recent face to face training day had been cancelled at executive level due to operational demand. Staff told us the online training was frequently completed in their own time as they did not get enough down time to complete in working hours.

The mandatory training was comprehensive and met the needs of patients and staff. Staff confirmed the face to face training was comprehensive, however, they were disappointed a two-day training had been condensed into one day as this did not allow time for any additional training for example, learning from serious incidents.

Staff had to complete a four-week blue light driver training course. The refresher for this course was one day and had to be repeated every five years, although staff were not able to tell us if they were informed when update training was due.

Clinical staff completed training on recognising and responding to patients living with mental health needs, learning disabilities, autism and dementia.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers were aware that the service was not meeting trust targets and told us training was suspended during the COVID-19 pandemic and restarted in February 2022. Managers told us there was a plan going forward with a trajectory for completion by the end of June 2022. General managers were positive that they would meet the target. The service had trained new trainers to conduct the training course. However, some members of staff told us that they were expected to complete mandatory training in their own time due to pressures on the system.

Emergency and urgent care

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. Staff knew how to make a safeguarding referral and who to inform if they had concerns.

The service had an up-to-date safeguarding policy which referenced the Mental Health Act 1983, Mental Capacity Act (MCA), and Deprivation of Liberty Safeguards (DoLs) and a multi-agency safety hub. Staff could easily access this from the trust intranet document library, from the station or their vehicle.

Staff had safeguarding training to level 1 and 2 in line with the intercollegiate document on safeguarding training guidance. Data received demonstrated the service had a 58% training compliance rate against a trust target of 95%.

Staff understood the referral process through the single point of contact (SPOC). The SPOC was a person or department that handled all requests and inquiries. They oversaw the communication, management, and the reporting of concerns in both adults and children.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act 2010. Staff completed online training in equality, diversity and human rights. They completed prevent (safeguarding against radicalisation) training and attended an interactive facilitated workshop to raise awareness of prevent (WRAP).

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff told us they were in a privileged position of entering a person's home and were uniquely placed for patients to share confidences or to make a judgement call about the home environment. Another member of staff told us about a patient they attended to in a care home who had not been reviewed by staff, they had made a safeguarding referral to protect the patient from harm.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff reported safeguarding concerns to a single point of contact (SPOC) based at the ambulance operations centre (EOC). The SPOC completed the safeguarding referral to the local authority safeguarding team. Staff were able to make safeguarding referrals directly themselves using their phone or tablet.

There was a safeguarding lead trained to safeguarding adults and children level 3 available to staff at each station and level 4 and 5 trained staff available in the wider trust.

Disclosure and Barring service (DBS) checks were in place. Staff were informed when an update was due. The paperwork for the checks was arranged locally. This process was confirmed by the sector resource planning manager.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment, vehicles and the premises visibly clean.

All areas we inspected were clean and had suitable furnishings which were clean and well-maintained. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Stations were cleaned by independent contractors.

Emergency and urgent care

The service conducted regular infection prevention and control (IPC) audits which included vehicles, uniform and station audits. Audit data reviewed following our inspection demonstrated the service produced progression charts to demonstrate compliance, areas for improvement and IPC incidents.

Vehicles we inspected were clean and well maintained. Cleaning of vehicles when they were in stations was performed by the make ready team, and daily vehicle cleaning records were entered onto the service's online audit programme which leading operational managers (LOM's) and assistant general managers (AGM's) had access to.

Deep cleaning of vehicles took place every 12 weeks. Deep cleaning of vehicles was logged on the service's online audit programme. Results were recorded by area general managers. For example, Peterborough was at 85% and Cambridge 78% against a trust target of 85%. The 12-week deep clean rates were at 84% for Peterborough and 86% for Cambridge in March 2022.

We checked 16 emergency vehicles. All vehicles we inspected were equipped with visibly clean equipment, clean and available linen, hand gel availability, personal and protective equipment such as aprons and gloves, and decontamination wipes. The vehicle's sharps boxes were all signed and dated. The mini sharps bins in the two grab bags we reviewed were not dated, this meant that we could not tell how long any dirty sharps had been in the grab bag.

Cleaning records were up-to-date and demonstrated that all vehicles were cleaned regularly. The make ready team undertook vehicle, equipment and station infection, prevention and control (IPC) audits. Audit data reviewed after the inspection showed that the service monitored compliance well and used audits to identify incidents and areas for improvement. Hand hygiene compliance was assessed by looking at staff performing hand hygiene and elements that facilitate hand hygiene such as instructional posters, sanitiser availability, and bare below elbows.

Staff did not always follow infection control principles including the use of personal protective equipment (PPE). We observed staff wearing face masks, but they did not always wear level 2 PPE which included gloves and plastic apron when attending to patients. `

Staff maintained the cleanliness of their own uniform and explained if their uniform became severely soiled or contaminated it would be disposed of in the appropriate waste bin and a replacement requested.

Staff performed COVID-19 tests on patients on arrival at the hospital, this helped hospital staff to cohort patients and reduce risk of cross infection.

The service had a team of dedicated COVID-19 marshalls who completed COVID-19 secure risk assessments and audits. They risk assessed each area of the station and implemented controls to reduce risk, including limiting room occupancy or cleaning work surfaces after use. Audit results were collated centrally and were shared in a monthly COVID-19 secure report which identified areas for improvement, good practice and overall compliance. Compliance from October 2021 to December 2021 was an average of 90%.

Staff cleaned equipment after patient contact, we observed staff consistently cleaning equipment they had used between patients to ensure it was clean for the next patient use.

Environment and equipment

The design, maintenance and use of facilities, premises, vehicles and equipment kept people safe. Staff were trained to use them. Staff did not always manage clinical waste well.

Emergency and urgent care

The design of the environment followed national guidance. Chelmsford, Southend, Peterborough and Waveney stations were well designed and large enough for the staff and vehicles that operated from them. They had a make ready service area and repair workshop. However, the Cambridge and Kings Lynn stations were more restricted in size and layout.

Staff had communal break areas to eat and relax, separate toilet and shower facilities, medicines and stock stores and garages to house vehicles during cleaning and restocking of equipment and consumables.

Staff carried out daily safety checks of specialist equipment. Daily vehicle inspections were consistently undertaken by staff before their shifts. Staff had checklists to complete and we observed these had been fully completed. These checklists were audited and results were fed back to assistant general managers (AGMs) and local operations managers (LOMs). The service had enough suitable equipment to help them to safely care for patients. Stations had a dedicated make ready team who were tasked with replenishing vehicle supplies when ambulances came in from a shift. In all stations we inspected, the make ready team tested equipment before it was put into service.

All the equipment in the emergency vehicles we reviewed, including carry chairs, scoops and patient monitoring equipment, were in good condition and had in date safety checks.

Sterile consumables such as syringes and dressings were stored correctly on ambulances and at stations. The module bags were sealed and tagged with expiry dates clearly documented on the tag. The service operated a stock rotation system which ensured the oldest stock was used first. All stock was checked for expiry before use. A random check of consumable stock at the stations and the emergency vehicles indicated all stock was in good condition and within their expiry date.

All vehicles we inspected had harnesses, chairs and trollies available for the safe transportation of patients, this included equipment for the safe transportation of children.

Staff disposed of clinical waste safely. Each ambulance had a clinical waste bin and a sharps bin which was labelled and not over-filled. Staff disposed of clinical waste in the secure clinical waste compound when returning the vehicle to the station. However, at Peterborough station not all clinical waste bins were locked. This was escalated to the AGM. Information received after the inspection indicated action had been taken and a reminder sent to staff ensure the bins were locked after use. The locking of clinical waste bins ensured waste was secure and posed less of a risk to anyone handling it. Clinical waste was collected and disposed of by an independent contractor.

At the Peterborough station we observed a large pile of non-clinical rubbish bags outside the station next to the disposal bins. The AGM informed us the bins were locked and had been delivered without keys. Information received following our inspection indicated this had been remedied.

The control of substances hazardous to health (COSHH) cleaning chemicals at Cambridge and Peterborough were in unlocked areas. The Cambridge store area was not visibly clean. This was escalated at the time of our inspection. At other locations cleaning chemicals were stored appropriately.

Emergency and urgent care

Staff raised concerns about the cab head height and rear layout of the new fleet of ambulances. Managers told us the vehicles had been risk assessed and requested occupational health assessments for staff. Following an occupational health assessment some staff members were exempt from driving these vehicles.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff monitored each patients' conditions using the National Early Warning Score (NEWS2) applying standards as defined within the Joint Royal College Ambulance Liaison Committee (JRCALC) guidelines. Staff accessed this through the Clinical APP which was regularly updated with new guidance. The service monitored the delivery of care for patients on a quarterly basis in line with the national Ambulance Clinical Quality Indicators.

Staff completed risk assessments for each patient, using a recognised tool, and reviewed this regularly, including after any incident. The electronic patient record system had clearly defined patient pathways and risk assessment tools, for example the non-conveyance risk tool. The non-conveyance risk tool was an electronic pathway with mandatory steps the staff had to complete before the decision could be made not to transfer the patient to hospital.

Staff knew about and dealt with any specific risk issues. The electronic patient care record (ePCR) contained protocols and flow charts for specific conditions such as head injuries. Staff were able to make an onward referral using the ePCR, for example to a patient's GP if they had identified a patient at risk of falls. A team of leading operational managers (LOMs) provided clinical support to ambulance staff. The LOMs were established and experienced paramedics in managerial positions who were available for advice by telephone. LOMs attended patients alongside their staff when the call information suggested the patient had a high level of acuity. The LOMs were notified by the dispatchers and would attend more serious incidents to support the attending ambulance crew. They were accessible to staff 24 hours a day and seven days a week through a duty rota.

Staff shared key information to keep patients safe when handing over their care to others. Patient handover in the emergency department was thorough and concise. The electronic notes were uploaded to the hospital system. Hard copy patient care records (PCRs) were filed in each patients' notes.

Shift changes and handovers included all necessary key information to keep patients safe. The service ensured a hospital ambulance liaison officer (HALO) was based in emergency departments to work with ambulance crews and hospital staff to reduce the time that an ambulance spends at the emergency department. We observed a detailed handover of patients who were cohorted, at the emergency departments we visited.

Leaders communicated to staff using a 'Need to Know' newsletter. National early warning score (NEWS2) and sepsis care bundles featured as educational topics. Managers were provided with communication for staff noticeboards to reinforce learning, we saw NEWS2 and sepsis was displayed on staff notice boards at all the locations we inspected.

Staffing

The service did not always have enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. However, managers regularly reviewed staffing levels and skill mix.

Emergency and urgent care

The service did not always have enough staff to keep patients safe. Staff rotas were managed by the sector resource planning team. The planners had a matrix for staff planning which included skill mix requirements. They managed annual leave, abstractions for training, relief and planning for the front-line vehicles.

The locality operations manager (LOM) could adjust staffing levels daily according to the needs of the service. The LOM reviewed the staffing levels daily and made local adjustments to the staffing in the event of sickness, late finishers impacting on staff start times, delays and operational needs.

Managers aimed to achieve the gold standard of double staffed ambulance (DSA) crews made up of two qualified staff; or as a minimum one qualified and one unqualified, however this was often not possible. When operational needs required managers to adjust staffing, they would often have to evoke the red planning guidance. This guidance allowed managers to maintain vehicle availability but had an impact on the skill mix of the staff, for example a non-clinical driver could be paired with an apprentice paramedic.

Managers recognised that a lack of qualified staff, a difference in skill mix across stations, individual factors and different shift start, and finish times meant that it was difficult to achieve the most optimal staff allocation.

LOMs were aware of the potential negative impact on patient safety and to staff mental health, they had escalated concerns and were committed to support staff wellbeing to the best of their ability.

The number of staff did not match the planned numbers. Data supplied by the service following our inspection demonstrated that the service actual staff numbers for each staff role against the budgeted establishment was not comparable. There was a significant vacancy rate at band 5 and above, especially with the student paramedics and emergency care practitioners.

The service had increasing turnover rates. Managers told us that staff were leaving to work in GP practices and private ambulance services where terms and conditions and development opportunities were reported to be more attractive. Data provided by the trust confirmed this. Managers told us they conducted exit interviews for staff planning to leave and encouraged staff retention. The overall trust staff monthly turnover rate was 9.74% in March 2022 compared to 5.16% in April 2021. There was an action plan in place to improve staff retention.

The service had increasing sickness rates. Data supplied by the trust following our inspection demonstrated the trust sickness rate for all emergency and urgent care staff was 13.33% in March 2022 compared to 7.11% in April 2021.

Managers used bank staff familiar with the service. Managers made sure all bank staff had a full induction and understood the service. Operational pressures required the service to use bank staff. A review of data supplied by the service following our inspection included guidance for managers for rapid onboarding during periods of pressure which included the induction requirements of staff new to the trust.

The service used relief staff to maintain cover. The service had some staff employed on a full-time relief basis and some who had relief as part of their core rota. The relief policy had been recently reviewed and frontline staff we spoke with welcomed the clarity in the policy, although the administration staff were impacted by the changes when planning rotas.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. Patient notes were recorded in a handheld electronic device. The electronic system had all relevant protocols and pathways available for the staff to access.

An update to the system had been planned and this would enable staff to view previous visits to a patient. This would enable staff to see if the patient had any recent call outs and would help to facilitate continuity of care.

In addition to the electronic system, staff still had paper versions of the notes available, in cases of electronic breakdown. There was a process in place for the safe collection and storage of paper records. We observed locked post boxes secured to the wall of the ambulance station at Peterborough and Southend for staff to file paper notes securely. These were then uploaded onto the electronic system.

When patients transferred to a new team, there were no delays in staff accessing their records. The electronic patient record system automatically downloaded onto the hospital servers, allowing hospital staff to access the record.

Records were stored securely. All the handheld electronic devices had one individual secure log in to the device and another log in to the patient record system. Any pictures taken as part of the patient record, for example, the patients medicines, were stored within the patient record and not on the device.

The service audited patient records. A review of the data provided by the service following our inspection demonstrated the audit included patient details, medications prescribed, and treatment offered or given. Due to operational pressures the audits had not been conducted regularly. The November 2021 audit resulted in an action plan to share results with staff and improve submission time frames with a plan to re-audit in October 2022.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. The electronic handheld patient record system allowed staff to accurately record any medicines administered to a patient and to record any medicines the patient may have already been prescribed.

The staff had patient group directives (PGDs) in place for the administration of medicines. PGDs provided a legal framework for healthcare professionals to supply and/or administer certain medicines to a group of patients without the need for a prescription, for example, a paramedic can administer paracetamol to patients in pain.

Staff stored and managed all medicines and prescribing documents safely. Medicines storage in stations and on vehicles was secure. At Peterborough station we saw that entry to the medicine storage areas was restricted to the staff that needed access.

Medicines storage was secured by keypad entry at all stations. Chelmsford and Peterborough had additional closed-circuit television (CCTV). Controlled medicines were stored separately with different access codes and appropriate signing in and out processes at all stations except Kings Lynn. We had concerns around the access to controlled medicines at the Kings Lynn ambulance station. Although the key safe to access controlled drugs was restricted to registered healthcare professionals there was no process to identify which staff member had entered the area, leaving the process open to misuse. We escalated this to the local operation manager at the time of the inspection. They told us that they would escalate to their manager.

The medication pouches were signed in and out of the lockers. A review of the logbook demonstrated recordings were correct and corresponded to the pouch contents.

The standard medicine bags had a tag system to indicate if the bag was ready to go. If a bag was closed and tagged it was ready to go. There was a separate storage area for untagged bags, which were not ready. The untagged bags had a sign off sheet to indicate why they had not been re-stocked for example a late shift finish and what contents needed replacing.

The services had a daily sign out sheet for the tagged medicine bags to be signed in and out. We observed this process during our inspection. However, at both Kings Lynn and Waveney stations the signing back in of medicines bags was inconsistent.

There was a medication bin drop box for empty pouches to be dropped off. Staff throughout the ambulance stations confirmed any opened unused medicines were disposed of in either the sharps boxes or preferably at the hospital, once patient care had been handed over.

Staff gave inconsistent responses to how they disposed of medicines on scene if required, for example, remaining 5ml of Morphine which was not required for administration. The trust acknowledged that there was no formal guidance for staff relating to the disposal of any controlled drugs (whilst on scene/after delivery of patient care). The trust management team had addressed this gap by drafting a standard operating procedure (SOP) for the disposal and denaturing of out of date-controlled drugs, this was due for approval at the next medicines management group meeting in May 2022.

Ambient temperature checks were not performed where medicines were stored. The service had a medicines management policy which required medicines to be kept within an acceptable temperature range as shown on the packaging, however it did not specify that ambient temperatures needed to be recorded. This meant that the effectiveness of medicines could be compromised.

Medicine and compressed gas storage facilities on vehicles was secure. There were compressed gas storage areas at each station. These were well maintained, ventilated and secure. However, at the Peterborough ambulance station the compressed gas storage area was poorly maintained. The storage cabinet was visibly dirty and rubbish had accumulated in the bottom of the storage area. This was escalated to the assistant general manager (AGM). Information received following our inspection confirmed this had been raised with the estates department.

Staff learned from safety alerts and incidents to improve practice. Staff reported medication incidents onto datix with the majority being unaccounted loss and a much smaller proportion accounted loss and recording errors. Staff demonstrated to us that the patient safety team emailed all staff to notify them of safety notices. We saw evidence the staff were signposted to the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) for updates and updated patient group directives (PGD) were issued and signed as a result of safety updates.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Emergency and urgent care

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Staff received feedback from investigation of incidents, both internal and external to the service. There was a culture of active reporting of incidents. Staff could tell us how they reported incidents and gave us examples of feedback and learning from incidents. Incidents were reported onto an electronic system that all staff had access to and were familiar with. Feedback was given in several forms such as in one to one conversation, in newsletters and displayed on staff noticeboards.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Staff we spoke with were aware of the duty of candour regulation and could reference the trust policy for this.

Staff met to discuss the feedback and look at improvements to patient care. At Peterborough and Cambridge stations the mentor support team (MST) were able to discuss learning from incidents and provided support and training for staff as a result. However, this was a localised practise and was not standardised across all areas we visited.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. The AGM at the Peterborough station demonstrated the overview they had of any open incidents. The overview included a unique identifier, date, investigator and status. Incidents included clinical, non-clinical, medicine and equipment incidents. The local operation manager (LOM) on duty was responsible for reviewing and allocating the investigation of open incidents.

Managers debriefed and supported staff after any serious incident. The area general manager (AGM) at the Peterborough station confirmed the operations centre would inform them of any serious incidents, and the duty LOM would attend the call to support staff if they had been involved in an incident where the patient had a suspected high level of acuity. We were informed as part of the investigation process witness statements would be taken from all staff involved in an incident. Support was available both formally, for example, from the LOMs and informally, from the chaplain. All serious incidents were investigated, and lessons learnt were circulated to all staff by email. In addition, serious incidents and lessons learned were displayed on staff notice boards throughout the locations we inspected.

Managers debriefed and supported staff after any serious incident. However, managers did not always share learning with their staff about serious incidents. Managers told us that systems and processes for learning lessons from incidents for staff working across stations could be improved.

Is the service effective?

Requires Improvement ➔➔

Our rating of effective stayed the same. We rated it as requires improvement.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The electronic handheld devices held current care plans, flow charts and policies for patient care and treatment. Policies reviewed after inspection were comprehensive, in date and version controlled.

Emergency and urgent care

Staff had access to the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines and were able to demonstrate how they could access them on their mobile devices. Where guidelines were available from JRCALC the service did not have a separate policy as the JRCALC guidelines were regularly updated and best practice. For example, the service does not have a separate sepsis policy but refers to the JRCALC guidelines.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. The service guidance for requesting conveyance for patients detained under the mental health act acknowledged that an ambulance response can escalate patient anxiety and contribute to the risk of the patient, carer and professional staff. It specified that "Patients should always be transported in the manner which is most likely to preserve their dignity and privacy, consistent with managing risk to their health and safety or to other people" MHA Code of Practice (2015).

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. The handheld electronic record device prompted staff to record patient pain scores as part of the patient record. The staff used a zero to 10 numerical pain scale to assess pain levels.

We observed staff asking a patient to rate their pain on a scale zero to 10. They gave an explanation that zero meant no pain at all to 10, the worst pain imaginable.

Staff used the Wong Baker sliding pain scoring system to assess pain. The Wong Baker tool uses a series of 10 faces, from smiling to crying to identify pain levels. This tool was especially useful for assessing pain in children, young people and those with learning disabilities.

Patients received pain relief soon after it was identified they needed, or they requested it. We observed staff confirming with a patient they had received the requested pain relief and asking the patient to rate their pain using the numerical pain scale.

Staff prescribed, administered and recorded pain relief accurately. Staff had access to pain relief in the form of compressed gases such as Entonox and medicines such as paracetamol. All medicines were documented on the electronic patient record.

Response times

The service monitored response times so that they could facilitate good outcomes for patients. Data showed a deteriorating response rate to category one to four calls over the previous 12 months.

Data supplied by the trust following our inspection demonstrated that in March 2022, 75% of category one calls were on the scene within 15 minutes of dispatch compared to 94% in April 2021 against a standard of 90%.

The percentage of category four calls on the scene from dispatch within three hours were 21% in March 2022 compared to 89% in April 2021 against a target of 90%.

Factors contributing to these delays were long delays at accident and emergency departments, staff vacancy rates, sickness impacting on the number of vehicles available and increased service user demand.

Emergency and urgent care

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients

The service participated in relevant national clinical audits. The service identified key clinical areas to improve the clinical care given to patients. These ambulance quality indicators (AQIs) linked into national quality indicators (NQIs) and formed a basis for measuring the effectiveness of the NHS ambulance service. Each one had an associated care bundle containing the things staff should be doing and recording for every patient seen with that condition.

AQIs included the conditions stroke (which occurs when the supply of blood to the brain is reduced or blocked completely, which prevents brain tissue from getting oxygen and nutrients), sepsis and ST-Segment Elevation Myocardial Infarction STEMI (which is a type of heart attack).

NQIs included care of patients with asthma, trauma patients with limb fracture, older people and paediatric patients with febrile convulsions under five years.

Outcomes for patients were positive and met expectations, such as national standards. For example, from March 2021 to March 2022 98% of patients who presented with a stroke in Mid and South Essex received the appropriate stroke package of care (care bundle).

Managers and staff used the results to improve patients' outcomes. Managers monitored patient outcomes on a monthly basis and shared this information with staff and commissioners. The service produced an annual quality account which included information on participation in national and local clinical audits, and the actions that have been taken consequently to improve the services provided.

Managers used information from the audits to improve care and treatment. Where improvements were identified the clinical audit manager highlighted to the local management team so that this could be raised with the staff and learning and improvement put in place.

Managers shared information from the audits. The local management teams were provided with information and posters to display on the station noticeboards each month. The information was seen displayed on the station notice board during inspection.

Improvement was checked and monitored by repeat audit at regular intervals.

Competent staff

The service did not always ensure staff were competent for their roles. Managers did not always appraise staff's work performance and hold supervision meetings with them to provide support and development.

Managers did not ensure staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers did not ensure staff received all the specialist training for their role. Although the service had processes in place to ensure staff had the right skills and competencies in place, due to operational pressures this was not applied. Professional updates and clinical skills updates were not being consistently completed which impacted mandatory compliance. At the time of our inspection 56% of staff had completed the mandatory professional updates against a target of 95%.

Emergency and urgent care

Managers gave all new staff a full induction tailored to their role before they started work. The trust had a corporate and local induction process in place for all new staff. Staff told us that due to operational pressures this was not consistently applied, for example, we were told it was trust policy for newly qualified starters to be supported for the first six months, however, this was not always the case in practice. This practice was risk assessed as part of the red planning process which was used to assess and escalate the use of non-qualified crews to meet high demand in the community.

Managers did not always support staff to develop through yearly, constructive appraisals of their work. The service had an annual appraisal process, called 'compassionate conversations', in place. This was a formal process to facilitate staff development, progress, training needs and career goals. Data provided by the trust showed that 29% of staff had received an annual appraisal. The service target was for 95% of staff to have had their appraisal completed.

Managers informed us the COVID-19 pandemic and operational pressures had impacted the appraisal programme and that there was an action plan in place to complete staff appraisals. However, some managers shared concerns that the capacity of the managers and ability to release staff to complete the programme of appraisals was not realistic.

Cambridge and Peterborough stations had mentor support trainers (MST) in place to support staff and deliver training. However, this was a local initiative and not available trust wide. The MST at Cambridge were trialling MST Thursdays for staff training and practice. Staff had attended on off duty days. Staff said that this training had been very positive. The MST had delivered the sessions in response to staff need. For example, sessions were used to work through challenging scenarios and training on new equipment. Sessions were delivered one to one or in group sessions. Staff told us it was hard to complete training when on the road if they do not get protected time allocated to receive training.

The service had clinical educators who supported the learning and development needs of staff. They were enthusiastic about their roles and told us that they had support from managers to restart essential care skills (ECS) training, paused due to COVID-19 and were prioritising staff whose training was most out of date.

Trainers who had attended a 'train the trainer' course organised additional 'drop in' training sessions for staff who were due to qualify, including airway management and cannulation. They had collaborated with other emergency services to source scenario training on attending house fires or extrication from a vehicle and were proud of recent progress made with training

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff meetings were held and staff who were unable to attend had updates sent via email. The updates were also displayed on the station noticeboard. The station ambassadors held meetings to discuss day-to-day issues.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff confirmed they were able to discuss specific training needs with their LOMs and local training teams. Staff told us it was very difficult to access training and courses for professional and career development and when opportunities did arise the application and selection was not transparent. Staff told us they did not receive feedback on why their application was unsuccessful.

Managers identified poor staff performance promptly and supported staff to improve. Local managers were responsible for staff support and for actions required to improve staff performance, for example, training needs or management of behaviours. Managers told us that there was a process in place to manage and escalate poor performance and behaviour. However, the processes were often delayed due to resourcing issues in areas such as human resources which were required to facilitate the process.

Managers told us there was a delay in getting staff on training programmes such as apprentice paramedics receiving emergency response ambulance driving (L3CERAD training). This training for apprentices was delivered by an external provider and there were significant delays in this training being delivered. This impacted the service directly as these staff members would have to be allocated as non-drivers limiting where they could be rostered and impacting on the number of vehicles a station could resource. Overall, there were 145 staff members requiring training for their driver certificate, 109 to be delivered by the external provider and 36 to be delivered by the trust. Data provided after the inspection demonstrated that the training would be completed by the end of August 2022 for the current cohort.

Multidisciplinary working

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. The hospital ambulance liaison officer (HALO) worked as a point of contact between staff conveying patients to hospital and emergency staff in hospitals to reduce staff waiting times in emergency departments, to aim to enable a smooth transfer of care, and release staff to attend their next contacts.

We observed staff handing over effectively to hospital staff. The exchange of information was comprehensive and prompt.

Staff who were responsible for the care and oversight of the cohorted patients demonstrated good communication skills when liaising with hospital staff over the care of the patients, for example with physiotherapists and nursing staff.

Staff worked across health care disciplines and with other agencies when required to care for patients. The single point of contact (SPOC) allowed the staff to communicate with the patients GP.

Ambulance staff and hospital staff told us that team working between hospital and ambulance staff was good. The system was under considerable pressure at the time of our inspection with delays impacting access to hospital for patients arriving at hospital by ambulance. All staff worked together to prioritise access for high acuity patients and deliver the best care possible to their patients.

Senior leaders attended twice daily system calls where an overview was given of the current risks system wide. All providers were experiencing capacity issues from the ambulance service, including the acute hospital, community hospital, mental health and adult social care. Managers reported that the meetings did not facilitate a system wide approach and each individual provider was managing their capacity issues in isolation.

Health Promotion

Staff gave patients practical support and advice to lead healthier lives.

Staff told us they would not give unsolicited advice to patients, however, they were uniquely placed to assess the home environment and asked if patients needed help accessing services, for example smoking cessation.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Emergency and urgent care

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff understood their responsibilities in obtaining consent from their patients before any care or treatment.

Staff demonstrated capacity to consent was a mandatory field on the patient record and the electronic handheld record would not allow staff to complete a record unless this assessment had been completed.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Staff explained when a patient could not give consent, they would make a best interests decision based on all the information they had available including information from families and carers.

Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients' records. The care plans and flow charts available on the handheld devices allowed staff to give patients accurate information on which to base their consent.

We observed staff gaining verbal consent from patients before taking observations and reiterating that consent every time observations were completed.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Mental health training was provided on induction to the trust and was refreshed in the mandatory training and professional update programme.

Is the service caring?

Good 

Our rating of caring went down. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients in a respectful and considerate way. Throughout our inspection we observed staff caring for patients who were cohorted in hospital corridors. Staff ensured the patients maintained their dignity by ensuring they kept covered and had clean sheets and gowns available.

We observed staff who were assisting patients with personal care to ensure this was carried out in private, maintaining the dignity of the patient.

Patients told us staff treated them well and with kindness. All patients we spoke with could not praise the ambulance service and the staff enough. They felt safe, well looked after and supported by the staff. All the staff had been friendly and approachable, and all their needs had been catered for despite any delays they were experiencing.

Staff followed policy to keep patient care and treatment confidential. All staff we spoke with understood patient confidentiality.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Staff explained although patients were assessed for suitability for cohorting patients who were feeling anxious or were agitated would be prioritised for moving.

Staff explained patients would be cared for in the privacy of the vehicle whenever appropriate, to maintain dignity.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. We observed staff talking to patients and providing reassurance. One patient told us that they were very worried that their relative would not be able to contact them and the ambulance crew had been very helpful in ensuring that the relative was updated putting the patients mind at rest.

Staff told us they were often in a unique and privileged position of entering a patient's home environment and would get insight into both the physical and emotional implications of the situation not only on the patient but also on their families and carers.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Staff told us patients had treatment options explained to them and demonstrated on the handheld electronic device the care pathways and information available for both the patients and staff.

Staff talked to patients in a way they could understand, using communication aids where necessary. We observed staff talking and interacting with patients. Staff did not use technical jargon and ensured patients understood their care and treatment. Staff told us that translation services were available, and they had a national tool known as the Wong Baker pain scale available on their electronic devices to aid pain communication.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. There was a tell us what you think page on the website which patients could access to give feedback. Patients could also feedback in writing or via email and there was a freephone number available Monday to Friday from 10am to 4pm.

Staff supported patients to make informed decisions about their care. Staff explained how patients were always involved in care decisions, for example, patients were involved in non-conveyance decisions. Non-conveyance documentation included a mental capacity assessment, which was a mandatory field that had to be assessed and completed before a final decision could be made.

Emergency and urgent care

Is the service responsive?

Requires Improvement 

Our rating of responsive went down. We rated it as requires improvement.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the needs of the local population. The sector resource planning manager oversaw planning for frontline vehicles. They attended twice weekly regional capacity meetings which reviewed each sector day and night cover. The review included local feedback and insight, patient facing hours and any identified trends.

The AGM or GM had a twice daily call to review resources for the next 14 days. This review included anything that could impact the service, for example, vehicle availability, HALO cover and staff sickness.

Staff could access emergency mental health support 24 hours a day, seven days a week for patients living with mental health problems, learning disabilities and dementia. Staff had the support of a single point of contact (SPOC) to raise concerns or to leave notes for the patients GP.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. The service made reasonable adjustments to help patients access services.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff understood how to support patients with specific needs such as those with mental health difficulties and those living with dementia. Staff who had joined with previous experience had shared strategies for reassuring patients, for example, a favourite stuffed toy or piece of music. Staff explained, when appropriate or necessary, the patient's primary carer could accompany the patient.

The mandatory training programme included training in equality, diversity and human rights.

The clinical notice boards displayed information and guidance for staff, for example, on the Peterborough clinical notice board we saw information on tips for treating patients living with downs syndrome.

Staff were equipped to deal with violent or aggressive patients. They received conflict resolution training and were supported by local police forces when attending to patients with known histories of violence.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters when needed. Staff had access to a translation service on the handheld devices.

Staff were informed of any known issues or communication problems by the central control service. Staff told us that on the next update of the handheld devices they would be able to access a patient's previous call out history, which would also give insight and information on any specific needs or considerations.

Access and flow

People could not always access the service when they needed it, in line with national standards, and could not always receive the right care in a timely way.

Staff supported patients when they were transferred between services. The hospital ambulance liaison officer (HALO) post provided an interface between ambulance crews and emergency department staff at hospitals. The role facilitated the handover of patients and kept staff and patients informed of any delays. This role is usually carried out by an experienced paramedic and performs an important role in oversight of patient care, ambulances waiting and crew welfare. The HALO role was different at each hospital, for example at Norfolk and Norwich there was a HALO 24 hours a day, seven days a week. At Kings Lynn the HALO was only seconded from 11am to 9pm. This meant the post was not always covered. Crews consistently told us the HALO roles were helpful in handing patients over smoothly at hospital.

Handover delays

Handover start time is defined as the time the ambulance arrives at the Emergency Department (ED), with the end time defined as the time the patient is handed over to the care of ED staff. National ambulance standards indicate handover should take place within 15 minutes of arrival at the emergency department.

The trust provided weekly handover time data from October 2021 until March 2022. The total number of handover delays over 15 minutes across the trust in March 2022 was 10,835.

Cohorting patients in the ED using ambulance staff happens when ED staff are unable to take over the care of patients. Under these circumstances, the care of these patients is overseen by ambulance service staff. One ambulance crew would remain at the hospital and care for a number of patients that were waiting to be admitted to ED. This meant that the crews that had transported these patients to hospital were able to safely leave their patient and attend to another call in the community rather than waiting at the hospital. The service had standard operating procedures in place with each hospital trust and a strict criteria for when cohorting of patients was initiated through an escalation plan and patient inclusion and exclusion criteria. The cohorted patients were triaged by the hospital and booked on to the hospital system. Data supplied by the service following our inspection demonstrated the mean waiting time for cohorted patients in March 2022. The mean wait time for patients in cohort areas was six and half hours.

Due to extreme pressures on the emergency pathway some patients were delayed in accessing the hospital from the ambulance. These patients were cared for by the ambulance crew in the ambulance. We observed ambulances waiting to offload their patients at all hospital locations we visited during our inspection. Patients were triaged by hospital staff in the ambulance and in some instances, we observed the ED clinicians administering treatment in the ambulance. At one location, we also observed ambulance crews taking a patient from the ambulance for diagnostic imaging and then returning them to the ambulance to continue to wait for admission.

Each hospital location that we visited had a hospital ambulance liaison officer (HALO). The HALO enables triage, assessment, monitoring and care to be delivered by bridging the gap between ambulance arrival and the patient being cared for by the emergency department team.

Emergency and urgent care

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff, including those in partner organisations.

Patients, relatives and carers could complain or raise concerns. The complaint process was available online however, it was not clearly displayed in patient areas such as the back of ambulances.

Staff understood the policy on complaints and knew how to handle them. Staff directed patients to the patient advice and liaison service (PALS) if they wished to raise a complaint. Staff were able to bring verbal complaints to the attention of the HALO, who would speak to the patient and would explain the formal complaint process if necessary.

Managers investigated complaints and identified themes. Assistant general managers (AGMs) were aware of their ongoing complaints, and any learning in relation to complaints investigations would be shared with the staff.

Managers shared feedback from complaints with staff and learning was used to improve the service. For example, there was a clinical update notice board at the Cambridge station and Waveney station which displayed information on complaints and compliments received. The noticeboard also displayed learning from experience which included corrective actions.

Is the service well-led?

Requires Improvement 

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. However, they did not always support staff to develop their skills and take on more senior roles.

Local leaders understood the challenges to quality and sustainability within the service and could identify the actions needed to address them. The emergency and urgent care service was under a lot of pressure resulting in capacity concerns for the ambulance service. Local leaders had oversight of the issues and took actions to mitigate risk and support staff.

All staff we spoke with told us the local operations managers (LOMs) and assistant general managers (AGMs) were available and supportive and they felt able to escalate concerns. The AGMs at all locations we visited felt supported by the general managers (GMs) and head of operations (HOO).

GMs told us they had good working relationships with their HOO and felt well supported. However, they told us that for issues requiring actions from senior leaders in the organisation there was often delays in getting a response impacting on their ability to deal with issues and concerns at a local level in a timely way. They were concerned about the impact the delays were having on staff wellbeing when they were waiting for outcomes.

Emergency and urgent care

Local leaders were not aware of any priorities for ensuring sustainable, compassionate, inclusive and effective leadership. The service did not have a clear local leadership strategy or development programme, and there was no succession plan. There were limited opportunities for staff to develop their skills and take on more senior roles and staff felt the process was not open and transparent.

General Manager (GMs) told us that the trust had identified staff development as a key focus and that a new strategy to support staff development at all levels had been developed, however this had not yet been communicated to the wider staff team.

There was a disconnect between senior leadership and the local leadership. Staff told us there was limited visibility of the executive team except for the chief executive officer.

Leaders told us that due to limited capacity in the Human Resources (HR) department there were delays in processes that required HR input and this had impacted on timely decision making and support being put in place for staff when required.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

The trust had a clear vision and a set of values.

Trusted to deliver compassionate care.

There were four goals:

- Be an exceptional place to work, volunteer and learn
- Provide outstanding quality of care and performance
- Be excellent collaborators and innovators as system partners
- Be an environmentally and financially sustainable organisation

The trust values were:

- Care - We value warmth, empathy and compassion in all our relationships
- Teamwork - Together as one, we work with pride and commitment to achieve our vision
- Quality - We strive to consistently achieve high standards through continuous improvement
- Respect - We value individuals, including our patients, our staff and our partners in every interaction
- Honesty - We value a culture that has trust, integrity and transparency at the centre of everything we do.

Some staff we spoke with were aware of the trust values and we saw these were displayed on staff notice boards.

General managers understood the trust strategy, which was aligned to local plans in the wider health and social care economy, however it had not been fully communicated to staff at all levels.

We did not see any evidence that progress against delivery of the strategy and local plans was monitored and reviewed at a local level.

The trust had implemented a "Fit for the future" programme to improve behaviours and culture within the organisations. However, very few members of staff were aware of the programme and had not been involved with it. However, some staff told us they were aware that work was taking place to address and improve attitudes and behaviours at work but were not aware of any specific initiative.

Culture

Staff did not always feel respected, supported and valued. They were focused on the needs of patients receiving care. The service was working towards supporting an open culture where patients, their families and staff could raise concerns without fear of reprisal.

Some staff felt supported, respected and valued. Staff we spoke with reported feeling supported and valued by local leaders. However, due to operational pressures, long waits outside emergency departments (EDs), late finishes and limited access to training and development was impacting on staff morale and feelings of not being valued by the organisation.

The culture within the organisation was centred on the needs and experience of people who used services. Staff were committed to delivering the best care possible to their patients and demonstrated these values in all patient interactions we observed.

Staff did not always feel positive and proud to work in the organisation. Capacity issues were impacting on staff welfare. They expressed concerns around their ability to deliver the best care to the patients due to delays at the EDs reducing their ability to support patients in the community. Delays meant that staff frequently finished late and missed meal breaks and crew skill mix was all impacting on staff morale.

Actions were being taken to address behaviour and performance that was inconsistent with the values of the organisation. However, capacity issues within the HR department and delays in action from the senior leadership team meant there were delays in decision making and action to be taken. Staff told us they felt there had been an improvement regarding bullying and harassment. However, staff were not confident of the outcome when concerns were raised.

The service encouraged, openness and honesty at all levels within the organisation. Leaders and staff understood the importance of staff being able to raise concerns. However, not all staff felt safe to raise concerns. Following our inspection, we received calls from staff raising concerns around treatment they had received at work and the lack of timely response from leaders to address their concerns. Appropriate learning and action were not always taken as a result of concerns raised.

There were not robust mechanisms in place for providing all staff at every level with the development they needed, including high-quality appraisal and career development conversations. Staff appraisal levels were low and training opportunities and opportunities for progression were limited. Staff told us that there was lack of transparency around promotions and access to training courses.

Local leaders had an emphasis on the safety and well-being of staff. Staff reported that local leaders were aware of safety and well-being issues. However, operational pressures were impacting on the ability of leaders to take action to address concerns raised.

Emergency and urgent care

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There were structures and systems of accountability in place to support the delivery of the service.

There were clear levels of governance and management in place. The governance structure included internal staff meetings, strategic meetings, operational meeting and meeting with external organisations. However, during the pandemic from March 2020 to date the trust told us that decisions were taken locally involving the Heads of Operations (HOOs), General Managers (GMs), Area General Managers (AGMs) and Locality Operations Managers (LOMs) to step-down routine non-essential meetings. This was in line with the trust resource escalation action plan (REAP) process.

Most staff were clear about their roles and understood what they are accountable for. Local leadership had good oversight of governance issues in their areas. We consistently found that LOM's, AGM's and GM's understood how their teams were performing to key performance indicators, their compliance to mandatory training, professional updates and appraisals, and any incident and complaint themes. However, some staff expressed concern that due to the capacity issues in the service non-qualified crews could be dispatched to higher category calls. Although there was a clear process in place for when this allocation could occur, staff felt they were not fully supported when working outside their scope of practice.

The service used monthly scorecards for each of its operations areas. These scorecards provided oversight of several aspects of service performance such as response times and operational productivity, key performance indicators (such as numbers of journeys undertaken and numbers of cancelled call outs), quality issues (such as complaints, incidents and safeguarding data), and workforce data.

The Operational Delivery Group (ODG) meetings covered governance issues such as risk and compliance, clinical updates, infection control and staffing. We reviewed meetings from ODG meetings for Waveney and Peterborough and Cambridgeshire. The minutes did not follow a standardised format and agenda items were not consistent. Therefore, we were not assured that there was standardised and robust oversight of governance across the different operational areas.

Each operations area attended an accountability forum every six weeks. This meeting was chaired by the Chief Executive Officer or Chief Operating Officer. The trust told us that the main function of the accountability forum is to deliver the principles of the accountability and performance management framework, to ensure delivery of the core business objectives.

Management of risk, issues and performance

Leaders and teams used systems to manage performance. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

There was a programme of clinical and internal audit to monitor quality and operational processes and systems to identify where action should be taken. Managers used information from the audits to improve care and treatment. Where improvements were identified there were processes in place for learning and improvement. For example, the records audit demonstrated compliance rates across the region, actions to improve compliance, leads for actions to be taken and re audit dates.

There were arrangements in place for identifying, recording and managing risks, issues and mitigating actions. The service had local risk registers for the station specific risks and a wider service risk register. The local risk registers had actions and responsibility documented. The risk registers we reviewed reflected the risks identified locally. For example, within Waveney and Kings Lynn we saw that the rurality of the area was a risk as it impacted on response times. In Mid and South Essex short term sickness had been identified as a risk and mitigated by fortnightly reviews with human resources to provide assurance of the sickness process and monitoring of themes of short-term sickness to support staff to return to work in a timely manner. Staff appraisal was a second risk which had been mitigated by the introduction of "appraisal on a page" and a trajectory to enable planning and completion of outstanding appraisals

Risks were discussed at business meetings which were attended by the AGMs, GMs and sector heads. AGMs told us they had no access to risk registers, although they were aware of the risks for their areas. GM's had oversight of the risk register and worked closely with AGM's to monitor and mitigate risks.

Potential risks were considered when planning services such as seasonal or other expected or unexpected fluctuations in demand. For example, in response to increased visitors in the summer Waveney provided a service where ambulance staff were available on the seafront, using bicycles as transport, in response to any incidents in the locality. However, the service was under considerable operational pressure due to high demand. There was a standard operating procedure (SOP) in place for escalation of risk and for actions taken in response. For example, there was a red planning process in place which risk assessed and escalated the use of non-qualified crew to higher acuity calls in order to meet high demand in the community.

Local managers worked with the central planning team and used safety huddles to inform and manage their staff in managing service demand and capacity. However, we were unable to ascertain the flow of information between local and senior managers and we were therefore not assured of the effectiveness of service risk management.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

There were clear and robust service performance measures, which were reported and monitored. These performance measures were shared internally and with external stakeholders.

Managers understood performance targets including quality and data from audits. Information was shared across the service to key committees and oversight groups to provide assurances on the quality, risk and performance within the service.

IT systems were integrated and secure, to prevent unauthorised access of information.

Engagement

Leaders and staff did not engage with patients, staff, and the public to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Information was shared with staff by email, daily huddles and newsletters. Staff felt that information flow was one way and there were limited opportunities to feedback through meaningful staff engagement.

Emergency and urgent care

Staff participated in a staff survey to gauge their feedback on the delivery of services and in shaping the culture of the organisation. The most recent staff survey had a response rate of 48%. Planned areas of focus identified from the survey response was appraisal, development and access to training as well as recognition for work and feeling valued.

There were positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population. For example, the service worked collaboratively with hospitals cohorting patients and worked with other healthcare providers to access pathways to refer patients to avoid conveyance to hospital.

There was a transparency and openness with all stakeholders about performance. Information was shared daily with the wider system to identify performance and escalate delays and extended waits at the EDs to discharge patients.

Learning, continuous improvement and innovation

All staff were committed to learning and improving services.

The ambulance service has been participating in research looking at female ambulance staff experiences of menopause transition. This aimed to evaluate current guidance, the support given and women's experiences of menopause in the workplace within the UK Ambulance Services. This project investigated reasonable adjustments that could be made to help employees such as partnering with experienced, familiar colleagues.

Emergency operations centre (EOC)

Requires Improvement 

Is the service safe?

Requires Improvement 

Our rating of safe went down. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills, however not all staff had completed it.

Not all staff had kept up to date with their mandatory training and staff training rates were low across all the emergency operations centres (EOC) and amongst the services community first responders (CFRs). At Norwich, staff achieved 78.11% compliance with all mandatory training, and 72.64% at Bedford, the service set a compliance rate of 95% for all mandatory training. At Chelmsford, staff achieved 100% compliance with preventing radicalisation but did not meet the 95% compliance for any other training. None of the services CFRs had achieved the services compliance rate for any of their mandatory training.

The mandatory training was not comprehensive and did not met the needs of patients and staff. Call handling staff we spoke with told us they did not receive any additional training in relation to supporting patients living with dementia, mental health conditions or learning disabilities. Often when callers called, call handling staff used their previous experience to manage calls. Staff did however receive additional training to manage distressing calls.

Clinical staff told us they used their professional training as either paramedics or nurses to recognise and respond to callers living with mental health needs, learning disabilities, autism and dementia. The service had employed registered mental health nurses (RMHN) as part of a pilot to provide additional support and training to staff within the EOC. Staff we spoke with told us this had been beneficial when supporting patient calls. Managers told us the service had not successfully recruited all the additional staff into these roles and the pilot was under review at the time of our inspection.

Managers monitored mandatory training, however training rates had been affected due to pressures within the service, for example staff absence due to sickness and vacancy rates.

Data supplied by the service following our inspection showed that 100% of staff across the EOC who were required to complete the “Strategic Gold Magic” training in relation to incident response and the joint emergency services interoperability programme had completed the training. Data showed that 80% of leading operations managers had completed National Ambulance Resilience Unit (NARU) operational programme, and 78% had completed the NARU tactical command course to deal with major incidents, this was below the service’s mandatory compliance rate of 95%.

Safeguarding

Not all staff had training on how to recognise and report abuse.

Not all staff had received training specific for their role on how to recognise and report abuse. Data supplied by the service following our inspection showed staff achieved 78.11% compliance with safeguarding adults and children training level 1 and 2 at Norwich, 72.64% at Bedford and 66.03% at Chelmsford. Safeguarding was delivered in line with the intercollegiate document Adult Safeguarding: Roles and Competencies for Health Care Staff 2018.

Staff we spoke with could give examples of how to protect callers from harassment and discrimination, including those with protected characteristics under the Equality Act 2010. The service launched an equality and human rights values and behaviours training programme due to concerns we raised with the service at our last inspection because of harassment and bullying within the service, with a target of 95% of all staff to have completed the training by the end of September 2022. At Bedford, 60.85% of staff had completed the training, 62.20% at Chelmsford and 79.34% at Norwich. All were below the trust 95% compliance target for mandatory training. However, staff we spoke with knew the service had launched this training and that it was a priority to complete.

We listened to a patient call where the call handler considered the use of the interpreter service and whether there were any patient safeguarding concerns, for example coercion and control, or domestic violence. However, the patient was safe and there was no requirement to escalate as a safeguarding concern.

Staff knew how to identify adults and children at risk of, or suffering, significant harm. Staff could flag safeguarding incidents on the services IT system and could make additional special notes regarding any concerns for when ambulance crews arrived on scene. The service had up to date policies for safeguarding adults and children, which referred to national and local guidance.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff referred directly to the single point of contact (SPOC) team within the service to escalate safeguarding concerns. The SPOC was a dedicated team based within the EOC at Bedford and were responsible for logging, escalating, and referring safeguarding and incident reports within the service. Staff and volunteers accessed the SPOC referral system by a dedicated telephone line, which was available 24 hours per day, 365 days per year.

The service did not hold any local EOC safeguarding action plans. Action plans were held and monitored by the service's safeguarding team for the regional service. For example, any Section 42 or 47 enquiries by a local authority to the service involved EOC staff as a point of contact and they would be considered in any investigation to support local authorities or other safeguarding agencies on a case by case basis. Action points from any safeguarding action plans were shared through safeguarding communications to the relevant staff or service wide, on a case by case basis including recommendations received and reviewed on the closure of any safeguarding investigation. The service made 3,025 safeguarding referrals between April 2021 and April 2022, based on concerns from received calls.

Environment and equipment

The design, maintenance and use of facilities, and equipment did not always keep people safe.

At the Chelmsford and Bedford location, advice on COVID-19, personal protective equipment (PPE) and hand sanitiser was available on entering the building. There was clear signage in place advising all staff and visitors to follow COVID-19 guidance, wash their hands or use hand sanitiser. When inspectors arrived at the Bedford location, they were asked for temperature checks, to show proof of COVID-19 lateral flow tests and requested to follow the services infection, prevention and control (IPC) processes, wear a face mask and follow the one-way system around the environment. These processes were not mirrored at the Chelmsford location. Staff at the Chelmsford location routinely walked between workstations without wearing a face mask, despite the service requiring this as part of its COVID-19 procedures.

Emergency operations centre (EOC)

Staff within the EOC's sat in designated areas with desks / workstations dependent on their role, for example dispatchers sat behind desks in one area, and call handlers in another area of the office. The service installed plastic screens between each desk / workstation to minimise contact between staff and ensure social distancing. Call handlers used telephone systems to speak with callers and dispatch staff used radio systems to communicate with ambulance staff.

At the Chelmsford EOC, we found the environment inside the call handling areas to be visibly dirty, with remnants of food on the floor, waste bins overflowing, and the rooms were dimly lit. The carpet was threadbare in places, staff did not have rise and fall desks to support changes in posture and staff told us the display screen equipment did not match the upgraded systems at Bedford and Norwich.

Staff at the Chelmsford base had food on their workstations, including snacks. We also observed several drinks making facilities on desks, such as kettles and coffee makers. Staff we spoke with told us that staff could have snacks at their desk, but they should use the main kitchen and rest areas for substantial meal breaks. The service had upgraded its kitchen and rest facilities at Chelmsford. These were visibly clean and had vending facilities, a rest area and private changing and toilet facilities. Staff we spoke with at Chelmsford told us that a business plan had been rejected in relation to upgrading the estates and equipment due to financial constraints. Staff told us that the rise and fall desks had been procured and a business case submitted for the upgrades to the Chelmsford EOC, but the changes had not been implemented.

Staff we spoke with told us the Chelmsford base had recently been deep cleaned and that domestic staff routinely cleaned the areas. Cleaning at the location was managed by an external contractor and there were no records in relation to cleaning activities at either the Chelmsford or Bedford locations. Following our inspection, we reviewed a range of quality assurance documents supplied by the service in relation to cleaning and the environmental standards. The audits were completed by the external contactor between November 2021 and March 2022. The audits stated all three of the EOC were either of a good standard or contract standard during this period. Audits were overseen by the services estates and facilities team but this did not corroborate with the standards we saw on inspection.

Data supplied by the service following our inspection showed that 3.65% of staff at Chelmsford were compliant with a display screen assessments (DSE), 61.21% of staff at the Bedford and 25.29% at Norwich. We were not assured that staff were assessed to safely use DSE equipment.

At the Chelmsford base, we noted that cables for electrical equipment were not fixed or safely held in conduits under desk areas. However, portable appliance testing, (PAT) and electrical safety checks had been completed on all electrical equipment at Chelmsford on 11 March 2022. However, we were not assured that the issue regarding uncovered wires, free use of kettles on desks had been risk assessed for safety.

The service ensured that its computer aided dispatch (CAD) system and the Advanced Medical Priority Dispatch System (AMPDS) were regularly updated to ensure they were fit for purpose and had the latest software in place. The service had one CAD outage on 10 November 2021, which led to the service implementing new systems to reduce the impact on the service if a further CAD outage occurred.

At the Bedford location, the equipment and environment were visibly clean, well-organised and staff had dedicated areas to take a break with access to rest areas, kitchen and changing facilities.

Call handlers gave clear advice regarding the use of masks and guidance on social distancing to all callers awaiting an ambulance.

Emergency operations centre (EOC)

Assessing and responding to patient risk

Staff did not always update risk assessments for each patient to remove or minimise risks.

Staff used a nationally recognised tool to identify deteriorating patients. Call handling staff used the AMPDS system when taking initial calls. The AMPDS system gave call handlers categories to enable them to prioritise callers due to the nature of their emergency or redirect callers to alternative services. For example, a Category one call for life threating illness or injuries would need an immediate emergency dispatch for an ambulance to arrive on scene within 15 minutes 90% of the time. A Category three call would require an emergency ambulance to be dispatched or a clinical call back within 60 minutes. Call handlers also advised callers how to locate and access community-based defibrillators to help in urgent health emergencies. Call handlers knew the location of the defibrillators which were recorded on the services CAD system.

Following the initial call being prioritised by the call handlers, the dispatch call team then identified the most appropriate resource to dispatch to the emergency within the correct time frames. We reviewed the services emergency standard operating procedure (ESOP) for deployment guidance and found this up to date with clearly defined roles, responsibilities and actions required to provide appropriate responses. Call handling staff could liaise with the call handling team leader or duty manager for additional advice on responding to a caller.

At the time of our inspection due to patient capacity and demands within the service, the service was on its highest level of escalation called “white”. At these times, the service implemented additional guidance to staff and instructed them to follow the services emergency operation standard operating procedures in relation to escalation and use of resources. This meant focusing on Category one calls and all other calls being either redirected to alternative services, closed at point of call with advice or placed into what the service called a “patient stack”.

The patient stack was a list of patients in call order, waiting in the stack until an available resource could be allocated. Call priority changed at varying points during the stacking process and risks were assessed as more information was obtained from the caller during welfare calls. Data supplied by the service following our inspection showed that between 1 October 2021 and 11 April 2022, there had been 101 incidents related to patients who had deteriorated whilst waiting in the call stack. During the same period, there were 52 occasions when staff had not followed the services procedures for carrying out a welfare call for a patient waiting within the call stack.

The service had a clinical coordinator and emergency clinical assessment and triage (ECAT) at each of its EOC’s. The teams comprised of qualified paramedics, registered general nurses and access to RMHN. The clinical coordinator led the ECAT team at each location to provide support to callers who may need clinical advice in relation to their condition, redirection to alternative care services, or welfare calls if the patient had been waiting for an extended period in the patient stack. Clinical staff used a clinical triage tool called “LowCode”, to enable them to assess the caller and provide appropriate care pathways, advice or increase their clinical priority for a more urgent ambulance dispatch.

During our inspection we noted patients waiting long periods in the stack, some for over 12 hours, and one patient who had waited over 24 hours for a resource to be dispatched. We were therefore not assured that the services existing system for monitoring the patient stack were effective, and there may be an increased risk associated with patients waiting long periods due to delays. We escalated our concerns regarding the risks within the patient call stack to the senior leadership team at the time of our inspection. The service was in discussions with the local and wider health care sector to discuss how to improve services and reduce waiting times and patient risk.

Emergency operations centre (EOC)

Staff shared key information to keep patients safe when handing over their care to others. Call handlers could add additional notes to patient records to identify any additional risks. For example, if there were other factors likely to affect the patient or the ambulance staff wellbeing or safety on site such as the environment, and violence or aggression towards staff.

Staff told us they had a fifteen-minute opportunity at shift changes to handover all necessary key information to keep patients safe.

Staffing

The service did not have enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm or to provide the right care and treatment.

A team of call handlers, dispatchers, managers, team leaders and clinical staff in the ECAT teams staffed each EOC. The SPOC team was based at Bedford and the regional coordination centre and incident command desk (ICD) were both based at Chelmsford. At the time of our inspection, actual staff numbers did not match those planned due to sickness absence and vacancies within the service.

At the start of the COVID-19 pandemic, the service predicted an increased demand within the service and worked with an employment agency to recruit additional call handling staff. This was called the emergency call handling module (ECHM) staff. These staff were not trained to the same AMPDS systems standard as emergency call handling and dispatch staff and did not complete comprehensive patient assessments when answering an urgent call. We noted on numerous occasions during our inspection that the EHCM staff had to call for assistance from the emergency call handling staff to manage their calls, this negatively impacted on flow and call response times. We raised this as a concern with the service and they told us that they were in the process of training all ECHM staff to the required AMPDS standards and then recruiting them with the AMPDS academy standard by June 2022. This was a known risk to the service and was on the services risk register.

The service had a team of business support staff who worked alongside EOC managers to predict capacity and demand and staff the EOC. The business support staff calculated resource requirement and implemented staff rotas for up to three months in advance including any cover for planned absences, maternity and secondments. Short term absence was managed at a local level with the EOC managers, and a range of social media tools were used to share vacant shifts or seek additional staff to cover any unplanned absences. Staff told us that short notice absences were the most difficult to manage and had the greatest impact on the service.

At the time of our inspection, the service had 1,019 active community first responders (CFR). The service had clear lines of accountability for the recruitment and training of the CFR.

Data provided by the service following our inspection showed that in March 2022, Bedford had the highest vacancy rate of 16.41%, and 8.62% of the vacancies were in relation to call handler roles. Data showed that vacancies amongst the call handling team were the services highest vacancies, with Chelmsford at 8.63% and Norwich at 7.93%. Staff we spoke with told us the services executive team had been slow to respond to requests to increase call handler numbers and that opportunities to retain staff recruited to manage projected increases in calls during the COVID-19 pandemic had been dismissed. Call handling staff employed during this time had not been retained, and the service was struggling to recruit and train new staff.

The service had increasing turnover rates. Turnover rates for call handlers had increased from 17.45% during 2020 and 2021, to 28.3% during 2021 and 2022. During the same period turnover rates within the ECAT team had increased from

8.66% to 9.56% and dispatch staff turnover had reduced slightly from 11.51% to 11.07%. Front line staff we spoke with described a hard-working culture, with lots of demands and work-related stress associated with their roles. Staff told us that sickness and vacancy rates had made their roles and workloads much more difficult, and they felt this had increased risks to callers who had to wait longer times for responses as they did not have the capacity within the teams.

The service had seen a spike in sickness rates in March 2022, with 33.2% sickness absence across the EOC teams. Managers we spoke with explained this was due to the impact of COVID-19. Sickness rates had been decreasing across the EOC's from 9.66% in December 2021, to 6.46% in February 2022.

The service had increased rates of bank and agency staff usage. Between April 2021 and December 2021, the service covered 15,920 shifts with agency staff. Highest agency staff usage was amongst emergency clinical assessment and triage assistants, call handlers and dispatch staff. Data supplied by the service following our inspection showed that the use of agency staff had continued from December 2021, with 4,283 shifts covered by agency staff between January and March 2022.

Managers told us they would try not to rely on agency staff, but the demands on the service had increased significantly following easing of COVID-19 restrictions and they were trying to recruit to permanent roles.

Managers made sure all agency staff had a full induction and understood the service. Agency staff went through a comprehensive competency process before being allowed to work independently in the EOC's.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, stored securely and easily available to all staff providing care.

We reviewed 22 patient notes and found these to be comprehensive, and these were easily accessible to staff who were authorised to access them. The service' IT system enabled the flow of information from call handlers to the dispatch staff. The service used a computer-aided dispatch (CAD) system to record callers' details and relay information to the dispatchers regarding the patient's needs and situation. Call handlers began completing the patient record as soon as they received an emergency call. Call handlers asked a set of dedicated questions following the AMPDS categories that enabled them to prioritise callers due to the nature of their emergency or redirect patients to alternative services, for example their general practitioner (GP).

Staff used 'special notes' to record additional patient details to support ambulance crews when arriving on scene with the patient. For example, we observed staff recording if patients were living with dementia, were end of life or how to guide ambulance staff to access keys to a patient's property if they couldn't open their own door. The service provided quality audit data in relation to the ECAT team records for March 2022. This showed 41 audits completed and an average compliance of 97% against the quality standards.

Records were stored securely. As the patient records were electronic, they were secure on the services IT system and required individual login to promote security.

Medicines

Staff gave advice on medicines in line with national guidance.

Call handlers asked callers whether they were taking any medicines or pain control medication as part of their initial assessment, and only provided advice on medicines which were identified in the AMPDS.

Emergency operations centre (EOC)

Call handlers would not otherwise give advice about medicines or prescribe medicines. If a patient needed advice about prescribed medicines, they would be transferred to the clinical coordinator or a member of the ECAT team on duty, who was a qualified clinician and could provide advice following up to date clinical guidance based on the callers condition.

Any advice relating to medicines provided by ECAT teams was provided in line with the services clinical advice line guidance document which stated that all advice must be in line with Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines and specific to the EOC clinical support team. The services medicine management group provided oversight of the services medicine management procedures.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff we spoke with knew that the service had an incident reporting policy and how to report incidents. At the time of our inspection the service's incident reporting policy was up to date. The policy set out clear expectations on staff roles and responsibilities, including sharing lessons learned and using outcomes from incidents to improve quality within the service.

In the 12 months before our inspection, the service reported no never events.

Staff received feedback incidents had been investigated, both internal and external to the service. The service used its intranet system "EAST 24", email, and staff bulletins to share the outcome of incidents. Staff we spoke with told us the "What's out Wednesday" was a good way of getting information to the team as meetings had been limited during the COVID-19 pandemic. "What's out Wednesday", was a core briefing sent to all staff each Wednesday. Emails and staff bulletins we reviewed showed managers shared incidents and learning from incidents with the staff teams and highlighted any increased risks, or changes in practice to improve patient safety.

Staff and managers we spoke with told us they held "Staff huddles" on Mondays and Fridays, depending on staff capacity. Staff huddles involved staff gathering at safe distances from each other to discuss any ongoing risks, capacity within the service and share feedback from incidents when appropriate. There was a designated area inside the EOC's where staff met for the huddle.

Staff reported serious incidents clearly and in line with service policy. We reviewed the records of four serious incidents that showed staff had escalated incidents in line with the services incident reporting policy. Incident records showed managers investigated incidents thoroughly and patients and their families were involved in these investigations.

Staff understood the duty of candour. We reviewed five serious incidents where the service had used duty of candour and their response was open and transparent and gave patients and families a full explanation when things went wrong.

Serious incident reviews identified the root cause of the incident and where appropriate set out action plans to address any areas of shortfall within the service as well as recognising any areas of good practice which had been followed.

Emergency operations centre (EOC)

There was evidence that changes had been made as a result of feedback. We reviewed an incident that showed changes had been made to staff guidance regarding the red flag processes used within the services IT system to identify patients with increased needs or higher risks. The service implemented “Bite sized” communications to staff to raise awareness of the red flag system and to consider recent patient history when formulating differential diagnosis and pathway choices.

Is the service effective?

Requires Improvement 

Our rating of effective went down. We rated it as requires improvement.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

Emergency operations centre (EOC) call handling staff used the Advanced Medical Priority Dispatch System (AMPDS) to assess and prioritise emergency calls. Managers we spoke with told us the system was regularly updated including changes to national guidance, protocols and procedures relating to the management of emergency medical conditions. The service had a dedicated IT team who worked with AMPDS staff to regularly update the system. The service was using the most up-to-date version of AMPDS at the time of our inspection.

Due to the levels of escalation and caller demand the service had developed a call handler script module, that was used support the call handler decision process. This ensured all the information needed was in one place rather than relying on paper-based flowcharts in order to manage calls.

Staff followed up-to-date policies and procedures according to best practice and national guidance. We reviewed six of the service’s emergency standard operation procedures (ESOPs), and found these were in date and reflected current best practice guidance on the service’s intranet. The service had a clinical lead who had oversight of the development and implementation of new guidance, and details could be shared by email, team meetings, and one to ones. The service used a process called “What’s Out Wednesday”, where any changes in policy or updates to the staff team by its IT systems were shared.

Clinical staff used the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidance for supporting clinical operations, which was accessible for emergency care assessment and triage (ECAT) staff. ECAT staff could access relevant National Institute for Health and Care Excellence (NICE) guidance through EAST 24, the service’s intranet. ECAT staff accessed “LowCode”, to aid with the clinical triage of callers and the MiDoS system to access a local directory of health care and alternative services to redirect callers who did not need an emergency ambulance. LowCode is an emergency care triage tool used by clinical staff to assess a patient’s clinical need.

The ECAT team provided newly qualified paramedics with a clinical support line and clinical advice was provided to call handlers and dispatchers. At the time of our inspection due to service demands, the advice was not provided in line with the services targets of 10 minutes for advice on clinical calls and 15 minutes regarding discharge. We noted that staff were waiting up to 42 minutes to access this advice.

Staff we spoke with said they did not always receive updates, often due to time constraints and managers we spoke with told us there was no central system to monitor staff compliance with reading and implementing any changes in policy or guidance. Staff told us that during the COVID-19 pandemic, guidance could change several times in any one day and this had been extremely difficult to manage.

Response times

The service monitored, but did not meet agreed response times

The service had moved to the new Category one to four standards outlined within the Ambulance Response Programme in October 2017 and provided data for Category one and Category two calls as these historically align to what were category A calls. Between April 2021 and March 2022, the service achieved an average 85% compliance with Category one calls and an ambulance arriving on scene within 15 minutes and 25.9% for a Category two call.

Managers told us that due to the new telephony system implemented in November 2021, they were unable to report on the percentage of abandoned calls at each EOC. The percentage of abandoned calls across the EOC's increased monthly from 0.55% in April 2021 to 21.06% in November 2021. This percentage then decreased to 12.34% in March 2022, giving a yearly average of 8.19%.

Patient outcomes

The service monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved outcomes for patients.

The service participated in relevant clinical audits. The AMPDS academy (International Academies of Emergency Medical Dispatchers – IAED) required the service to demonstrate compliance to AMPDS standards through the auditing of 1% of 999 calls per annum and all call handling and dispatch staff were required to re-certify with the academy every two years. Audits were completed by quality assurance staff listening into a randomly generated sample of calls. Audit data was used to make improvements within the service and provide additional training and support to staff who did not meet the required performance targets within the call handling process, for example call handling times, professionalism on calls.

Managers shared and made sure staff understood information from the audits. Staff received feedback on audit activity, this was shared by email and could be followed up with managers meeting individually with staff to provide feedback on audits.

Improvement was checked and monitored and staff who achieved high compliance during call audits received awards to recognise their compliance and their impact on patient safety.

Managers used information from the audits to improve care and treatment. Following our inspection, the service told us that the ECAT audit team were undergoing a change in their audit process. Calls triaged with the use of "LowCode" historically were audited through a local audit document designed initially during the implementation of the software. LowCode is an emergency triage tool used by clinical staff to assess a patient's clinical need. The service told us that whilst this was fit for purpose at the time, they were in the process of moving over to an advanced quality assurance tool (AQUA) for quality assurance. The service aimed to audit 1% of all "LowCode" calls taken per day once the new system was in place and the service currently audited 1% of all emergency calls as part of its quality assurance processes.

We reviewed ECAT triage data from September 2021 to January 2022 that showed the ECAT team routinely achieved above 95% compliance with triage standards.

Emergency operations centre (EOC)

Re-contact rate

Between April 2021 and March 2022, the percentage of patients who re-contacted the service within 24 hours following discharge by telephone was routinely below 10%. At the Chelmsford base between the same period, 8.9% of patients re-contacted the service within 24 hours following discharge by telephone, with 8.63% at Bedford and 8.97% at Norwich.

Frequent callers

The service had an up to date frequent caller procedure which staff followed. Frequent callers had a wide range of reasons that made them use the service frequently and led to them being flagged on the services IT systems to ensure staff knew of their history and any additional needs. Between April 2021 and March 2022, the serviced handled 146,657 calls from frequent callers, which was 10.07% of the total number of calls received during the same period. Staff followed set processes for welfare or return calls to frequent callers based on the caller's clinical condition and ongoing needs. All staff we spoke with knew the frequent caller procedure and how to escalate any changes in the caller's condition or unusual patterns in their calling behaviour.

Competent staff

The service did not make sure staff were competent for their roles. Managers did not routinely appraise staff's work performance or hold supervision meetings with them to provide support and development.

We were not assured that staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers did not always provide support for staff to develop through yearly, constructive appraisals of their work. Staff had not had opportunity to discuss training needs with their line manager or gain support to develop their skills and knowledge.

Staff we spoke with, especially at the Chelmsford EOC base, told us they had not received appraisals or one to one conversation, in some cases for over two years. Data supplied by the service showed that appraisal rates across all the EOC's was low, with 32.07% compliance at Bedford, 53.06% at Norwich and 39.43% at Chelmsford. Managers we spoke with told us this was due to capacity and not enough time available to carry out appraisals due to the capacity and pressures within the service. Managers told us they were aiming to improve appraisal compliance, but this would be difficult due to the ongoing demands within the service.

Call handling staff at the Bedford EOC told us they had received or were about to receive an appraisal, but time constraints within the service meant these were difficult to attend. Staff also told us whilst they had done some online training, they felt they needed more training to manage calls from patients with specific needs, for example those with mental health conditions, living with dementia, autism or learning disabilities.

Managers had not fully identified training needs for their staff or given them the time and opportunity to develop their skills and knowledge as appraisals and one to ones had not been completed for all staff. We spoke with some staff who told us that career progression was difficult, due to not having the time or support from managers. We were given examples of poor communication from managers regarding training and support, and in some cases, managers deliberately holding staff back or refusing to provide career support and progression.

Emergency operations centre (EOC)

Managers had not supported clinical staff to develop through regular, constructive clinical supervision of their work. Clinical staff we spoke with told us they had struggled to access additional support and supervision due to the demands within the service, working hours and lack of additional staff to relieve them from their clinical call handling duties.

Managers told us that due to the COVID-19 pandemic and demands within the service it had been difficult to arrange staff team meetings and they had relied on IT to have online meetings where possible. Managers we spoke with told us they did try to meet with the staff, have safety huddles and share information but these meetings were not officially minuted so staff would not have access to full notes.

Managers we spoke with told us that managing poor staff performance promptly and supporting staff to improve was an extremely difficult process. Managers explained that due to long standing grievances within the service and staff not seeing any change when disciplinary action was taken that many managers felt powerless when tackling poor performance. Managers gave examples of challenging staff and requesting they follow the service guidance and professional standards; however, staff would then counter this by making grievances or allegations of bullying against them.

Managers ensured that all new staff had a full induction tailored to their role before they started work. Staff we spoke with explained that they had been through a comprehensive series of tests and reviews carried out by experienced staff to ensure they could handle calls or dispatch vehicles.

All new call handler and dispatch staff had a comprehensive induction period. Call handlers completed a four-week training package to ensure they could correctly use the decision-making computer software, extra training on computer aided dispatch (CAD) and then a minimum of 12 mentored shifts before being signed off. Sign off was deferred if a new member of staff had not met the required grade and they were given additional support to complete their induction. Dispatchers had two weeks of training on the CAD and related software, followed by a month with a mentor before being signed off as competent.

Multidisciplinary working

All those responsible for delivering clinical care worked together as a team to benefit patients.

Clinical staff within the emergency clinical assessment and triage (ECAT) were led by a clinical coordinator. ECAT staff were either qualified paramedics, registered mental health nurses (RMHNs) or registered general nurses (RGNs) and liaised with each other when supporting callers.

The ECAT team had access to the callers GP records where appropriate and liaised with the GP services if there was an opportunity to redirect patients to other care providers and pathways.

Health Promotion

Staff gave patients practical support and advice to access appropriate services.

Callers could speak to the emergency operations centre clinical coordinator or emergency clinical assessment and triage staff (ECAT) for advice and guidance on their condition. ECAT staff had access to an online directory of specialist health care services and could signpost callers to other local services for ongoing care and treatment.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patient consent.

Emergency operations centre (EOC)

The service had an up to date policy for staff to follow in relation to mental capacity and consent. Staff gained consent from callers for their care and treatment and recognised when patients could not give consent. For example, call handlers may take an emergency call where the caller was unable to complete the call due to an injury or suspected cardiac event. In these cases, staff made decisions in the caller's best interest and followed the AMPDS guidance to manage their emergency.

Mental Capacity Act (MCA) training was provided within the services safeguarding training, training rates were routinely below the services 95% compliance level. Acute behavioural disorder was included within the training and staff had access to a separate video through its online training platform.

Staff could describe and knew how to access the service MCA policy on the services intranet and guidance was also available on staff notice boards and pocket guides around the EOC.

Is the service caring?

Good ➔➔

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We listened to calls received by the call handlers and noted that staff understood the caller's needs, offered reassurance and gave them time to express their needs.

Data supplied by the service following our inspection showed that 88.1% of people who used the service within the Mid and South Essex area between April 2021 to March 2022 were satisfied overall. Data in relation to call handling showed that during the same period, 89.5% of callers were satisfied overall with the handling of their emergency call and 97.7% said they were treated with dignity and respect.

During busy periods, call handlers did not take patients through the full triage process. Staff asked patients a limited number of questions and then told them the service was very busy. We listened to calls and heard several examples of patients being asked to call their GP or find alternative responses to their condition. Call handlers read from a dedicated script, which enabled them to end calls as quickly as possible. Staff told us that the use of scripts could make calls sound less supportive, even though staff did feel empathy towards the caller. Staff also told us they received abuse from some callers who demanded an ambulance, told them their taxes pay their wages and that they have paid National Insurance and are entitled to an ambulance. The service had up to date emergency standard operating procedures to enable staff to manage abusive or prank calls, and frequent callers.

Staff spoke to callers compassionately and treated them with dignity and respect. Staff listened to what callers were saying and clarified information when necessary to ensure the appropriate level of support and resources were offered whilst trying to respect the callers wishes. Staff were sensitive and supportive whilst on the phone, in some difficult situations. For example, we observed staff speaking with distressed callers on the phone on several occasions who were requesting emergency ambulances in non-emergency situations.

Emergency operations centre (EOC)

Call handlers were often challenged by the public, as to why they could not have an emergency ambulance, despite their symptoms not warranting an emergency service. Often callers lived within a short distance of their local hospital, refused to get a taxi or make their own way to the hospital, despite only having minor issues, but still demanding the service sent an emergency vehicle. Call handlers were sensitive and kind to the callers and professional despite the level of challenges they faced.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. The calls we listened to during our inspection demonstrated that staff took on board individual needs and any requests. Staff knew how to respond should a caller ring regarding a patient who was end of life and had a do not attempt cardiopulmonary resuscitation (DNACPR) in place, guiding the caller towards respecting the individual's choices whilst awaiting the ambulance arriving.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress.

Staff gave patients and those close to them help, emotional support and advice when they needed it. We listened to a caller who was elderly and frail and had recently been hospitalised and was calling for advice regarding their ongoing care and treatment. The call handler identified this as a non-emergency call, but still took the time to complete the call handling process, offer the patient reassurance and guide them to more appropriate care services.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff we spoke with said that at time of extreme demand, the scripts they followed meant they ended calls early or redirected callers to other services. In one call we heard the caller demanding an ambulance as they could not afford a taxi, had no transport or family to help. The call handler remained professional and kind, offered empathy with the caller but explained due to the patient's condition not being life threating and due to capacity within the service the caller would have to make their own way to hospital or see their general practitioner (GP). The call handler explained they fully accepted the callers social and economic situation and empathised with the caller, but the service was not able to cope with every demand they received.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Call handling staff checked with callers to ensure they understood what was going to happen and why. Callers were asked to repeat key information to the call handler to ensure details were recorded correctly, and to ensure that the patient fully understood potential waiting times and to call back if their condition changed.

Staff talked to patients in a way they could understand. Call handlers followed dedicated scripts when speaking with callers. The scripts were clear and concise to ensure all callers received consistent communication and information in a way they would understand. Call handlers did not deviate from the scripts to ensure information was shared consistently. The service carried out audits to demonstrate compliance and make improvements if staff did not meet the expected standards.

Emergency operations centre (EOC)

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients could leave feedback, both compliments and complaints by using the services website and submitting feedback to its patients experience team by email or completing a "Tell us what you think" online form. The service had a patient advice and liaison service (PALS) and complaints processes, with a free phone number for anyone wishing to raise a complaint regarding their care.

Is the service responsive?

Requires Improvement 

Our rating of responsive went down. We rated it as requires improvement.

Service delivery to meet the needs of local people

The service could not provide care in a way that met the needs of local people and the communities served.

Managers could not plan and organise services, so they met the needs of the local population. This was due to capacity issues within the service and the inability to comprehensively handle calls, dispatch vehicles and have oversight of patients waiting for ambulances to be deployed. Managers were working with limited resources and using the services escalation process to prioritise calls, however patients waited extended periods for ambulance responses due to delays in the community and resources being delayed at NHS Trusts.

Managers we spoke with said they had meetings with key stakeholders within the local health care economy, for example the clinical commissioning groups, integrated care system and primary medical services to discuss demand and access to services.

The service had three emergency operations centres (EOC) that were located across the East of England, including at Norwich, Bedford and Chelmsford. Managers we spoke with told us that the service was reviewing its current EOC facilities to ensure they were fit for purpose in line with the *National Ambulance Resilience Unit NARU Service Specification for NHS Ambulance Services Emergency Preparedness, Resilience & Response (November 2012).*

The service held calls every morning with the police to look at resource, discuss resilience and any issues likely to affect the operation of the service. The police would also share details of any large events or increased risks in the area, for example any threats from terrorism, large congregations of people or major events.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

Call handling staff we spoke with told us they had no specific training in meeting the needs of patients living with mental health problems, learning disabilities or dementia. However, we noted that staff demonstrated an awareness of these needs during calls and followed the appropriate processes to ensure callers received the necessary care to meet their needs. Call handling staff could add special notes to the patient record to guide ambulance staff to any additional needs the patient may have, for example how to access their building or informing relatives about the patient's condition.

Emergency operations centre (EOC)

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff we spoke with during our inspection knew the service had access to a language line and translation services.

Staff could also access a text speech system to support patients who were hearing impaired.

Access and flow

People could not access the service when they needed it, in line with national standards, or receive the right care in a timely way.

Managers monitored waiting times; however, patients could not always access emergency services when needed or receive treatment within agreed timeframes and national targets. At the time of our inspection and in line with other ambulance services, the service had implemented its highest level of escalation due to demands within the service. This meant that priority was given to life threatening emergencies and that some callers waited extended periods for an ambulance response.

For example, a Category one call for life threating illness or injuries would need an immediate emergency dispatch for an ambulance to arrive on scene within 15 minutes 90% of the time. A Category three call would require an emergency ambulance to be dispatched or clinical call back within 60 minutes. The service implemented additional guidance to staff and instructed them to follow the services emergency operation standard operating procedures in relation to escalation and use of resources. This meant focusing on Category one calls and all other calls being either redirected to alternative services, closed at point of call with advice or placed into what the service called a “patient stack”. During our inspection, we noted patients waiting long periods in the stack, some for over 12 hours, and one patient who had waited over 24 hours for an ambulance to be dispatched. Between April 2021 and March 2022, the service provided 63,087 ambulance journeys to hospital for Category one calls, 355,766 journeys for Category two calls, 75,222 journeys to Category three calls and 2,305 journeys for Category four calls.

At our last inspection in March 2018, the inspection team noted that the EOC’s frequently struggled to match resources to calls with senior staff stating that handover delays were a major barrier in providing a timely response to calls. During our recent inspection we noted this was still an issue for the service and delays at hospital contributed significantly to a lack of resources being available for dispatch. The service had implemented a rapid release process at two locations, but this was in its infancy and too early to provide any audit data on, however staff we spoke with told us this did release resources more quickly and was being considered for other locations.

Staff could see their own and other EOC’s call handling times and staff availability to take calls displayed on IT screens placed around the EOC’s. Managers we spoke with told us they needed a more efficient way of identifying and managing staff call handling performance. Call handling data could not be broken down to individual staff level without administration staff going into the IT system and manually entering call details from a spreadsheet. Managers told us that whilst internal audits monitored the quality of the calls, they required better IT systems to help them manage call handling and dispatch performance.

If calls were not answered within five seconds at an EOC, it was then open to other regional EOC’s to be answered. During our inspection, we saw that calls were not always answered promptly and there were delays during peak periods.

Staff followed emergency service operational procedures to shorten call lengths where there was sustained demand on the service, which included early call exit protocols. The procedure set out when call handlers should stay on the line,

when call handlers could hand over mid-call, and when a call handler could disconnect a call without providing full post-dispatch instructions. The procedure included detailed exclusions to manage the risk to patients, for example, where the patient was actively bleeding with major haemorrhage, or where instructions were required to provide cardiopulmonary resuscitation (CPR).

At the start of the COVID-19 pandemic, the service predicted an increased demand within the service and worked with an employment agency to recruit additional call handling staff, called emergency call handling module (ECHM) staff. These staff were not trained to the same Advanced Medical Priority Dispatch System (AMPDS) as emergency call handling and dispatch staff and did not complete comprehensive patient assessments when answering an urgent call. We noted on numerous occasions during our inspection that the EHCM had to call for assistance from the emergency call handling staff to manage their calls, this created a lack of flow and increased call response times. The service assured us that it was in the process of training all ECHM to the required AMPDS standards and then recruiting them with the AMPDS academy standard by June 2022. This was a known risk and was on the services risk register.

Calls closed with telephone advice / Hear and treat

Between April 2021 and March 2022, the percentage of calls resolved by the services hear and treat service ranged between 10.7% at Chelmsford, 9.1% at Bedford and 9.2% at Norwich. During the same period, 35.4% of calls received a face-to-face response from the ambulance service that did not need transport to hospital emergency departments.

Time to answer calls

The service set a call answering target of less than five seconds for emergency calls. Data supplied by the service following our inspection showed that between January and March 2022 average compliance at all three of the EOC was below 55%. Chelmsford EOC achieved an average 55% compliance, with Bedford and Norwich achieving an average 53% compliance. Factors affecting this included staff making themselves unable to take calls whilst they were updating records, established call handling staff helping the EHCM staff with calls and the sheer volume of calls and lack of available call handlers due to vacancies and sickness absence.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Patients, relatives and carers knew how to complain or raise concerns. The service had a complaints process that was accessible on the service's website. Call handlers could also escalate complaints as soon as they were received to the duty manager or the call handling team leader. Between April 2021 and March 2022, the service received 106 complaints, during the same period the service responded to 1,456,105 calls across its three EOC's. The service received 76 complaints by email, 13 by telephone, five by letter and 15 by other methods. None of the complaints were closed in line with the timescales set out in the services complaints policy and at the time of our inspection 16% of the services complaints were ongoing. Most complaints related to delays in ambulance arrival and waiting times. Complaint responses had been affected by staff capacity within the service.

Staff understood the policy on complaints and knew how to handle them. Staff we spoke with knew the service had a complaints policy and how to access this and guide callers towards the complaints process. Staff told us they would refer callers to the team leader or duty manager if an immediate response was required or if they were receiving any verbal abuse or threats from callers.

Emergency operations centre (EOC)

Managers investigated complaints and identified themes. Staff we spoke with told us that manager shared feedback from complaints and actions taken to improve the service.

Managers shared feedback from complaints with staff and learning was used to improve the service. Themes regarding calls would also be identified during the call audits processes and details from call audits were shared with staff. These included complaints regarding the quality of the call, the accuracy of information shared or waiting times for ambulances, which was a common theme of complaints to the service.

Is the service well-led?

Inadequate 

Our rating of well-led went down. We rated it as inadequate.

Leadership

Leaders did not always understand or manage the priorities and issues the service faced. They were not always visible and approachable in the service for staff.

Since our last inspection the service had been through several leadership changes both at executive and local levels. The services deputy chief operating officer led the emergency operation centres (EOC's) supported by the head of ambulance operations centres. Local leadership of the EOC's was performed by a team of senior operations centre managers.

Managers we spoke with described local senior management as supportive and willing to go the extra mile to deliver the services. However, staff told us that executive managers were not supportive, or visible and that some senior leaders made decisions that were not in the best interests of the staff or the leadership of the EOC. Examples of this included the business case for upgrading the work environment, employing additional call handling staff and the purchase of equipment. Staff described the senior executives as out of touch, unwilling to compromise and that some of them had a singularity view which all staff had to comply with.

Staff and managers, we spoke with described a poor human resource (HR) service, where decisions took a long time, there were inconsistencies in approach towards staff performance and for grievances, or employment issues were not dealt with in a timely way. Managers told us the HR team were worried about making decisions or taking any form of disciplinary action with staff as there was a culture of counter grievance when performance management activities were implemented. One example of this was requesting staff did not use their personal mobile phones whilst on duty in the control room, which managers said they had tried to implement. HR had not been supportive, and staff had pushed back against this decision, so managers had been unable to implement this change or enforce any rules regarding the use of personal mobile phones due to fear of grievances being raised.

Staff we spoke with said that the senior operations centre managers (SOCMs) spent a lot of time in offices and were not always visible in the control rooms. Staff gave examples where senior staff had made decisions regarding flow and access in the services that had not been communicated effectively with the EOC team leaders or duty managers.

At the time of our inspection, the service had 1,019 active community first responders (CFRs). The service had clear lines of accountability for the recruitment and training of the CFRs, however data provided by the service following our inspection showed that all training rates for all CFRs were below the services compliance rates.

Emergency operations centre (EOC)

Staff we spoke with within call centres were not aware of the services "Fit for the future" programme, and said that leaders at a local level had been in post a long time, and not had the training necessary to enable them to support the staff team. The "Fit for the future" programme sets out key priorities and activities to ensure the service is meeting current demands whilst developing its services to meet demands in the future. During our inspection we had several contacts from staff who described poor leadership. Examples included local managers not following policies and procedures, failing to recognise requests for reasonable work adjustments, failing to follow occupational health guidance, concerns regarding discrimination on the grounds of protected characteristics, and favouritism amongst the leadership team.

Vision and Strategy

The service had a draft strategy and vision for what it wanted to achieve. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

The service had an overarching strategy titled *"Clinical Excellence, Team Growth & Effective Leadership – 2021-2026",* which included the "East of England Ambulance Service NHS Trust's Ambulance Operations Centre's Five-Year Strategy Document". The strategy was developed after reviewing national guidelines, other strategy and documents produced by other ambulance services and directorates.

The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. The service held meetings and workshops to draw up their initial plans and identify priority areas for the coming five years. This was an improvement from our last inspection in 2018, when the EOC did not have its own strategy, because it was incorporated within the service's wide strategy.

Staff we spoke with knew the services values and the behaviours expected of them and that the service aimed to provide outstanding care to patients and support for staff.

Managers we spoke with knew that the service had a vision and strategy, however they felt that the years of change in leadership had impacted on the services ability to move forward and make improvements. Managers felt that some of the executive team were difficult to work with, describing some managerial network as "The old boys club" and that financial and human resource issues were not dealt with swiftly or properly, so they had lost faith in the services ability to reach its vision or make the improvements necessary.

Culture

Staff did not feel respected, supported or valued and there was a lack of professional standards being adhered to and a lack of urgency and ownership of responsibilities within the service.

During our inspection we found a range of views from staff on the culture within the service.

Dispatch staff were often waiting for deployment of resources and had time when they could support the call handling team or clinical assessment and triage staff (ECAT) with welfare calls. However, we noted during our inspection that these resources did not effectively work with each other to reduce call waiting times or manage the patient "Call Stack".

Staff were overwhelmingly committed to providing callers with the right support and ensuring services were provided on time and were disappointed when they failed to achieve this. Staff told us they did feel valued by colleagues, but the sickness and vacancy rates had affected their morale. The work was hard and relentless, staff were frustrated that there

were not enough staff or resources to meet the demands within the service. Staff often cited the impact on work pressures on their health and wellbeing, particularly from a mental health perspective. Local managers were described as supportive, and the service did have additional support services for staff to use to discuss their wellbeing, but staff said the service had been under pressure for so long they felt change would never happen.

Some staff described a culture where harassment and bullying had been an issue and that managers had been slow to deal with these issues. Other staff described senior managers as not visible, not engaged and that there was a network of managers that all knew each other for years and that these networks suppressed change from happening across the service. “My way or none” was often a term used to describe the senior leadership team.

In Chelmsford, we found staff working in unclean areas, with equipment they described as out of date and that did not match equipment in other areas. Staff here said they had become used to this and managers felt the environment was affecting staff wellbeing and not creating a professional environment for them to work in. In Bedford the environment was much more organised, clean and lighting was much better.

The temporary leadership structure and interim roles had led to a culture of uncertainty amongst the staff team and lack of trust in relation to senior managers. Staff described feeling let down that changes had not happened or been followed through. Some staff descried a toxic culture, where bullying did happen and staff were treated badly, and managers did not provide the support required to do their jobs.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations.

The service had a clear governance structure across the EOC’s with defined roles and responsibilities. However, we were concerned that despite the service identifying risks, they had not been responsive in terms of implementing changes as a result of the risks they had identified, for example the environmental issues at Chelmsford EOC. The ambulance operational delivery group (AOCDG) had oversight of governance throughout the EOC’s. Its main function was to manage and support the delivery of the East of England Ambulance Service NHS Trust’s (EEAST) contractual operational performance, patient safety targets, service delivery and performance improvement and sustainability. AOCDG met monthly but could meet at other intervals if requested to do so by the group’s chair or the Chief Executive.

The AOCDG reviewed compliance against core safety measures, focused on continual quality and safety improvement and ensured that risk assessments were carried out where appropriate to new or amended EOC procedures, instructions or process changes.

The EOC governance structure was supported by several sub committees including the quality improvement unit, dispatch review committee, clinical review group, dispatch steering committee, and the compliance and risk group. We reviewed AOCDG meeting minutes from October, November, December 2021, and January 2022 that demonstrated key areas of governance, and risk were considered, clear actions were outlined to mitigate risks and improve the quality of services.

Management of risk, issues and performance

Leaders and teams identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Emergency operations centre (EOC)

The EOC had a dedicated risk register that reflected current risks within the service. Risks included but were not limited to, not having enough call handling staff, failure to reduce sickness absence in the EOC's, call priority upgrades while a 999 call was in progress and incorrect vehicle deployment. All risk had dedicated owners, risk and effect, control measures and risk ratings.

Risks were reviewed monthly by the AOCDG to ensure risks were managed in accordance with the services risk management strategy including identifying new risks, monitoring of high scored risks across EOC and escalation of significant risks to the clinical risk group (CRG). AOCDG minutes we reviewed from October 20221, December 2021 and January 2022 demonstrated that the risk register for the EOC was a standing agenda item and that risks were escalated from front line services to the appropriate governance and risk subgroups for consideration and action.

At the time of our inspection, the service told us it was completing a significant piece of work to completely re-write the EOC business continuity plans using a "back to basics" approach following the EOC compromise incident in November 2021. The EOC leadership teams had a draft plan that was going through the services governance processes for sign-off before implementation. The service had implemented several action cards in place to support EOC in the event of a failure at anyone of the three sites for contingency purposes as well as for a total loss of EOC critical functions.

The service followed the national guidance for referrals to the hazardous area response teams (HART) team and the services overall major incident (MI) plan was due to be reviewed in October 2021, following the Manchester enquiry to ensure that any learning or recommendations were included within the final document. However, the inquiry report had been delayed. The service was planning for the MI plan to be signed off in May 2022.

During our inspection we raised concerns with the service regarding the management of the patient call and risks to patients waiting long periods in the stack, who may not receive welfare calls, or deteriorate whilst waiting for resources to be deployed. We noted that the services risk register acknowledged these were ongoing risks due to capacity and lack of resources within the service.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

Managers understood performance targets including quality, data from audits, dispatch operations, and finances. Information was shared across the service to key committees and oversight groups to provide assurances on the quality, risk and performance within the service.

Quality assurances processes were embedded to review how information was stored and shared when handling calls and dispatching resources.

IT systems were integrated and secure, to prevent unauthorised access of information.

Engagement

Staff told us that engagement with local managers and senior managers was limited.

Staff we spoke with told us that most communication was done by email, core messages and bulletins. Opportunities for one to one and supervision had been reduced due to demands within the service and the impact of COVID-19.

Emergency operations centre (EOC)

Staff told us that the senior leadership team was not visible within the service, and that senior managers only attend EOC's infrequently.

The service had a whistle blowing policy and 'Freedom to Speak Up' Guardians in place for staff to speak with. Staff told us that they felt the freedom to speak up roles really hadn't had the impact they expected as many of the cultural and support issues had not been dealt with effectively, despite being raised to the freedom to speak up guardians.

The service had recently published its 2021 staff survey outcomes; however, results were not specific to the EOC staff groups.

Managers told us about an internal award scheme called the "Hidden Gems" where managers and other staff could nominate staff that have gone the extra mile in their day-to-day duties and receive a certificate of recognition. Staff we spoke with showed us their awards and told us how they had been nominated by other staff, and how this made them feel valued by colleagues for the work they did.

The Norwich EOC supported the "Listening Project", where every Thursday night from 6pm to 10pm, a charity who offer support for people in crisis was on hand to provide welfare to staff, listen to concerns and offer support for personal or professional issues.

"InTouch EEAST" is the services stakeholder newsletter sent out by email every two months which included an update from the services Chief Executive as well as highlights of the services most recent news and information. The newsletter was distributed to councillors, MP's and stakeholders across the region, as well as individuals who had subscribed by the services website.

Chelmsford EOC emergency clinical assessment and triage staff (ECAT) co-produced a survey with members of a local mental health charity network for staff to ascertain their views and confidence with handling calls from patients with mental health illness or in a mental health crisis. This was followed up by staff engagement sessions run by the service's mental health team and the local mental health charity to provide training opportunities for staff.

The service used a range of patient engagement methods with patients and communities covered by the EOC including face-to-face public engagement events, school and education visits with children and young people. Community group educational visits, talks and presentations for community groups, patient story discovery interviews (filmed and shown at the services board or for staff training), links with community and patient network groups and specific patient groups such as adults with learning disabilities, carers support groups, and young patients.

Learning, continuous improvement and innovation

The service had made some developments to improve services.

Due to the levels of escalation and caller demand the service had developed a call handler script module, that was a PDF tool to support the call handler decision process. This put all the information needed in one place rather than relying on paper flowcharts to manage calls.

The service had taken the decision to integrate into a national register for community defibrillators and use the computer aided dispatch (CAD) process to enable call handlers to provide callers with the most accurate information available in relation to a community defibrillators location and supply the necessary information needed to get to it.

Emergency operations centre (EOC)

Historically this information was added to the CAD manually and when a defibrillator had been used it would take time for it to show as inactive on the CAD. With the circuit being fully integrated, the service received updates every five minutes from the national register, this ensured that when callers went to retrieve a defibrillator the service knew it had not been used and was responder ready.