East Midlands Ambulance Service NHS Trust

Emergency operations centre (EOC)

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services effective?	**Inspected but not rated**
Are services caring?	**Inspected but not rated**
Are services responsive to people's needs?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Emergency operations centre (EOC)

Inspected but not rated

East Midlands Ambulance Service NHS Trust provides emergency 999 and urgent services and serves a population of 4.8 million across the East Midlands (Derbyshire, Leicestershire and Rutland, Lincolnshire, Northamptonshire and Nottinghamshire), covering 6,425 square miles.

East Midlands Ambulance Service provides the following core services:

• Emergency & Urgent Care (E&UC)

• Patient Transport Services (PTS)

• Emergency Operations Centre (EOC)

• Resilience Services including the hazardous area response team (HART).

The service exists to respond to 999 calls and responds to over 730,000 emergency and urgent incidents per year, with over 2,000 emergency calls per day being received.

The front-line E&UC staff include paramedics, technicians, emergency care support workers (ECSWs) and specialist practitioners. They are based in up to 90 ambulance stations across the region. The trust also subcontracts some of its work to voluntary and private organisations.

The trust has two emergency operations centres (EOC). One in Lincoln and a larger EOC at trust headquarters in Nottingham. This inspection will only visit the Nottingham EOC.

The two EOC's work as one virtual EOC and all calls are routed to the next available operator across the two centres. Clinicians work at both EOCs triaging lower priority calls and providing clinical advice to patients.

The EOCs manage emergency calls from Health Care Professionals, GP urgent calls for Lincolnshire and to the community first responder (CFR) calls for the whole of the East Midlands area. Nottingham EOC responds to calls for the rest of the East Midlands including the air ambulance service.

There is also a clinical assessment team (CAT) within the EOC. The CAT supports both 999 and workflow. The resilience service works with the police, the regional fire and rescue services, and local authorities to ensure preparedness for major serious incidents in the region.

The incident command desk (the coordinated response for major incidents) is in Nottingham. The emergency operations centre receives calls from all age groups.

Our findings

At the last inspection in 2019 the EOC was rated 'Good' in all five key questions. Practices recognised as outstanding were the management of frequent callers and that the trust was the first to start transferring calls digitally to other English ambulance services.

As this was a focused inspection, we did not look at every question in our key lines of enquiry, we did not re-rate the service at this time.

On our inspection we reviewed the Nottingham Emergency Operations Centre. We looked at elements of the safety, effectiveness, caring, responsiveness and leadership of the staff and teams at the centre responding to 999 calls.

A summary of CQC findings on urgent and emergency care services in Leicester, Leicestershire and Rutland.

Urgent and emergency care services across England have been and continue to be under sustained pressure. In response, CQC is undertaking a series of coordinated inspections, monitoring calls and analysis of data to identify how services in a local area work together to ensure patients receive safe, effective and timely care.

We have summarised our findings for Leicester, Leicestershire and Rutland below:

Provision of urgent and emergency care in Leicester, Leicestershire and Rutland was supported by services, stakeholders, commissioners and the local authority.

We spoke with staff in services across primary care, integrated urgent care, acute care, mental health services, ambulance services and adult social care. Staff had worked very hard under sustained pressure across health and social care services.

People reported difficulties when trying to see or speak to their GP. Some GP practices had invested in new technology to improve telephone access. Staff working in GP practices signposted patients to extended and out of hours services to prevent people attending emergency department whenever possible.

Staff working in urgent care reported an increase in demand and an increase in acuity of patients presenting to their services. Some staff reported frustrations in relation to urgent care pathways; staff working in advanced clinical practice were not always empowered to make referrals into alternative pathways.

Staff working in urgent care services reported challenges due to the volume of pilots focused on admissions avoidance running across Leicester, Leicestershire and Rutland. Many pilots ran for relatively short periods of time and were often impacted by staffing issues. This made it difficult to maintain oversight of pathways available to avoid acute services. However, some pilots had proved successful and prevented ambulance responses and hospital admissions.

Staff working across urgent and emergency care services raised concerns about their skills set. Some staff in urgent care services felt they needed additional training to meet the needs of patients presenting with higher acuity.

Patients seeking advice from NHS111 in Leicester, Leicestershire and Rutland experienced some delays getting through to the service, when compared against national targets. However, at the time of our inspection, performance was better than England averages for key indicators including the percentage of calls answered within 60 seconds, and call abandonment rates. Staffing continued to be a challenge across NHS111, however recruitment was on-going.

Our findings

Out of hours care had been challenging throughout the pandemic as staff were redeployed to other key services, this had particularly impacted on home visiting services.

The emergency department serving Leicester, Leicestershire and Rutland is within a large, city centre hospital. and poor patient flow across health and social care has further increased the significant pressure on the emergency department. This pressure has resulted in long delays in care and treatment. Long delays in ambulance handovers have, in turn, resulted in a high number of hours lost to the ambulance service whilst their crews wait outside hospital. This causes further delays in responding to 999 calls to patients in the community with serious conditions.

Ambulance crews reported an increase in the volume of patients calling 999 who told them they had been unable to see their GP and crews often signposted patients back into primary care.

We found psychiatric liaison services at the city centre hospital were well run and designed to meet people's needs. Staff demonstrated effective partnership working with a person-centred approach and good use of alternative pathways to avoid admission into acute or social care services.

We found that staff working across specialisms in acute services did not always provide sufficient in-reach into the emergency department to improve patient flow and the care received. This was particularly apparent at night. Beds were not allocated to patients until they had been accepted by specialists, this meant some patients spent additional time waiting in ED. During our inspection, between 45 and 60 beds were needed for new patients waiting in ED. Some patient transfers to other hospitals in Leicester, Leicestershire and Rutland stopped at 8pm, this restricted patient flow out of the city centre hospital.

Some staff reported frustrations with escalation processes across health and social care in Leicester, Leicestershire and Rutland. At times when the city centre hospital and the ambulance service was under significant pressure, staff felt there was a lack of diverts available to other sites or services and that system partners were slow to respond. There was a rapid ambulance handover process when services were in escalation; however, staff reported these were not effective.

There was a high number of patients in hospital who were medically fit for discharge but remained in acute services. System stakeholders worked together to consider discharge pathways; however, at the time of our inspections the number of patients awaiting discharge remained very high. Delays were still commonplace and capacity in community and social care services impacted on the ability of staff to safely discharge patients. Communication about discharge and discharge processes were impacting on the quality of transfers of care to social care services.

People living in social care setting experienced long delays, particularly when accessing 111 or 999 services. Although advice was provided, this had resulted in significant waits and poor outcome, especially for people who had fallen and remained on the floor. Staff working in social care services told us they had limited access to support and advice and relied on GPs, 111 or 999.

System wide collaboration, accountability and risk sharing needs to improve to alleviate pressure on key services in Leicester, Leicestershire and Rutland.

Summary of East Midlands Ambulance Services NHS Trust - Nottingham Emergency Operations Centre

For the emergency operations centre we found:

Our findings

The service controlled infection risk well. Staff used equipment and control measures to prevent the spread of infection. The design and use of facilities were reviewed and changes made by management in response to the COVID-19 pandemic to keep people safe.

Staff new about and dealt with any specific risk issues. Staff used a recognised script which they followed when communicating with the caller.

The service had enough staff with the right qualifications, skills and training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service monitored and met agreed response times so that they could facilitate good outcomes for patients. 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.

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. Staff felt respected, supported and valued. The service promoted equality and diversity in daily work and provided opportunities for career development.

How we carried out this inspection

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

For the emergency operations centre inspection, we met with staff from across the organisation. We spoke with the chief executive officer, deputy director of operations, duty managers, team leaders, call handlers, emergency medical dispatchers and clinical assessment team.

We listened to calls coming into the service from the public and observed how they were answered by the emergency medical dispatchers and the clinical assessment team. We viewed minutes of meetings, records and documents relating to the service operation.

Is the service safe?

Inspected but not rated

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to prevent the spread of infection.

The service was visibly clean, well-maintained and was following infection prevention and control practices in relation to COVID-19 pandemic precautions. Appropriate personal protective equipment (PPE) was available with masks at reception for visitors. Sanitizer and alcohol wipes were located on the desks and we observed staff using them. Where possible some staff were working from home to minimise the risk of cross infection.

Our findings

We saw evidence that the risk of COVID-19 virus was included in the risk assessment reviewed by the strategic commander and actions were taken to mitigate the risks, which included reviewing the layout of the working environment to incorporate social distancing.

On the service's website there was information for patients regarding infection prevention and control and the disclosure of any infection they may have when making a 999 call. There was also information relating to the national frameworks to manage calls from GPs and healthcare professionals when requesting an ambulance for patients who needed urgent or emergency transportation to hospital.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them.

The service had reviewed the layout of the emergency operations control area in response to the COVID-19 pandemic. The service summarised the findings of an ergonomic usability assessment in a document that we viewed, where they identified the need to reduce staff face to face contact through reviewing the layout of the area. We discussed with management the importance of the team leaders being visible across both areas and not isolated to one area. The document identified the importance of the ergonomic process to improve team working interactions and that a task analysis had been undertaken with staff to establish their interaction priorities to support the room design process. Both the document and emails viewed recognised that staff were involved in the new office design which highlighted staff influencing practice.

Within the premises the service adhered to a one-way system, blue door in and red door out, and ensured the newly refurbished desks were two metres apart to promote a safe working environment.

The clinical assessment team (CAT) were working in the same part of the building as the dispatch team. The CAT and dispatch team were allocated separate kitchen and toilet facilities to prevent cross infection. We saw handwashing instruction posters on the walls of the kitchen and staff toilets.

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 knew about and dealt with any specific risk issues. If the team took a call which was identified as higher priority, it was passed to the team leader to re-prioritise, for example a diagnosis of sepsis.

We listened to calls coming into the centre during the inspection. Staff used the recognised script which they followed when communicating with the caller. We observed clear communication between the staff member and the caller. Staff approach was respectful with staff taking the relevant details to enable them to decide on the most appropriate response.

The clinical assessment team (CAT) told us they triaged and completed notes on the same computer system as other healthcare services to ensure continuity of care, for example with GP services. The clinical navigator monitored the calls and would prioritise if required. This was communicated over their team's system so all staff were aware of the priority. The service had a dedicated person to review calls based on the review times.

Our findings

Staff shared key information to keep patients safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep patients safe.

Staffing

The service had 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. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

The service had enough staff to keep patients safe. Staffing levels were maintained although the service told us that had been challenging. The service used bank staff when required.

Staff told us they felt supported and although the demand was high, they did not feel pressurised to take on extra work. Those who did additional work, said they felt appreciated. Incentives were introduced and staff told us they received recognition 'thank you' emails from management.

Staff said managers were approachable and friendly. Annual performance and development reviews were undertaken, and staff told us they received online training including relevant training following an incident. From the annual review records, we saw that dispatch staff and managers within the control room received annual refresher training on joint emergency services interoperability principles (JESIP), a joint decision model to assist commanders to make effective decisions together.

Staff training was 91% completed and 70% of staff had received an appraisal. The service had a system in place to allocate staff training to ensure staff received mandatory training, job role education and continuous professional development (CPD).

The service had a contingency process in place when additional staff were required. Through the patient administration system (PAS) the service was able to call on reserve staff, and if necessary other emergency control centres could take calls for the regions. Managers told us that if there was an excessive number of calls, the service was able to divert the calls to other ambulance trusts.

Managers accurately calculated and reviewed the number of staff on duty. We viewed the staff rota which identified any potential shortages which would be highlighted in red. We discussed mitigation in relation to staff shortages. The service monitored staffing levels using a recognised regulatory information system to prioritise the workload.

Meetings were held during the day to monitor the local weather conditions and response times. Daily operational meetings with the senior controller were held to review any issues. The service held an evening meeting to prepare for the night shift. Staff told us night duty was very busy and on occasions there were not enough staff although they told us they can raise any issues with management.

The local team supervised and reviewed the skill mix. Conference calls were held three times a day. We viewed the conference call plans which were identified as the 'daily service delivery plan'. When required, solo crew were sent to the hospital accident and emergency department to relieve day shifts that may had been at the hospital for a long time due to delays.

Our findings

Is the service effective?

Inspected but not rated

Response times

The service monitored, and met, agreed response times so that they could facilitate good outcomes for patients. They used the findings to make improvements.

We saw from the 2020-2021 annual report that between the two EMAS EOC services, the clinical assessment teams undertook 70,000 hear and treat events during the year. The hear and treat response model refers to the scenario when emergency 999 calls are provided with a response that does not involve dispatch of a vehicle. The model of care trust comparison audits showed the service had similar performance responses for hear and treat patients as other counties. Audits additionally showed that the percentage of hear and treat patients had increased over the past three years, thereby reducing the number of patients required to go to accident and emergency departments.

Service records demonstrated that the EOC call answering times had improved in 2022. The service monitored monthly the accident and emergency performance standards following the ambulance response programme (ARP) in relation to call response times. This related to the four categories; life threatening, emergency, urgent, and less urgent.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

We spoke with staff who handled the calls and they told us they liked working for the service. New employees were supported with their training and had been assigned mentors. Staff received weekly emails and newsletters highlighting any changes. Staff received 3-monthly reviews and an annual appraisal. Staff told us they felt confident to speak up if they had any concerns.

Staff meetings were held every two weeks where they would review the emergency operations centre environment planning.

Patient outcomes

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

Outcomes for patients were positive, consistent and met expectations, such as national standards. Staff were extremely passionate about their role and were patient focused. We observed staff with a caring nature towards each other and their patients.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The service carried out a daily service delivery plan which was analysed, and actions taken. Managers and staff used the results to improve patients' outcomes.

Multidisciplinary working

Our findings

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.

The service had a Clinical Safety Plan with specific scripts for the call handlers to follow to assess the category of the call. The multi-disciplinary team (MDT) leader told us they also take calls from other trusts.

The Chief Executive Officer (CEO), told us the service worked closely with five integrated care systems and the six police and fire services who serve the area covered by the East Midlands Ambulance Service. The CEO told us the service was viewed as a collaborative provider and demonstrated a lead role on provider collaboration. As a care 999 provider, they were considering the delivery of 111 service through a provider collaborative partnership with the 111 provider. The plan was to reduce the number of separate services and to simplify the experience for service users. The service had a business case in place to move to NHS pathways as a triage system. The CEO told us they had engaged with all integrated care systems (ICS) of joint working with the 111 service.

Staff worked across health care disciplines and with other agencies when required to care for patients. The service had a good relationship with 'blue-light' partners including fire service crews and ambulance trusts. During the height of the COVID-19 pandemic, the services had an agreement to utilise fire service crews for non-life-threatening calls. This resulted in some of the fire service personnel joining the EMAS on a permanent basis.

The service attended local resilience forums which provided an opportunity to determine joint working arrangements. It was recognized that challenges in the social care sector had an impact on the demand for ambulance services. Partnership working with the violence reduction groups should also reduce the demand on emergency services.

The manager told us the operational layout of the service was similar to other counties with the introduction of picture archiving communications systems (PACS) software which supported staff with vision and time management.

Is the service caring?

Inspected but not rated

Compassionate care

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

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude. Staff received training in how to interact with challenging and distressed callers. Staff were allocated a mentor for support and worked with them for 12 shifts. We observed staff attending mentoring sessions where they took calls with experienced staff. Support was given after the call through dedicated debriefing sessions. Staff had access to mental health support and the MDT lead told us team leaders were given peer to peer support for staff.

Staff said they had a script to follow when answering calls from aggressive callers and had access to pastoral care through debriefing and counsellors.

Our findings

Is the service responsive?

Inspected but not rated

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.

Facilities and premises were appropriate for the services being delivered. The service had introduced a new office layout in response to the COVID-19 pandemic to provide social distancing in line with infection prevention and control guidelines.

Managers planned and organised services, so they met the needs of the local population. Managers ensured there were enough staff on duty with the required skill mix to manage the calls effectively. The service had systems to help care for patients in need of additional support or specialist intervention.

Access and flow

People could access the service when they needed it, in line with national standards, and received the right care in a timely way.

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets. To reduce the waiting times for callers, the clinical assessment team had been increased with nurses, paramedics and doctors to provide advice and reassurance to patients through the call-back process. Audits identified there had been an improvement in call answering times in 2022 with the longest waits only 18 seconds in February. Comparisons with other counties identified the service experienced shorter call answer times than callers nationally.

The service had introduced processes to reduce the time ambulances spent waiting outside accident and emergency departments and prioritised calls appropriately.

The doctor triaged the calls and arranged call-back after re-prioritising the calls. The clinical safety plan had been amended to incorporate new scripts which included asking the patient if they could make their own way to the hospital or GP surgery. Local offices around the counties provided extra care to prevent the need to visit accident and emergency.

To ensure continuity of service, there were additional staff, dispatch officers, who would support with calls when required. The service had recruited new call handlers to complement the workforce. Staff told us they were able to raise any issue.

Is the service well-led?

Inspected but not rated

Our findings

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

There was a redesign of the EOC management structure with clearer demarcation between the operational and service delivery. Staff were complimentary about the senior and executive teams and said managers were approachable.

We viewed the annual review of the interoperable capabilities of the service. The review identified that significant improvements had been made in the corporate prioritisation of the emergency preparedness, resilience and response (EPRR). The trust had increased the hazardous area response team (HART) which are a specialist team who are trained to provide life-saving medical care in complex environments.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

The service promoted equality and diversity in line with the Equality Act 2010 and had appointed a Black, Asian and minority ethnic (BAME) Lead. The BAME lead told us they had been in post for two years and they promoted the employment of BAME staff.

Management supported new innovative ways of working, for example reverse mentoring with the BAME lead acting as mentor to the Chief Executive Officer (CEO). The lesbian, gay, bisexual and transgender (LGBT) staff were well supported. The services strategy of transformation included reverse mentoring with staff on panels which made them feel valued. Staff told us they felt supported in their role.

The service had a freedom to speak up guardian and a wellbeing lead who held meetings regularly with the BAME lead which included mentoring and training. We viewed the EMAS annual report which referred to the online training for staff regarding the freedom to speak up. The trust saw an increase in freedom to speak up referrals and the process had become an established route for staff to raise concerns in a safe and confidential way.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Staff told us they were confident to raise any issue and it would be taken seriously. Staff said they currently had no complaints and said the leaders were approachable. The welfare of staff was supported with incentives, including approving time off and overtime which was monitored to ensure continued staff well-being. Staff told us they receive welfare telephone calls from management to assess on the mental health of staff.

A weekly meeting was held for management to update executives about performance. Daily conference calls were held for all managers where an agreed action plan was applied by the duty commander. We viewed minutes of the control service delivery groups management meetings where risks had been identified and action required with dates of completion documented.

Our findings

Managers recognised that there was a risk of two teams developing, however senior managers were able to work between sites fostering a good working relationship.

We were told that there had been high demand during the past three months which included tactical planning to help with responding to a terrorist incident. The service had increased the numbers of practice educators.

Staff told us that they had clinical support from the team leader however they did not know the full escalation pathway for clinical support. Staff said they did not document when they sought advice from the team leader. The service had a doctor or nurse conducting a clinical review of each call category on the clinical assessment team to prioritise calls.

The CEO told us they were enthusiastic about the integrated care system (ICS). The ICS is a partnership that brings together provider and commissioners of NHS services across a geographical area. The service was looking at new ways of working within the health care system to ensure that resources were used effectively. The ICS supported career progression into other providers or roles.

Our findings

Areas for improvement

SHOULDS

Core service

The trust should continue to monitor the workload capacity to ensure that workload is managed effectively at peak times.