South Western Ambulance Service NHS Foundation Trust

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Quality Report

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

Are acute services at this trust safe?	Requires improvement
Are acute services at this trust effective?	Requires improvement
Are acute services at this trust caring?	Outstanding
Are acute services at this trust responsive?	Good
Are acute services at this trust well-led?	Requires improvement

Letter from the Chief Inspector of Hospitals

South Western Ambulance Service NHS Foundation Trust is one of 10 ambulance trusts in England. On March 1,

Summary of findings

2011 the trust became the first ambulance service in the country to become a Foundation Trust, and acquired Great Western Ambulance Service in February 2013. It provides services in the following geographical area:

• Cornwall

• Isles of Scilly (IOS)

• Devon

• Dorset

• Somerset

• Wiltshire

• Gloucestershire

• The former Avon area (Bristol, Bath, North and North East Somerset and South

• Gloucestershire)

The area is made up of approximately 5.3 million people with an additional 17.5 million visitors per year and covers 10,000 square miles (around 20% of mainland England). It spans 13 Clinical Commissioning Groups and serves 18 acute trusts.

The trust employs over 4,000 mainly clinical and operational staff, including Paramedics (1,788), Emergency Care Practitioners, Advanced Technicians, Ambulance Care Assistants and Nurse Practitioners), plus GPs and around 2,785 volunteers (including community first responders, BASICS doctors, fire co-responders and volunteer PTS drivers).

The trusts primary role is to respond to emergency 999 calls, 24 hours a day, 365 days a year. 999 calls are received in one of three emergency operation centres (EOC), where clinical advice is provided and emergency vehicles are dispatched if required. In addition, the trust also provides patient transport services, hazardous area response teams, NHS 111 services for the people of Cornwall, Devon and Dorset, urgent and emergency care at one minor injuries unit in Devon and out of hours GP services in Gloucestershire and Dorset. The service also provides clinical teams for six air ambulances.

In 2014/15 the trust responded to 867,505 emergency and urgent incidents, received 918,227 NHS 111 calls, helped 155,965 patients calling their out of hours service and completed 99,907 patient transport journeys.

We carried out this inspection as part of the CQC's comprehensive inspection programme. We undertook our announced inspection between 6-10 June 2016 and conducted unannounced inspections on 17, 20 and 22 June 2016 and inspected the following core services:

Emergency Operations Centres

Urgent and Emergency Care

Patient Transport Services

Resilience

Emergency and Urgent Care

Out of Hours

Overall, the trust was rated as requires improvement. We rated caring as outstanding and rated responsiveness as good. Safety, effectiveness and well led was rated as requires improvement.

Our key findings were as follows:

Safe

- Not all staff were reporting incidents, particularly when they were verbally abused by callers and in some areas staff did not routinely report incidents related to patient safety. Some staff felt that due to the demands on the service they did not have time to report all incidents.However, the trust had taken steps to make the reporting process more straightforward by providing a link within the electronic patient record. This allowed staff to complete incident forms without having to return to the ambulance station.
- Feedback to staff following incident reporting did not always take place. Whilst not in all areas, some groups of staff were unable to identify learning from incidents that had occurred during the twelve months preceding our inspection.
- Some incidents were logged and resolved but not reported on the trust wide incident reporting system. This meant that managerial oversight of the themes occurring from all incidents was not comprehensive.
- Some areas of the service was significantly below the trust's target for updating mandatory training. Within these services, the levels of staffing were not sufficient to provide relief at all times when staff were training, on holiday, off sick, or taking special leave.

Summary of findings

- Medicines systems used by staff were not always safe and trusts policies, procedures and protocols were not always followed. Within the urgent care centre, prescription pads were not monitored sufficiently in order to prevent misuse.
- Ambulances and rapid response cars were not always secured when staff were escorting patients into emergency departments at hospitals or tending to patients at other locations. This meant that unauthorised people could access the ambulances
- Cleanliness and control of infection was not being managed effectively. Clinical waste was not always disposed of as required. The trust was not meeting its targets for cleaning of vehicles or stations. Infection control training for staff was not meeting the trusts targets for the number of staff who had completed this.
- Within patient transport services, there were several vehicles with ripped seat covers and one with a hole in the internal wall. These defects meant that the vehicle could not be cleaned adequately to prevent the spread of infection.
- In patient transport services, not all staff were completing vehicle daily inspection checklists. Checklists were not reviewed effectively to enable the safety of vehicles to be assured. Only 21.3%of vehicles had been consistently deep cleaned every eight weeks or less during the twelve months preceding our inspection.
- There was insufficient space in the urgent care centre waiting area for the number of people attending the centre.
- Safeguarding arrangements for vulnerable adults were not sufficiently robust within the minor injuries unit.
- Patient confidential information was not always stored securely.
- Some staff within patient transport services provided treatment for patients but no records of these interventions were completed. These treatments included administering Entenox (nitrous oxide and oxygen gas mixture) and adjusting oxygen.
- At the time of our inspection, emergency preparedness drills had not been completed on the patient transport boat on the Isles of Scilly. However, the emergency preparedness drills are part of the Domestic Safety Management Plan for the Star of Life that went live in June 2016. The first drill is scheduled for September 2016.
- Within the minor injuries unit, the environment and use of facilities was not designed to ensure the safety of children. Initial clinical assessment of patients was undertaken by experienced healthcare assistants. However, they did not use an assessment framework to do this and there was no competency assessment to ensure their practice was safe. Computer errors in patient records could not be corrected. This sometimes led to an incorrect diagnosis or medicines dose remaining on patient records.

However:

- There was a good system in place for reporting incidents, carrying out investigations, providing feedback to staff, learning and making improvements. In places the culture for incident reporting was very positive.
- Within the majority of services there were reliable practices for safeguarding people from abuse.
- Patients' records were held securely on electronic systems and special notes were available to help support and protect patients and staff.
- When calling, the risks to patients were assessed with approved triage systems. Decisions were monitored and revised by clinicians when appropriate, or risks changed.
- There had been a good implementation of the pilot for the ambulance response programme. This triage system was being trialled by the service to assess the safety, effectiveness, and responsiveness of the service should it move away from time-target based responses to sending the right response, first time.
- The service was able to respond to major incidents and change priorities in times of extreme pressure. There were protocols for staff to follow in high-risk situations to keep staff and the public safe.
- The service had recognised the growth in call volumes and was responding by increasing staffing levels above establishment levels in the emergency operation centres.
- There was a good skill-mix among the staff within emergency operations centres, and there were plans to broaden the experience in future.
- Staff training met the national requirements set out by the National Ambulance Resilience Unit (NARU).
- Within emergency and urgent care saw that staff regularly cleaned their hands and we observed staff

cleaning their vehicles at the end of shifts. The vehicles we checked were visibly clean and equipment and vehicles were serviced in line with manufacturer's instructions to make sure they were fit for purpose.

Effective

- Within the emergency operation centres, staff were not being assessed for their competency and performance and the service was significantly below the trust's target for completing these appraisals each year. Some senior staff had not had appraisals for a number of years, but the organisation was not aware of this, and not addressing it. This issue had been on the trust's risk register for over nine years.
- The rate of annual performance appraisals within emergency and urgent care was variable ranging from 38.4% for specialist paramedics to 87.7% for paramedics. This was below the trust target of 90%. The quality of the appraisals was also variable.
- Staff in patient transport services did not participate in the learning development review process and compliance with appraisals was low
- Due to other training priorities, there had been a reduction in the number of calls audited for their quality and safety. The emergency operation centres had not been able, therefore, to determine if the handling of incoming calls was effective at all times. However, we recognised this was being addressed, and improving.
- The service was struggling with rising call volumes and this had resulted in more calls being abandoned.
- Response times for most categories were consistently below the England average. The proportion of Red 2 calls responded to within 8 minutes was worse than the England average from April 2015 to January 2016. The trust had not met the national target of 75% since October 2014. From May 2015 the data provided showed a steady decline in performance.
- From February 2015 to January 2016 the proportion of A19 calls responded to within 19 minutes was mainly worse than the England average. The national standard of 95% was not met for 10 of these 12 months.
- From April to October 2015 the average proportion of patients who received angioplasty (unblocking of a coronary artery) following ST segment elevation myocardial infarction within 150 minutes was worse than the national average.
- The average proportion of patients assessed face to face who received an appropriate stroke or transient ischaemic attack care bundle in April to October 2015 was worse than the national average.
- Not all staff were competent in providing treatment and care to patients with mental health issues.
- Within patient transport services, competencies of intermediate care assistants to administer Entenox (nitrous oxide and oxygen gas mixture) and perform cardiac monitoring had not been refreshed. Standard operating procedures were not accessible to staff when they were out and about transporting patients. Staff were not informed when patients were diabetic and this meant that staff did not have access to important information that may be needed by emergency crews attending to assist. The process of gaining consent was not recorded.

However:

- There were evidence-based systems to provide assessment and advice for patients. The emergency operations centre teams were using national guidelines and following best practice protocols to assess people's needs and provide the right service.
- Staff had the skills and knowledge to deliver effective advice and guidance. There were internal and external development opportunities and training available for staff.
- There was multidisciplinary work between teams and other local stakeholders. Hazardous area response teams, critical care and the air operations teams worked more closely together as 'special operations' to enhance the care patients received. The EPRR teams worked well and had good co-ordination with a range of other agencies including NHS Providers, other emergency services, local authorities, commercial operators, voluntary organisations and the different departments internally.
- There was good access to information with special notes being used to provide effective outcomes for people where there were known risks or other issues.
- The service was performing within its target for 'hear and treat' calls, although this was above (not as good as) the England average.
- The proportion of Red 1 calls responded to within 8 minutes was better than the England average for 16 out of 19 months between July 2014 and January 2016.

Summary of findings

- From April to October 2015 the average proportion of patients with ST elevation myocardial infarction who received an appropriate care bundle was better than the national average.
- The service provided evidence based care and treatment in line with national guidelines such as the Joint Royal Colleges Ambulance Liaison Committee and the National Institute for Health and Care Excellence.
- The trust had developed an initiative to reduce the number of patient transfers to hospitals. There were pathways to prevent hospital transfers and staff had received additional training to enable them to treat patients at home. This had reduced the number of hospital transfers.
- The patient transport service was achieving the targets identified in key performance indicators for commissioner satisfaction and patient satisfaction and the service was working well with local acute hospitals to provide useful information that enabled wards to plan better for patient arrivals and departures
- Business continuity plans were developed in line with International Standardisation Organisation (ISO) standards.
- The special operations team were supported by six air ambulances provided by five charities providing cover for the whole of the geographical area covered by SWAST.
- Within the minor injuries unit (urgent and emergency care), pain relief was administered quickly and effectively. X-ray results were reviewed by a specialist radiology doctor within 24 hours and there was a low rate of unplanned re-attendances.
- Clinical audits took place within the minor injuries unit and the information gained was used to improve care and treatment. The learning needs of staff were identified at six-weekly clinical supervision sessions and at annual appraisals.

Caring

- Staff in all areas consistently demonstrated a high level of compassion, kindness and respect towards people, whether callers, patients or relatives/ carers. At all times patients, relatives, and callers were treated as individuals and given support and empathy in often the most difficult circumstances.
- Feedback from patients and those close to them was consistently very positive. We accompanied crews on emergency and urgent calls and spoke with patients and relatives in emergency departments. Without exception, patients, relatives and other healthcare professionals told us that ambulance staff acted with care and compassion.
- Staff were passionate about their patients' care and wellbeing. We saw numerous examples where staff 'went the extra mile' to ensure their patients' comfort and wellbeing.
- Staff recognised when patients required further information and support and this was provided at all times.
- Staff made sure people had understood the information given back to them by telephone advisors. Staff asked questions in a calm approach but with empathy and clarity. Staff recognised it was hard for people calling the service to interact over a telephone line, but staff got the best information and gave the best responses they could when they were otherwise not able to see the patient. Distressed and overwhelmed callers were well supported by staff. Staff used their initiative and skills to keep the caller calm, and provide emotional support in often highly stressful situations.
- There were systems to support patients to manage their own health and to signpost them to other services where there was access to more appropriate care and treatment. Staff involved patients in decisions about their care and treatment. When appropriate, patients were supported to manage their own health by using non-emergency services such as their GP
- Staff took time to interact with patients and were supportive to them and to their relatives/carers and treated patients with dignity and respected their privacy at all times.
- Staff showed understanding of the challenges faced by patients and their carers
- Communication with children and young people was age appropriate and effective.

Responsive

- The emergency operations service was operating a responsive 'hear and treat' service to ensure the best use of limited resources. Resources were used where they were most needed.

Summary of findings

- The trust had been commended for its service to reduce and respond to frequent callers and to reduce unnecessary admissions to emergency departments
- There was service planning to meet the immediate urgent and emergency care needs of local people. There was flexibility, choice and continuity of care which was reflected in the types of services we saw. Most patients had timely access to initial assessment, diagnosis or urgent treatment.
- The ambulance response project or ARP started 19 April 2016. The expected outcome of ARP was to ensure that the most appropriate response vehicle was sent to each patient's correct location rather than just meeting a time target by sending the nearest vehicle. Call centre staff would provide additional time to triage patients on the phone when it was clinically safe and appropriate to do so, and this helped them to decide on the best vehicle to send. The full impact of the ARP project was not known during the inspection period, as it was still in pilot phase.
- The trust used a network of volunteer community first responders, responders such as fire co responders, doctors and others including trust staff that could supplement core ambulance resources
- Reasonable adjustments were in place for some patients. Action was taken to remove barriers to patients with physical disability, those with reduced mobility or those who had bariatric needs who found it physically hard to use or access services. The trust also ran blue light days where people with a learning disability could familiarise themselves with ambulance vehicles, equipment and staff to understand the service better. This also enabled staff to better understand the needs of people with learning disabilities.
- Two new Patient Transport Service bases had been opened at Weston Super Mare and Soundwell ambulance stations to meet local need. There was a '24/7'service which consisted of one vehicle and a crew available between 6p.m.and 6a.m. Escorts were encouraged to accompany patients living with dementia or learning disability or for patients whose first language was not English. This enabled staff to meet the patient's individual needs
- The resilience facilities were purpose built and located to cover the majority of the SWAST operational area.
- SWAST was supported by five air ambulance charities with six aircraft providing good air ambulance coverage.
- The events team took the lead for assessing, planning and resourcing public events to minimise the effect on the trust's normal business.
- 99.8% of patients attending the minor injuries unit were treated, discharged or transferred within four hours in the year ending March 2016. The average time to treatment was 49 minutes. Waiting times were constantly monitored in real-time by clinical staff.
- Complaints were handled with sensitivity and time was taken to provide a considered response within most core services. There was learning and improvements made when people complained about the service they received, though not all complaints were being responded to in the time required.

However:

- It wasn't easy for patients or people close to them to know how to complain or raise a concern. Staff gave a variety of responses of how patients could make a complaint describing that patients could telephone or submit their concerns online on the trust website. Not all vehicles had complaints forms or information for patients to read or take away with them.
- There were no communication aids or hearing loops within patient transport vehicles. Staff did not use interpretation facilities when patients did not speak English as their first language. Instead they relied upon patients bringing an escort for the journey. However, staff could access the language line for translation services whilst at the ambulance base.
- The triage systems used within the emergency operations centres did not prompt staff to ask whether a person was vulnerable, such as living with dementia or a learning disability.
- The HART teams were able to respond quickly to emergencies within their area, except within Cornwall due to the distance from Exeter.
- Within the minor injuries unit, X-ray services were not always available when patients needed them. The x-ray department closed at 5pm during the week and was only open for four hours a day at weekends. Although patients told us they did not mind returning the next day, there was a possibility of delayed treatment.

Summary of findings

Well led

- Quality, in terms of patient outcomes and experience, did not feature highly at operations meetings, although a quarterly quality report had recently been introduced.
- Within most areas, risks to quality and safety were well understood at a local level but were not locally recorded and accountability for managing these risks was not defined. Risk registers maintained at directorate and corporate levels did not align with the risks and worries described to us by staff and managers. We saw little evidence that the risk register was regularly discussed at service line or division or actions to mitigate risks reviewed. There were some risks on the risk register that had remained there too long without resolution. This included the poor performance in staff appraisals which had been added in 2007 and staff turnover added in 2013.
- We were concerned about a lack of local oversight in respect of infection control. This highlighted a disconnection between different reporting lines.
- Whilst the trust had made significant efforts to support staff wellbeing, their efforts were somewhat overshadowed by the intensity of work, due to relentless and increasing demand on the service and the pressures this placed on staff. Staff morale and motivation was mixed. Some worrying messages had emerged from the 2015 staff survey in relation to frontline ambulance staff. Staff dissatisfaction was reflected by results which showed that a significant proportion of staff felt unwell due to work related stress, felt pressurised to work despite not feeling well enough to perform duties, and had experienced musculoskeletal problems as a result of work activities. The survey also highlighted that a significant proportion of staff suffered physical violence and/or harassment, bullying or abuse from patients, their relatives or other members of the public. Local action plans had recently been developed but this was work in progress. The leadership was not aware of when the levels of professional support given to staff were failing.
- There was a culture in which there was an unspoken expectation that staff would work longer hours than they were contracted to work. Staff told us they regularly finished their shifts late, missed their meal breaks, arrived early for work to undertake vehicle checks and undertook activities such as reading email updates and bulletins and undertaking training in their own time.
- The intensity of work undoubtedly contributed to staff absenteeism and high levels of staff turnover. There was a variable degree of and formality in one-to-one support for staff.
- There was a limited approach to obtaining the views of patients and staff were not engaged in this process.
- The 2013/2014 integrated business plan included was some evidence of forward planning for service improvement in the patient transport service. However at a local level, leaders appeared demotivated to effect improvement.. As a result there was no forward vision of service improvement at a local level. Staff did not feel valued by their employers or by the managers of their service where the culture was described as insensitive to the needs of staff.
- Some aspects of governance related to safety issues were not adequately monitored within patient transport services, for example, infection control. Risk registers did not capture all known risks, including clinical risks and the governance processes did not identify a lack of incident report. Identified training needs were not acted upon.
- There was very limited oversight of quality in the Patient Transport Service other than performance against key performance indicators. Some aspects of governance related to safety issues were unclear and were not monitored effectively.

However:

- There was a clear vision and credible strategy for the emergency operations service. The leadership reflected the values of the service and were open, approachable and supportive. The service was innovative and looking for ways to improve and sustain.
- There was a clear vision in place for the EPRR teams, especially special operations and where they wanted to take the service over the coming five years.
- The governance framework had clear responsibilities.
- The trust had introduced the 'Staying Well' service in December 2015 in response to a year-long staff consultation and staff requests for a coordinated support system, with an emphasis on mental health.

Summary of findings

There was a peer support network introduced in April 2016 and the trust had 38 trained peer supporters. Staff could also access 'fast track' physiotherapy treatment, which was funded by the trust.

- There was a well-publicised mission statement and a set of core values within emergency and urgent care. Whilst not all staff could articulate these, they consistently demonstrated their commitment to delivering high quality care to patients.
- Leaders of the patient transport service had ensured that all staff were fully informed about the outcome of the tendering process. Performance of the service against the key performance indicators was monitored effectively.
- Staff within the EPRR teams attended/chaired a wide variety of national groups and committees to lead and share best practice.
- The trust conducted traumatic risk monitoring and the 'staying well service' were available to staff should they need it.
- A dedicated events team had taken responsibility for planning, resourcing and managing SWAST attendance at public events.
- A computer application 'SWAST Commander' had been developed for iPad and Android platforms to be used by operational commanders during major incidents

We saw several areas of outstanding practice including:

- The trust was influencing service improvements at a national level, for example the ambulance response programme.
- The Aspire programme, developed by the trust, was providing excellent opportunities for personal and career development to all staff.
- At times, outstanding professionalism and grace under pressure among the emergency medical advisors in the Bristol and Exeter emergency operation centre (clinical hub) teams. We heard staff being criticised, shouted at, called abusive names and threatened. All of this was disruptive to staff and unsettling. The staff remained calm, and handled the callers with courtesy and patience.
- Staff in the emergency operations centres showed outstanding compassion and understanding to people in difficult and stressful situations. Staff made a genuine connection with patients and others who were scared or anxious and developed an, albeit temporary bond, with the person trying to help them. Staff would, appropriately, say "take care" and "all the best" to people, and this was often repeated back to staff by people who had appreciated their friendliness and warmth.
- Although the emergency operation centres' call-quality audit programme was not completed as often as required because of other priorities, and staff shortages, it had been previously commended and recognised for its quality. There was, nevertheless, an outstanding quality to the audits when they were being undertaken. This included the feedback, which was delivered with thoughtfulness, professionalism and the intention for staff to do well. There had been changes based on staff being asked how they found the process to make it more empathetic for those being examined.
- There was an outstanding and commended programme to manage frequent callers to the service. This was helping to release the organisation's limited resources to more appropriate situations. There was strong multidisciplinary working to support frequent callers with the service promoting the issue among the wider community and partner organisations.
- At the time of our inspection the service had just embarked on a trial, known as the Ambulance Response Programme. This 12-week pilot aimed to improve response times to critically ill patients, making sure the best response was sent to each incident first time and with the appropriate degree of urgency. The trust was one of two ambulance services nationally participating in this trial.
- The introduction of Right Care had resulted in 56.8% of patients, who called for an ambulance, being treated at the scene or referred to other services, rather than being conveyed to hospital emergency department.
- Operational staff took time to interact with patients and were supportive to them and to their relatives/carers. Staff treated patients with compassion and dignity and respected their privacy at all times.
- The range of staff support schemes provided showed a commitment to improving staff wellbeing and we received positive feedback from staff who had used these services. The introduction of a fast track physiotherapy service had resulted in a reduction in sickness absence due to musculoskeletal injury.

Summary of findings

- The trust had a dedicated events team to manage the assessment, planning and resourcing for public events.
- The trust produced a newsletter called "twentyfourseven" published for members of the public with news, long-service awards for staff, notable events taken place or coming up in the trust's area, and success stories. These newsletters were available on the trust's website. The high-quality publication provided the public with good information about the service and its achievements.

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

Importantly, the trust must:

- Ensure mandatory training for all staff, including safeguarding for vulnerable people, is updated and maintained in accordance with the trust's target.
- Ensure staff appraisals are completed each year to meet the trust's target. The organisation must also ensure it is aware of those staff who have not had an appraisal for many years, and offer support and recognition where warranted.
- Ensure risk registers are aligned with operational risks and that risk registered are reviewed regularly to monitor and mitigate risks
- Ensure work intensity and fatigue is monitored and actions put in place to mitigate risks to staff
- Ensure governance meetings at local levels contain a strong focus upon quality and safety. This will include performance reports on training, appraisals, patient outcomes, complaints and incidents relevant to the local level. Actions from addressing any shortcomings or changes must be recognised and completed. Leaders of the Patient Transport Services must ensure that staff are encouraged to report incidents and that feedback and learning from incidents is shared with the team. Incidents should be an integral part of the governance process and viewed as a positive opportunity for learning.
- Ensure patient transport service engage in a regular programme of audit including infection control, safety of vehicles. These audits should be recorded and an agreed action plan documented and progress monitored through the governance processes.
- Ensure accurate, contemporaneous and complete record of all treatment undertaken by Patient Transport Services staff and that across all services records are stored securely at all times to prevent unauthorised access.
- Ensure adequate guidelines and protocols are in place to guide staff in their clinical decisions regarding adjustment of oxygen therapy.
- Ensure a system is put into place which informs patient transport service crews of any important clinical information relating to the patients they convey, such as when a patient has diabetes.
- Ensure that healthcare assistants who undertake initial clinical assessment of patients are assessed as competent before working independently
- Ensure that all staff are familiar with their responsibilities in regard to the safeguarding of vulnerable adults and that robust reporting arrangements are in place.
- Ensure partly administered controlled medicines no longer required are disposed of in accordance with the service standard operating procedures and that medicines are stored securely in the back of ambulances and cars when the crew is not present.
- Review the management of clinical waste in ambulance stations to avoid risks to staff.
- Ensure infection control issues identified in this report are addressed.
- Ensure complaints are handled effectively. Information and guidance about how to complain must be available and accessible to everyone who uses the service in a language and format to meet the needs of the people using the service, for example those who were hearing or sight impaired.
- Take action to meet locally agreed thresholds in respect of Ambulance Clinical Quality Outcomes.

In addition the trust should:

- Ensure all staff have the time and resources to directly report incidents, and all staff recognise and respond to their duty to report them in a timely way following trust policy.
- Make improvements to the delays in investigating and reporting on serious incidents within the period granted.

Summary of findings

- Be clear as to how the feedback from serious incidents is disseminated to staff in future.
- Extend the infection control policy in the emergency operations centres so the procedures for staff around the use of hand gels were clear and consistent for all members of the teams.
- Consider implementing occasional test or practice runs for IT system failures in the emergency operations centres when most convenient and safe to do so.
- Continue with the work to provide commonality among the systems used within the emergency operations centres.
- Ensure all emergency operations centres staff are aware of the need to have clinical input into the decision to stand down an ambulance from a scene.
- Consider possible solutions for emergency operations centres staff from having outdated special notes linked to an address where the notes were no longer relevant.
- Undertaken a staff review within the emergency operations centres to review the percentage of relief cover modelled against the increasing call volumes. Ensure staff can be released for training, holidays, special leave, and sickness, for example, without this affecting the quality of the service and pressure on remaining staff.
- Remodel the staffing rotas to take account of the known or predictable changes in seasonal demand.
- Ensure the major incident room in Exeter is not being used for other things preventing it being established for its purpose at immediate notice.
- Re-focus upon the emergency operations centres call-quality audit programme to provide staff with good feedback, encourage improvement, and reward excellence.
- Provide some relevant and useful mental-health training to all emergency operations centres staff.
- Improve the response to stroke patients so at least 57% of patients reach a hyper acute stroke centre within 60 minutes of their call to the service.
- Look for methods for emergency operations centres staff to spread out their continuing despatch education throughout the year and not just prior to their recertification being due.
- Consider specific training or guidance for emergency operations centres staff for communicating with young children.
- Ensure there is a formal handover period factored into the working pattern of the emergency medical dispatchers in the emergency operations centres.
- Establish one-to-one sessions for staff and line managers to take place within the emergency operations centres on a regular basis. Ensure these are taking place and add value to the staff concerned and the organisation.
- Ensure all staff who do not have direct access to emails or the trust's intranet are kept up-to-date and well informed of new or updated information at all times.
- Review how a patient's mental health status is determined. Triage protocols do not proactively determine if the person is living with dementia or might have a learning disability.
- Develop and nurture valuable connections between staff in the emergency operations centres in Bristol and Exeter.
- Review security for all staff working in the emergency operations centres, when the surrounding area was largely unoccupied by other people, were able to leave the offices safely.
- Work to develop a more positive culture within patient transport services. This includes taking action to listen to all groups of staff in a forum that is perceived to be safe and confidential, and addressing the development needs of staff in leadership positions.
- Ensure exit interviews are conducted and take action to address concerns identified by staff within these exit interviews.
- Ensure regular staff meetings occur within patient transport services and these are recorded for the benefit of those staff unable to attend.
- Ensure the environment in the urgent care centre is safe for children.
- Ensure that there is sufficient space in the waiting area and that waiting patients can be viewed by staff at all times.
- Review the lighting for vehicles reversing onto the quay in St Agnes to ensure safety of staff and patients when reversing onto the quay to meet the boat.
- Review the audit of the services provided on the Isles of Scilly undertaken in June 2015, to ensure actions identified have been implemented.
- Review the provision, availability and contact ability of community first responders on the Isles of Scilly.

Summary of findings

- Ensure that patient transport services monitor compliance with The National Institute for Health and Care Excellence (NICE) Quality Standard QS72 Renal Replacement Therapy services for Adults.
- Ensure the handheld electronic patient care record devices are fit for purpose in all areas.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Emergency and urgent care services	Requires improvement 	**We rated the emergency and urgent care service as requires improvement because:** • Medicines systems used by staff were not always safe and trust policies, procedures and protocols were not always followed by all staff. • Ambulances and rapid response cars were not always secured when staff were escorting patients into emergency departments at hospitals or tending to patients at other locations. • Feedback to staff following incident reporting did not always take place. • Cleanliness and control of infection was not managed effectively .Clinical waste was not always disposed of as required. The trust was not meeting its targets for cleaning of vehicles or stations. • Patient confidential information was not always stored securely. • Response times for most categories were consistently below the England average. • From April to October 2015 the average proportion of patients who received angioplasty (unblocking of a coronary artery) following ST segment elevation myocardial infarction within 150 minutes was worse than the national average. • The average proportion of patients assessed face to face who received an appropriate stroke or transient ischaemic attack care bundle in April to October 2015 was worse than the national average. • The rate of annual performance appraisals was variable, ranging from 38.4% for specialist paramedics to 87.7% for paramedics. This was below the trust target of 90%. The quality of the appraisals was also variable. • Not all staff were competent in providing treatment and care to patients with mental health issues.

Summary of findings

- Quality, in terms of patient outcomes and experience, did not feature highly at operations meetings, although a quarterly quality report had recently been introduced. Risks to quality and safety were well understood at a local level but were not locally recorded and local accountability for managing these risks was not defined. Risk registers maintained at directorate and corporate levels did not align with the risks and worries described to us by staff and managers. There was a lack of local oversight in respect of infection control. This highlighted a disconnect between different reporting lines.
- Whilst the trust had made significant efforts to support staff wellbeing, their efforts were somewhat overshadowed by the intensity of work, due to relentless and increasing demand on the service and the pressures this placed on staff. There was a culture in which there was an unspoken expectation that staff would work longer hours than they were contracted to work. The intensity of work undoubtedly contributed to staff absenteeism and high levels of staff turnover.

However:

- There was a genuine culture where staff could report incidents and these were viewed as learning opportunity. Staff felt they were well supported when involved in incidents.
- Safeguarding of adults, children and young people was given sufficient priority. Staff knew how to recognise and report allegations or incidents of abuse.
- Staff recognised and responded in a timely way to the changing condition of patients.
- Feedback from patients and those close to them was consistently very positive. We accompanied crews on emergency and urgent calls and spoke with patients and relatives in emergency departments.

Summary of findings

Without exception, patients, relatives and other healthcare professionals told us that ambulance staff acted with care and compassion.

- Staff were passionate about their patients' care and wellbeing. We saw numerous examples where staff 'went the extra mile' to ensure their patients' comfort and wellbeing.
- Staff adopted a person-centred approach when attending to patients and supporting those close to them. Staff considered the needs of the individual and took actions to promote their dignity, showed consideration for individual preferences and promoted independence by actively involving patients in decisions about their care and treatment.
- The service provided evidence based care and treatment in line with national guidelines
- The proportion of Red 1 calls responded to within 8 minutes was better than the England average for 16 out of 19 months between July 2014 and January 2016.
- From April to October 2015 the average proportion of patients with ST elevation myocardial infarction who received an appropriate care bundle was better than the national average.
- There were pathways to prevent hospital transfers and staff had received additional training to enable them to treat patients at home.
- Consent was obtained from patients prior to treatment or care being given.
- Staff took time to interact with patients and were supportive to them and to their relatives/carers. Staff treated patients with compassion, respect and dignity.
- Most patients had timely access to initial assessment, diagnosis or urgent treatment.
- Staff feedback on issues which prevented 'right care' from being delivered was

Summary of findings

captured with over 5,000 incidents highlighted up to the date June 2016. This was used to identify further changes required to improve patient care.

- The service was leading on the national ambulance response project or ARP which commenced 19 April 2016. The full impact of the ARP project was not known during the inspection period, as it was still in pilot phase.
- The trust used a network of volunteer community first responders, responders such as fire co responders, doctors and others including trust staff that could supplement core ambulance resources.
- Action was taken to remove barriers to patients with physical disability, those with reduced mobility or those who had bariatric needs who found it physically hard to use or access services. The trust also ran blue light days where people with a learning disability could familiarise themselves with ambulance vehicles, equipment and staff to understand the service better. This also enabled staff to better understand the needs of people with learning disabilities. Translation services were available and were used.
- Complaints and concerns were taken seriously and listened to but not always responded to in a timely way
- There was a well-publicised mission statement and a set of core values which staff consistently demonstrated in their commitment to delivering high quality care to patients.
- Local managers were visible, accessible and supportive to staff. Staff felt valued and supported.
- The trust's management recognised staff wellbing as a priority and had made significant efforts to support staff. A range of staff support schemes had been developed and staff who had used these services spoke positively about the support they had received.

Summary of findings

Patient transport services (PTS)

Requires improvement

We gave an overall rating of requires improvement for the patient transport services. This was because:

- There was a lack of consistency around incident reporting. There was no evidence of feedback or learning from incidents during the 12 months preceding our inspection.
- There were infection control risks caused by vehicle defects such as ripped seat covers and punctured internal walls.
- Vehicle daily inspections (VDI) were not consistently completed on a daily basis. VDI checklists were not reviewed or audited leading to a lack of assurance regarding vehicle safety.
- Staff administered nitrous oxide and oxygen gas mixture (a medical gas that is used to relieve pain) to patients. There were no clinical pathways or set protocols to guide the clinical reasoning of staff using this gas. Staff did not record when they gave this treatment to patients. Leaders of PTS could not provide assurance that this gas was administered safely. Immediately following our inspection, the trust withdrew this treatment from PTS.
- Staff administered oxygen to patients and adjusted oxygen levels according to their assessment of the patients need during their journey. There was a flowchart for staff to guide their clinical reasoning, but this was insufficiently comprehensive. Staff did not record their interventions.
- Staff did not participate in the learning development review process and compliance with appraisals was poor.
- The process of gaining patient consent for treatment was not documented.
- There was very limited oversight of quality in the PTS other than performance against key performance indicators. Some aspects of governance related to safety issues were not monitored effectively.
- Staff told us they did not feel supported or valued by their management team or their employer.

Summary of findings

- Staff described the culture as insensitive and poor communication was frequently highlighted by staff as a concern.

However:

- The service had performed well against the key performance indicators set by commissioners. These related to patient and commissioner satisfaction, timeliness and responsiveness of journeys and management reporting.
- Managers were working closely with local hospitals to improve turnaround time when dropping off and collecting patients.
- Compliance with mandatory training was good at 95.9%
- There were high levels of patient satisfaction and low numbers of complaints reported.
- Staff showed compassion and understanding toward patients and carers.

Emergency operations centre

Good

We rated the emergency operation centres, overall, as good because:

- There was a good system for reporting incidents, carrying out investigations, providing feedback to staff, and learning and making improvements.
- There were reliable practices for safeguarding people from abuse.
- Patients' risks were well assessed and monitored and good records maintained.
- The service was able to respond to major incidents and change priorities in times of extreme pressure. There were protocols for staff to follow in high-risk situations to keep staff and the public safe.
- The service had recognised the growth in call volumes and was responding by increasing staffing levels above establishment levels.
- Staff had the skills and knowledge to deliver effective advice and guidance.

Summary of findings

Evidenced-based systems were well integrated. There were internal and external development opportunities and training available for staff.

- There was multidisciplinary work between teams in the EOC and partner organisations.
- All staff demonstrated outstanding compassion, kindness, and respect towards callers and patients often under a high level of pressure. In 120 calls we listened to, without exception this was consistently demonstrated.
- There was a strong and visible patient-centred culture with all staff wanting to help people by showing them kindness and respect.
- The caring of all staff was outstanding, despite them not knowing who they were going to be speaking with next, and how they would be required to respond. This was notable particularly with a significant crisis for a patient with mental health needs, and how staff acted promptly to give them strong and compassionate support.
- The needs of local people were met by good planning and delivery of services.
- There were procedures and protocols for supporting people in vulnerable circumstances.
- Resources were used where they were most needed. The trust had been commended for its service to reduce and respond to frequent callers.
- The trust was prioritising resources with a good 'hear and treat' service.
- There was learning and improvements made when people complained about the service they received. Complaints were handled with sensitivity and time taken to provide a considered response.
- There was a clear vision and credible strategy for the service. The leadership reflected the values of the service and were open, approachable and supportive.

Summary of findings

- The governance framework had clear responsibilities and most risks were understood and managed.
- There was a strong wellbeing and support service for staff and good engagement with staff and the public.

However:

- The service was significantly below the trust's target for updating mandatory training.
- Staff were not being assessed for their competency and performance and the service was significantly below the trust's target for completing these appraisals each year.
- The levels of staffing were not sufficient to provide relief at all times when staff were training, on holiday, off sick, or taking special leave.
- There was a lack of quality review at local level.
- The leadership was not aware of when the levels of professional support given to staff were failing.
- There were missed opportunities for better integration with the staff working in the different EOCs.

Resilience planning

Outstanding 

Overall we rated resilience planning as outstanding because:

- There were robust systems in place to keep equipment and vehicles clean, well maintained and fit for purpose.
- The numbers of staff, the training they received and the policies they followed was compliant with national recommendations from the National Ambulance Resilience Unit (NARU).
- The EPRR teams worked well and had good co-ordination with a range of other agencies including NHS Providers, other emergency services, local authorities, commercial operators, voluntary organisations and the different departments within SWAST.

Summary of findings

- Specialist computer applications had been developed for managing staff training records (i-auditor) and for use in major incidents (Commander).
- The special operations team were supported by six air ambulances provided by five charities providing cover for the whole of the geographical area covered by SWAST.
- Staff treated patients with respect, patience and sensitivity. The paramedics were calm and professional in their approach but remained friendly to quickly build a rapport with the patient.
- Staff took time to listen to patients and their families and consistently explained what they were doing and continually offered reassurance.
- Robust governance and assurance systems were in place across the EPRR teams to share information across the teams and the trust board.
- Leaders were both supportive and visible, inspiring and motivating staff across all EPRR teams. Staff welfare was of great importance and various services such as traumatic risk monitoring and the 'staying well service' were available to staff should they need it.
- There was a proactive approach to change and innovation. A dedicated events team had taken responsibility for planning, resourcing and managing SWAST attendance at public events.
- A computer application 'SWAST Commander' had been developed for iPad and Android platforms. This was used by operational commanders during major incidents.

Urgent and Emergency Care

Good

Overall, we rated the urgent care service (Tiverton Minor Injuries Unit) as good because:

- Safety performance was monitored and reported to senior managers on a monthly basis. Openness and transparency about safety was encouraged.

Summary of findings

- There were sufficient staff to treat and care for the patients who attended.
- Nurses and paramedics were well qualified and demonstrated the skills that were required to carry out their roles effectively and according to best practice. They worked collaboratively with multidisciplinary teams from community services and acute services at neighboring hospitals
- Staff used evidence based guidelines in order to ensure effective treatment was delivered.

- Feedback from patients and those close to them confirmed that staff were caring and kind.

- We observed staff taking trouble to maintain people's privacy, dignity and confidentiality. They demonstrated empathy towards people who were in pain or distressed and were skilled in providing reassurance and comfort.
- Services were planned to meet the needs of all patients, including those who were vulnerable or who had complex needs.
- 99.8% of patients were treated, discharged or transferred within four hours in the year ending March 2016. The average time to treatment was 49 minutes.
- There was a cohesive strategy for the urgent care centre and this was supported by the staff who worked there.
- Clinical leaders were respected by staff. They were knowledgeable about quality issues and priorities, understood what the challenges were and took action to address them. They promoted a strong sense of teamwork.
- Governance arrangements were well structured with risks and quality being regularly monitored and action taken if necessary.

However:

Summary of findings

- The environment and use of facilities was not designed to ensure the safety of children.
- There was no competency framework for, or formal assessment of, staff in the initial clinical assessment of patients.
- Safeguarding arrangements for vulnerable adults were not sufficiently robust.
- There was insufficient space in the waiting area for the number of people attending the centre.

South Western Ambulance Service NHS Foundation Trust

Detailed findings

Services we looked at
Emergency and urgent care; Patient transport services (PTS); Emergency operations centre (EOC); Resilience; Urgent and emergency care; Out of hours

Detailed findings

Contents

Background to South Western Ambulance Service NHS Foundation Trust

On March 1, 2011 the trust became the first ambulance service in the country to become a Foundation Trust, and acquired Great Western Ambulance Service in February 2013. It covers the following geographical area

- Cornwall
  - Isles of Scilly (IOS)
  - Devon
  - Dorset
  - Somerset
  - Wiltshire
  - Gloucestershire
  - The former Avon area (Bristol, Bath, North and North East Somerset and South
  - Gloucestershire)

The area is made up of approximately 5.3 million people with an additional 17.5 million visitors per year and covers 10,000 square miles (around 20% of mainland England). It spans 13 Clinical Commissioning Groups and serves 18 acute trusts.

The trust provides the clinical teams for six air ambulances (two in Devon, one in Cornwall and the Isles of Scilly, one shared across Dorset and Somerset, one in Wiltshire and one based near Bristol). There are three control rooms (clinical hubs); in St Leonards, Exeter and Bristol.

The trust provides the following services:

- 999 ambulance services
- HART (hazardous area response teams)
- Patient transport services
- GP out of hours services
- Minor injuries unit (Tiverton, Devon)
- NHS 111 (Devon, Cornwall, IOS and Dorset) – This was inspected in March 2016 and is reported separately.

The trust employs over 4,000 mainly clinical and operational staff, including Paramedics (1,788), Emergency Care Practitioners, Advanced Technicians, Ambulance Care Assistants and Nurse Practitioners) plus GPs and around 2,785 volunteers (including community first responders, BASICS doctors, fire co-responders and volunteer PTS drivers).

Calls from the public and urgent calls from healthcare professionals are received and triaged in one of three emergency operations centres (Bristol, Exeter and St Leonards, Dorset) where callers are provided with advice and ambulances are dispatched as appropriate. The emergency operations centres also provide assessment and treatment advice to callers and manage requests from health care professionals to convey people either between hospitals or from community services into hospital.

In 2014/15 the trust responded to 867,505 emergency and urgent incidents, helped 155,965 patients calling their out of hours service and completed 99,907 patient transport journeys.

Detailed findings

Resources and teams include:

- 306 ambulances
- 234 rapid response vehicles
- 57 patient transport service vehicles
- 7 motorcycles
- 6 helicopters
- 5 bicycles
- 1 boat
- 96 stations and two Hazardous Area Response Teams (HART), based in Bristol and Exeter.

Patient transport services (PTS) provided non-emergency transport for adults and children in Bristol, North Somerset and South Gloucestershire, who were unable to use public or other transport due to their medical condition. Vehicles were based at six sites: Bristol, Almondsbury, Yate, Nailsea, Soundwell and Weston Super Mare. The trust also utilised a boat to facilitate patient transport services in the Isles of Scilly. Eligibility criteria were applied by the healthcare professionals who made the referral to the PTS control center. There were 120 members of staff working in PTS. During April 2015 to March 2016, the service provided 105,317 patient journeys, accounted for 2% of the budget held by the operations team, and was responsible for 10.4% of the patient activity undertaken by the trust.

We inspected this location as part of our planned comprehensive inspection programme. Our announced inspection took place on 6-10 June 2016. During the inspection, we visited PTS premises, ambulance stations, HART bases and hospital locations in order to speak to patients and staff about the ambulance service.

Our inspection team

Our inspection team was led by:

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

Head of Hospital Inspections: Mary Cridge, Care Quality Commission

The team of over 45 included 19 CQC inspectors and inspection managers, a pharmacy inspector, an analyst, an inspection planner and variety of specialists including past and present directors and associate directors of NHS Direct, NHS 111 and urgent care, an assistant director for performance improvement, director of nursing and governance, a director of special operations, HART Trainer, a consultant in adult & paediatric emergency medicine, contact centre team leader and manager, paramedics, a senior emergency care practitioner, emergency care technician, clinical supervisor and a community responder volunteer.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The inspection took place from 6-10 June 2016.

The inspection team inspected the following services:

- Emergency operations centre (EOC)
- Emergency and urgent care
- Patient transport services (PTS)
- Resilience
- Urgent and emergency care
- Out of hours

Detailed findings

The 111 service was inspected in March 2016 and is reported separately.

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about the trust. These included local clinical commissioning groups (CCGs); NHS England; NHS Improvement, Health Education England (HEE); College of Emergency Medicine; General Dental Council; General Medical Council; Health & Safety Executive; Health and Care Professions Council; Nursing and Midwifery Council; National Peer Review Programme; NHS Litigation Authority; Parliamentary and Health Service Ombudsman; Public Health England; the medical royal colleges; local authorities, local NHS Complaints Advocacy Service; local Healthwatch groups; and local health overview and scrutiny committees.

The inspection team also spoke to staff trust-wide at focus groups the week before the inspection.

We visited two emergency operations centres (Bristol and Exeter) and 20 ambulance stations, two hazardous area response teams and the patient transport service base. We spoke to staff during our visits including call handlers, dispatchers, clinicians, managers, paramedics, emergency care technicians and emergency care assistants, patient transport managers and crew, community first responders, infection prevention and control, and safeguarding leads. We also spoke with managers within the services inspected as well as directors of the trust.

We spoke with the relatives, carers and patients. We also examined information sent to us by the public.

We inspected ambulances and reviewed patient records. We also attended hospitals, where we observed the interaction between ambulance crews and hospital staff. Whilst there, we spoke with emergency department staff to get feedback on the service provided by the ambulance trust and observed patient handovers at emergency departments. We rode in ambulances in order to observe interactions between staff and patients and listened in to emergency calls in the operations centres.

We spoke with staff in various roles including paramedics, emergency medical technicians, team leaders, station officers, senior managers and community first responders and PTS staff. We looked at vehicle maintenance, cleanliness, the planning of vehicle servicing and MOT testing.

Facts and data about South Western Ambulance Service NHS Foundation Trust

Demographics:

The area is made up of:

- approximately 5.3 million people
- 10,000 square miles (around 20% of mainland England)
- 13 CCGs
- 18 acute trusts and has 17.5 million visitors per year

In 2014/15 the trust:

- Responded to 867,505 emergency and urgent incidents
- Received 918,227 NHS 111 calls
- Helped 155,965 patients calling their out of hours service
- Completed 99,907 patient transport journeys

Resources and teams include:

- 306 ambulances
- 234 rapid response vehicles
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- 96 stations and two Hazardous Area Response Teams (HART), based in Bristol and Exeter.

The trust provides the clinical teams for six air ambulances (two in Devon, one in Cornwall and the Isles of Scilly, one shared across Dorset and Somerset, one in Wiltshire and one based near Bristol). The trust's three 999 control rooms (clinical hubs) are in St Leonards, Exeter and Bristol. The trust employs over 4,000 mainly

Detailed findings

clinical and operational staff, including Paramedics (1,788), Emergency Care Practitioners, Advanced Technicians, Ambulance Care Assistants and Nurse Practitioners) plus GPs and around 2,785 volunteers (including community first responders, BASICS doctors, fire co-responders and volunteer PTS drivers).

Our ratings for this service

Our ratings for this service are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	Requires improvement	Requires improvement	☆ Outstanding	Good	Requires improvement	Requires improvement
Patient transport services	Requires improvement	Requires improvement	Good	Good	Inadequate	Requires improvement
Emergency operations centre	Good	Requires improvement	☆ Outstanding	Good	Good	Good
Resilience planning	☆ Outstanding	Good	Good	Good	☆ Outstanding	☆ Outstanding
Urgent and Emergency Care	Requires improvement	Good	Good	Good	Good	Good
Overall	Requires improvement	☆ Outstanding	Good	Requires improvement	N/A	Requires improvement

Notes

Emergency and urgent care services

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

Information about the service

Emergency and urgent care, otherwise known as the accident and emergency service line, is managed over three divisions. The east division covers the counties of Somerset and Dorset. The west division covers Devon, Cornwall and the Isles of Scilly and the north division covers Bristol, Gloucestershire and Wiltshire. Each division was managed by a head of operations. Within each division, ambulance stations were managed in sectors by operations manager, officers, while at station level, operations officers provided day-to-day management, including incident support at serious incidents. There are 96 ambulance stations trust-wide. Resources and teams overall include:

- 306 ambulances
- 234 rapid response vehicles
- 57 patient transport service vehicles
- 7 motorcycles
- 6 helicopters
- 5 bicycles
- 1 boat

In the east division we visited ambulance stations in Taunton, Weston super Mare, Yeovil, Dorchester, Poole and Bournemouth. In the west division we visited ambulance stations in Redruth and Truro, Bodmin, Plymouth, Torquay, Exeter and Barnstable. In the north division we visited ambulance stations in Salisbury, Stroud, Staverton, Swindon, Bristol, Almondsbury and Bath. We spoke with a range of staff and managers. We also visited the main receiving hospitals and spoke with staff in emergency departments, intensive care and maternity.

We accompanied ambulance staff on their vehicles, observed care, reviewed records and spoke with patients, staff, relatives and carers.

Emergency and urgent care services

Summary of findings

We rated the emergency and urgent care service as requires improvement because:

- Medicines systems used by staff were not always safe and trust's policies, procedures and protocols were not always followed by all staff.
- Ambulances and rapid response cars were not always secured when staff were escorting patients into emergency departments at hospitals or tending to patients at other locations.
- Feedback to staff following incident reporting did not always take place.
- Cleanliness and control of infection was not being managed effectively. Clinical waste was not always disposed of as required. The trust was not meeting its targets for cleaning of vehicles or stations.
- Patient confidential information was not always stored securely.
- Response times for most categories were consistently below the England average.
- From April to October 2015 the average proportion of patients who received angioplasty (unblocking of a coronary artery) following ST segment elevation myocardial infarction within 150 minutes was worse than the national average.
- The average proportion of patients assessed face to face who received an appropriate stroke or transient ischaemic attack care bundle in April to October 2015 was worse than the national average.
- The rate of annual performance appraisals was variable ranging from 38.4% for specialist paramedics to 87.7% for paramedics. This was below the trust target of 90%. The quality of the appraisals was also variable.
- Not all staff were competent in providing treatment and care to patients with mental health issues.
- Quality, in terms of patient outcomes and experience, did not feature highly at operations meetings, although a quarterly quality report had recently been introduced. Risks to quality and safety were well understood at a local level but were not recorded locally and local accountability for managing these risks was not defined. Risk registers maintained at directorate and corporate levels did not align with the risks and worries described to us by staff and managers. There was a lack of local oversight in respect of infection control. This highlighted a disconnect between different reporting lines.
- Whilst the trust had made significant efforts to support staff wellbeing, their efforts were somewhat overshadowed by the intensity of work, due to relentless and increasing demand on the service and the pressures this placed on staff. There was a culture in which there was an unspoken expectation that staff would work longer hours than they were contracted to work. The intensity of work undoubtedly contributed to staff absenteeism and high levels of staff turnover.

However:

- There was a genuine culture where staff could report incidents and these were viewed as learning opportunity. Staff felt they were well supported when involved in incidents.
- Safeguarding of adults, children and young people was given sufficient priority. Staff knew how to recognise and report allegations or incidents of abuse.
- Staff recognised and responded in a timely way to the changing condition of patients.
- Feedback from patients and those close to them was consistently very positive. We accompanied crews on emergency and urgent calls and spoke with patients and relatives in emergency departments. Without exception, patients, relatives and other healthcare professionals told us that ambulance staff acted with care and compassion.
- Staff were passionate about their patients' care and wellbeing. We saw numerous examples where staff 'went the extra mile' to ensure their patients' comfort and wellbeing.
- Staff adopted a person-centred approach when attending to patients and supporting those close to them. Staff considered the needs of the individual and took actions to promote their dignity, showed consideration for individual preferences and promoted independence by actively involving patients in decisions about their care and treatment.
- The service provided evidence based care and treatment in line with national guidelines

Emergency and urgent care services

- The proportion of Red 1 calls responded to within 8 minutes was better than the England average for 16 out of 19 months between July 2014 and January 2016.
- From April to October 2015 the average proportion of patients with ST elevation myocardial infarction who received an appropriate care bundle was better than the national average.
- There were pathways to prevent hospital transfers and staff had received additional training to enable them to treat patients at home.
- Consent was obtained from patients prior to treatment or care being given.
- Staff took time to interact with patients and were supportive to them and to their relatives/carers. Staff treated patients with compassion, respect and dignity.
- Most patients had timely access to initial assessment, diagnosis or urgent treatment.
- Staff feedback on issues which prevented 'right care' from being delivered was captured with over 5,000 incidents highlighted up to the date June 2016. This was used to identify further changes required to improve patient care.
- The service was leading on the national ambulance response project or ARP which commenced 19 April 2016. The full impact of the ARP project was not known during the inspection period, as it was still in pilot phase.
- The trust used a network of volunteer community first responders, responders such as fire co responders, doctors and others including trust staff that could supplement core ambulance resources.
- Action was taken to remove barriers to patients with physical disability, those with reduced mobility or those who had bariatric needs who found it physically hard to use or access services. The trust also ran blue light days where people with a learning disability could familiarise themselves with ambulance vehicles, equipment and staff to understand the service better. This also enabled staff to better understand the needs of people with learning disabilities. Translation services were available and were used.
- Complaints and concerns were taken seriously and listened to but not always responded to in a timely way
- There was a well-publicised mission statement and a set of core values which staff consistently demonstrated in their commitment to delivering high quality care to patients.
- Local managers were visible, accessible and supportive to staff. Staff felt valued and supported.
- The trust's management recognised staff wellbing as a priority and had made significant efforts to support staff. A range of staff support schemes had been developed and staff who had used these services spoke positively about the support they had received.

Emergency and urgent care services

Are emergency and urgent care services safe?

Requires improvement

We rated the safety of emergency and urgent services as requires improvement because:

- Medicines systems used by staff were not always safe and trust's policies, procedures and protocols were not always followed by all staff.
- Ambulances and rapid response cars were not always secured when staff were escorting patients into emergency departments at hospitals or tending to patients at other locations. This meant that unauthorised people could access the ambulances and cars and have access to equipment and at times medicines.
- Feedback to staff following incident reporting did not always take place. Some staff felt that due to the demands on the service they did not have time to report all incidents.
- Cleanliness and control of infection was not managed effectively. Clinical waste was not always disposed of as required. The trust was not meeting its targets for cleaning of vehicles or stations. Infection control training for staff was not meeting the trust's targets for the number of staff who had completed this.
- Feedback from staff about their training indicated they felt more was required to meet their needs and those of the service to keep patients safe.
- Confidential patient information was not always stored securely.

However:

- There was a genuine culture where staff could report incidents and these were viewed as learning opportunity. The trust had taken steps to make the incident reporting process more straightforward by providing a link within the electronic patient care form. Staff felt they were supported well by managers and the trust when they were involved in incidents.
- Safeguarding of adults, children and young people was given sufficient priority. Staff knew how to recognise and report allegations or incidents of abuse.
- Staff recognised and responded in a timely way to the changing condition of patients.

Incidents

- All staff we spoke with understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses. Reporting of Incidents was via an electronic reporting system, all staff members we spoke with were confident in the process, and received confirmation emails that the incident had been logged. However, some felt that at times they were too busy dealing with emergency and urgent work to report all incidents.
- The majority of staff told us they were encouraged to report incidents and received feedback when they did so. However, some staff that we spoke with said they received little or no feedback from the outcome of investigation from incidents they reported. One staff member told us they did not report incidents because they saw “no point” as they did not receive feedback and concerns were not addressed. In addition, staff who attended a focus group told us they did not receive feedback following an incident and were expected to complete incident reports in their own time. The electronic reporting system required managers to complete the incident by providing feedback to the staff member who had reported it. Incidents could not be closed until the feedback box was ticked. A senior member of staff in one division had recently presented a paper at an away day for all managers setting out recommendations around personal feedback to staff, as opposed to computer generated feedback via the incident form.
- A system was in place for reviewing and investigating incidents. Incident reports were sent through the electronic reporting system to senior staff and managers who would review them and if necessary, investigate them. Once completed, they were sent to the quality and risk team who reviewed the reports and identified themes and patterns of incidents. Operational Managers also reported monitoring incidents for themes and concerns. This helped to reduce the incident reoccurring and identified areas where similar incidents reoccurred. The most frequent incident reports were those relating to injuries to staff Between October 2015 and April 2016 in the east division, the most common reason for reporting incidents was verbal and physical. We asked what training had been provided in response to this. A senior manager in the east division told us some conflict resolution training had been provided (there was one

hour's training included on the 2016/17 development day) but in their view this was not sufficient. The clinical hub staff placed an alert on a patient's addresses if they had a history of abuse towards staff and the trust wrote to them to inform them that an alert had been put in place at their address.

- Despite a flagging system being in place to alert of previously reported incidence of violence and aggression, crews were not always informed. The minutes of a safeguarding operational meeting in May 2016, detailed 41 incidents reported since 1 April 2016 in relation to the management of mental health patients. Sixteen of these related to physical/verbal aggression. One theme was that warning flags were not being passed to crews by the control centre. It was not clear what actions had been taken or were planned in relation to this.
- A system was in place to share learning from incidents but not all staff had time to read the clinical updates. Individual staff received support in the form of learning and reflection Learning was incorporated into development days, where the content of the syllabus each year reflected areas of concern. For example following an incident where the packaging of a medicines was altered which had resulted in administration of another medicines with similar packaging. At several ambulance stations, there were clinical notice boards, which included for example, a document outlining learning from incidents and clinical information. A quarterly report produced called 'Reflect' was produced which reported on emerging themes and learning following incidents. We reviewed three copies of this bi-monthly newsletter. We saw details about incidents and learning from these and information about Duty of Candour.
- In the 2015 NHS staff survey 30% of respondents reported witnessing potentially harmful errors, near misses or incidents in last month. However, this was slightly better than the national average for ambulance trusts.
- In the 2015 staff survey the trust's score in relation to the fairness and effectiveness for reporting errors, near misses and incidents was 3.4 out of five which was better than the national average for ambulance trusts.
- Remote workers kept up to date with changes in policies or procedures from safety incidents or alerts. A member of staff we spoke with from a remote ambulance station said their manager informed them of updates at their monthly station meeting. They also received a monthly newsletter electronically, which was also displayed on the staff notice board.
- Staff were debriefed and supported after a serious incident. Several members of staff spoke in detail about the support they received from senior managers following a serious incident and the changes made in practice. This included the introduction of the Staying Well and Fit Together service, which provided welfare support to staff. Other staff we spoke with informed us they had accessed the service and felt it had provided good support. Staff received a telephone call from the welfare service if they had been involved in a serious incident and were appointed a welfare officer if required to provide ongoing support.
- Managers told us staff involved in serious incident investigations were invited to be involved in the investigation and root cause analysis. This meant they were aware of the process and able to share their experiences. Serious incidents (including those identified from complaints) were presented to a Serious Incident Review meeting, to which staff involved were invited.
- There were seven serious incidents reported in the 12 months prior to our inspection. A root cause analysis investigation had been undertaken or was underway for each of these incidents. Three incidents were still under investigation. Of the remaining four, three were unexpected deaths and learning points from these were identified.

Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation, which was introduced in November 2014. This Regulation requires the trust to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm, which falls into defined thresholds. We spoke with managers and staff who described it as having an open and honest culture with patients when incidents happen but some had to be prompted to state that an apology would be required. We saw in three serious incidents evidence that Duty of Candour had been applied.

Mandatory training

- All new staff completed a period of induction training which included the on-line mandatory training as part of their local induction. Staff described being provided with time to complete online training which had been useful and beneficial for their role. A mandatory training workbook was provided to new staff and they had six months to complete all elements of the training.
- The trust's training and development policy stated that all Emergency Care Assistants, Technicians, Advanced Technician, Advanced Nurse Practitioners, Nurses, Paramedics, and Specialist Paramedics, no matter whether permanent or bank, must attend an annual classroom-based Statutory, Mandatory and Essential training day (re-named development days in 2016). The trust had set a target of 90% compliance. They also had to complete the mandatory workbook over a three-year period but some staff told us they did not think this was sufficient. The policy stated that classroom training consisted of various subjects, as required by the trust during that period. Some staff raised concerns about the lack of updates they received following their initial training. They told us there were a number of areas where they had not had updates and they felt this could put them at risk. For example, infection control and the use of some equipment which was not regularly used.
- Mandatory training covered core subjects such as information governance, fire training and manual handling. Other subjects were included when a need was identified or as learning from a serious incident. Examples of themed mandatory training sessions were paediatric resuscitation, and the recognition and management of sepsis. The topics for the classroom based training changed each year with a view to staff completing all of the mandatory training over a period of three years.
- Electronic on-line training was available to staff. Staff told us they were not provided with the time to complete this training and a large number commented they completed it in their own time and at home. Other staff members stated they did not do this as they valued their time off and therefore had not kept up to date with their training. There were 'stand by' stations where staff were directed to locate themselves at between jobs. In four out of the five 'stand by stations' in one area staff had access to a computer where they could complete their on-line training. Staff we spoke with stated that in reality they were rarely at the 'stand-by' stations for long enough to complete the training programmes.
- In addition to development days, there were annual learning and development review (LDR) shifts provided to frontline clinical staff. This provided each staff member with a day-long one-to-one learning shift. A learning and development officer worked with staff on a shift in their normal clinical setting. During the shift statutory, mandatory assessments, such as manual handling, infection prevention and emergency driving were undertaken. Staff were also engaged by dialogue around care pathways, their own continuing professional development, their clinical assessment and reasoning skills, wellbeing and other subjects. The trust told us that operational pressures during the last year had impacted their ability to provide training.
- Recognising that statutory and mandatory elements were included in both development days and learning and development review shifts, a decision was taken to ensure that as many staff as possible had received one, other or both. They told us that during 2015/16,(up to 30 April 2016) 97% of operational staff had accessed at least one of these training sessions during the year This was broken down as follows:
- 87.7% of staff had completed Statutory, Mandatory and Essential (SME) training
- 65% had completed learning and development review (LDR) shifts
- 53% had completed both
- 4.1% had not completed any of the above.
- We did not request from the trust how they planned to address the 4.1% of staff who had not completed either training.
- A number of staff in the east division spoke very positively about the development day they had recently attended. However, we spoke with staff across all divisions and majority felt the provision of classroom-based training was inadequate. One staff member in another division told us "We are lucky if we get one day a year". They told us that clinical guidelines were issued regularly by email and printed copies were left on the table in the crew room to read. Occasionally, they told us, they were required to sign to acknowledge that they had received and read a communication, for example, a new policy, but they said this was inconsistent. However, there was no assurance that staff were up to date. Another staff member told us "the current system of yearly training is not fit for purpose. It does not meet the clinical requirements of road staff." Staff who attended focus groups in Bristol and Bath told

us that their annual update days were good but they would like more "hands on" training and staff echoed this across all divisions. A staff member who contacted us prior to our inspection told us "Staff have not completed advanced life support training for several years". They complained about a lack of clinical training and assessment. During the inspection, a senior member of staff in one of the division told us that staff did not receive regular advanced life support training and that clinicians had responsibility for ensuring they were current. They told us there was no assurance that clinicians were up-to-date. Although an overtime payment was offered, some staff were not able to work these additional hours due to home commitments. A staff member told us "The vast majority of training and education is only available on overtime, I as a registered paramedic have not been offered any instructor led resuscitation training for a number of years. Many staff are the same. I personally find this alarming." The trust told us that paramedics undertook advanced life support training on a three year rolling cycle , although training had not taken place during 2015/16 due to the fact that national resuscitation guidance was changing. They told trust told us as part of the SME for 2015/16 day, 91% of frontline staff received an update on advanced life support.

- The infection prevention and control policy stated training was provided as part of the development day; however, this was not what we found. It was covered in the three yearly, mandatory workbook completion and was also covered at local development reviews. However not all staff completed these reviews in 2015/16 and as a result had not received infection prevention and control updates.
- Staff in Taunton, Yeovil, Dorchester and Poole ambulance stations complained that it was difficult to compete e-learning while at work because the IT was poor. They told us this had been reported but no solutions had been found.
- Administration staff mandatory training was mainly online, easy to access and they completed it as part of their working day as they were not given supernumerary time for it.
- Staff were identified to attend training on the electronic rota system. However, at one of the stations we visited it was not clear how the senior staff knew who had attended the identified training and who was required to attend mandatory training. At other stations the operations managers held electronic training records for all staff based there. However, on examination some of these were not up to date as one operations manager informed us there were a number of staff at their station who had completed additional training, which was not reflected on their electronic database. The trust told us mandatory training was managed and reported centrally and operational managers received a monthly report of compliance.
- A three-week training course was provided at induction for driving under blue lights, then staff were required to be assessed every two years. Staff we spoke with told us they were unable to drive using lights and sirens prior to this training. Positive comments were made regarding the usefulness of the training.
- The engineers/mechanics who worked in the workshops servicing and maintaining vehicles were provided with training and updates at a nationally recognised centre.
- The trust's Responder Governance Policy set out that all Community First Responders were required to undertake three days of classroom training as an induction into the role. This included basic life support training, scenarios set to assist the understanding of the role and life support skills, conflict resolution training, systems, and processes used by the trust. Thereafter, they were expected to attend a proficiency assessment every six months. The policy stated "Any Responder who fails to achieve the required standard, or has not attended a proficiency assessment within seven months of their last course for Responders and on an annual basis for Establishment Based Responders, will be withdrawn from responding until the required standards have been achieved and/or training has been completed. "Regular meetings will be held for Community First Responders where refresher training will be delivered. This will typically be on a monthly basis. Responders who do not attend sufficient refresher training sessions within a 12-month period will need to re-qualify at the discretion of the Community Responder Officer". We requested training records for community first responders. Data provided showed that all responders had received basic life support refresher training in the last 12 months. However, one staff member from the Isles of Scilly contacted us prior to our inspection told us "training for first responders is virtually non-existent - should be every month but it is lucky to be every six months which has led people to leave because of lack of support."

- A Community First Responder Personnel File Update was completed for each responder to verify that driving licence and vehicle checks had taken place and that they had completed an assessment of basic life support and use of an automated external defibrillator.
- The trust planned to introduce a nationally recognised level three certificate for Community First Responders, which was due to be delivered to new recruits from August 2016. The trust advised that existing staff would migrate to this qualification with a target for all Community First Responders to complete over the next three years.
- An annual training programme was developed and sent to all Community First Responders. We were provided with the 2015 and 2016 training programmes for Community First Responders on the Isles of Scilly. The programme included quarterly meetings, which were held on St Marys Island or on one of the off islands and enabled these staff to update their basic life support training and be signed off as competent to use the defibrillators.

Safeguarding

- There was an effective system for front line staff to report safeguarding concerns.
- All crews we spoke with were aware of how to recognise and report safeguarding concerns. These were reported through a single point of access within the local council using the electronic patient care record system or intranet. There was a decision tool incorporate into the patient care record which helped staff make a judgement about the need for referral.
- Staff had access to a safeguarding lead officer for guidance and information should they require this prior to reporting a safeguarding concern. The safeguarding team followed up the concern and gave feedback to the staff involved. Staff said the system worked well and the safeguarding team usually contacted them immediately after they received the concern. Staff also reported receiving feedback regarding safeguarding concerns they had reported.
- Ambulance staff received level two-combined adult and children safeguarding training. This was provided as part of the development days and from the workbook. Over a three period ambulance staff were required to complete a minimum of four hours scenario based safeguarding training.
- The total number of safeguarding referrals the trust made as whole for 2015/16 (from May 2015 to April 2016) was 10,473.
- Guidance on female genital mutilation had been circulated to staff via email. We saw information displayed on a noticeboards at a number of ambulance stations.

Cleanliness, infection control and hygiene

- Cleanliness and control of infection was not being managed effectively.
- The Infection prevention and control policy stated that monthly audits of all premises were undertaken. We were provided with audit results for the months of March, April and May 2016. They were rated as 'red amber or green'. Results were as follows:
- March 2016: Overall compliance for station cleanliness (trust-wide) was 76% (rated as red) and for vehicle cleanliness 80% (amber). Ninety-one out of 105 stations (87%) submitted data during this month.
- April 2016: Overall compliance for station cleanliness (trust-wide) was 78% (red) and for vehicle cleanliness 76% (red). Only 67 out of 105 stations (64%) submitted data during this month.
- May 2016: Overall compliance for station cleanliness (trust-wide) was 83% (amber) and for vehicle cleanliness 82% (amber). Only 89 out 105 stations (85%) submitted data during this month. It was reported that posters were being designed to increase understanding of infection control issues and operational managers were reminded to ensure completion of the monthly audits on all stations.
- All divisions had an increase in operational demands, which influenced vehicles being released for deep cleaning.
- There were rotas for environmental cleaning of ambulance stations. However, we found practices and levels of cleanliness varied between stations. We saw weekly cleaning rotas at stations but most were out of date or incomplete. At Barnstaple station, the rota was in date but no signatures were entered onto it to show areas had been cleaned. We found some stations had cleaning staff and for other stations, it was the responsibility of the clinicians. Staff said there was not always time for the cleaning to take place due to the volume of calls to clinical incidents. At Barnstaple station, we were told they had a contract cleaner who came in for five hours a month to carry out cleaning but

they were unable to provide cleaning schedules or logs of the cleaning had been carried out. At Exeter station, we were informed there was a cleaner for the station but the sluice, the supplies store for sterile consumables and the medical devices store rooms were not part of the cleaning schedule. We were told these rooms were not routinely cleaned. In most of the stations we inspected, boxes of equipment were kept on the floor of storage areas making effective cleaning difficult. We saw debris and dirt on the floor around the boxes.

- Sluice rooms were available in most of the stations. In some of the smaller stations where there was no sluice room sinks were designated for disposing of contaminated water from cleaning vehicles and for equipment cleaning. The sluice rooms varied in their cleanliness and tidiness and the equipment stored in them also varied at each station we visited. For example, in one sluice room only mop heads and specialist cleaning wipes were stored. In Launceston station, cleaning chemicals, clean equipment and soiled storage boxes were stored in there, which was an infection control risk to have clean equipment stored in a sluice. The work surface area in this sluice was damaged and could not be effectively cleaned. We raised our concerns regarding this at the time of the inspection. We later carried out an unannounced inspection visit of this station to review the arrangements in place. Some cleaning had taken place in the sluice and the soiled storage boxes had been removed. The trust reported that other areas of potential risk of cross contamination due to the environment in the sluice were due for refurbishment in June 2016. These included the damaged work surface and replacement of a missing ceiling tile.
- Following concerns observed and raised to the trust regarding the infection control and cleanliness at Plymouth Station we carried out an unannounced inspection. We saw action had been taken to clean the area around the medical devices store and that guano from nesting birds had been removed however, the birds were still in situ. A local company had visited the station to review the possibility of netting the ceiling area to stop birds nesting and provide a quote for regular cleaning. The trust stated to reduce the entry of birds into the station the garage doors would automatically close and they would be able to exit through a small hole in the wall. However, during our visit the garage doors remained open. We discussed with a member of staff the open doors and we were told they remained open during the day and were closed at night. While we carried out the unannounced inspection, we saw clean linen and stores had been delivered and placed in the area outside the medical devices room. Two linen bags had been opened, leaving clean linen exposed to the risk of guano dropping on them. Two bags had spilled from the crate and were on the floor of the garage. We were informed the station and staff had been busy. As a result, the linen and stores would be put away when there was time. This did not prevent the clean linen and equipment from being soiled in the meantime. Therefore, the response to our concerns that had been provided by the trust was inaccurate.
- The ambulance station on St Marys was accessible to birds and it was noted during a review of the services by the trust in June 2015 that there was a significant amount of bird guano in the garage and work areas used by the staff. We requested an update on this action. This was not provided.
- Consumable items were mostly appropriately stored in designated storerooms. We noted however, in Dorchester station, consumable items, including masks, disposable bedpans and neck braces were stored in the sluice. We were concerned that there was a risk that these items could be contaminated by splashes. We drew this to the attention of a manager at the time and we were advised that shelving was on order for an additional store room, which meant that consumables could be moved from the sluice. The trust subsequently informed us that they had assessed the area and concluded there was no risk of contamination through spillage.
- Sterile consumables were appropriately stored in cupboard on ambulances.
- Hand washing facilities were available at the stations we visited. Staff knew when it was appropriate to wash their hands or use the alcohol based gel. Staff used approved hand washing/decontamination techniques at appropriate times. There were suitable hand washing sinks at the stations. All staff carried hand decontamination gel and this was also available in the vehicles we inspected.
- Ambulance staff were wearing visibly clean uniforms. Staff were provided with five full sets of uniform when commencing work with the trust. They were aware of how to launder their uniforms correctly and informed us

they were encouraged to order new uniforms when they became worn. We saw bags of old uniforms in locked storage areas awaiting disposal. One crew member told us that they had to change their uniform mid shift as a patient had vomited on them. They said they had spare uniforms at their base and they were allowed to return to change before being sent on another job.

- The infection prevention and control policy stated that all clinical staff must be bare below the elbow whilst in operational uniform. The exception to this was when staff were required to wear personal protective equipment such as high visibility jackets. In these cases sleeve protectors should be worn. We observed that staff complied with this standard.
- Ambulances were mostly appropriately stocked with personal protective equipment, including gloves, aprons and masks.
- Staff were responsible for cleaning their vehicles during their shift. Equipment was available on ambulance stations for this purpose. There were also appropriate cleaning materials on each vehicle to clean equipment between patients and staff described the process to us. They told us they were always allowed time to clean their vehicle before clearing on an incident and making themselves available for further work. Staff told us that they were required to clean their vehicles during the last 20 minutes of their shift; however, many staff told us they rarely had time to do this. Staff told us that if this was the case they would inform the incoming crew. Crews were aware that if their vehicle was seriously contaminated they could arrange for the vehicle to be deep cleaned.
- Vehicles and equipment were appropriately and safely cleaned and ready for use. Make ready operatives were employed in the larger stations. They were responsible for routine and emergency deep cleaning of vehicles. A weekly schedule of vehicles was planned; these were vehicles which were based at the station and from smaller stations in the locality. In one make ready station, we saw up to date records of deep cleans and vehicle maintenance records. Deep cleans were recorded in vehicle logbooks and a sticker on the inside of the windscreen showed when the next deep clean was due. The logistics department monitored the deep cleaning schedule. Make ready operatives collected vehicles prior to routine cleaning and returned them afterwards. When a vehicle required emergency deep cleaning the crews brought the vehicle to the station and transferred to another vehicle. The make ready operatives we spoke with said it took approximately six hours to thoroughly clean and prepare a vehicle. One member of staff told us they followed a set proforma for which they had received training when they commenced employment six years previously. They had not received any update or infection control training since their induction. One make ready operatives told us there had been training provided by a member of staff from the local hospital acute trust four years previously but this had been very basic and had not included all the information required when cleaning vehicles. Another told us they had been shown by a colleague how to carry out a deep clean but had not had any infection control training or updates. The trust told us that infection control training was covered in the mandatory work book which all staff completed. A make ready booklet was issued to all staff in January 2016 with a detailed section on infection prevention and control. We were told the cleaning of vehicles was carried out using hot soapy water and specialist cleaning wipes. A steam cleaner was available for the floor and upholstered surfaces.
- In one of the make ready stations (this was where all the cleaning equipment used for cleaning ambulances and rapid response cars was stored) the general cleanliness of the station was poor with discarded buckets and bins full of water kept outside. The crates used for unloading clean supplies were stored next to these so there was a risk of contamination of the clean supplies. We carried out an unannounced inspection of this station and no changes to the outside area at the station had been made despite us raising concerns. For example, the full water butts were uncovered and full of stagnant water and the crates, which were used for the transporting of clean stores, and linen had been left outside.
- Systems were in place for the management and disposal of clinical waste. However, processes and practices for clinical waste varied and at some of the ambulance stations and the management and disposal of clinical waste was not safe. For example, some clinical waste bins in the stations did not have lids meaning their contents could easily spill out if the bin was overturned. Some of the large clinical waste storage bins were not locked and were visibly dirty with used items in the bottom. The trust informed us they had contractors for cleaning the bins but this was not done routinely and had to be requested. At Redruth station

we were told the large clinical waste storage bins were emptied and the waste removed weekly. However, we saw a number of sharps bins which were stacked up as they would not fit into the disposal bin. The date on one sharps bin, which reflected the date it was sealed ready for disposal, was the 15 May. This was over three weeks before our inspection. Staff were unclear why this had not been removed. Many of the staff we spoke with were not able to explain the process for waste disposal and collection. At Launceston station there was an overturned waste bin with a red lid. Staff told us this was for contaminated items but the bin was being used for general waste. We saw food wrappings and empty milk bottles on the floor, which had fallen, out of the bin. We noted that in a rapid response vehicle in Taunton contained an open clinical waste bag with clinical waste within. This was attached to the dashboard, which created a risk of the spread of infection. We also observed at Stroud ambulance station that normal domestic rubbish had been put in with the clinical waste and in the sharps bins. This was reported to the manager.

- Sharps were appropriately disposed of on ambulances in rigid containers. We noted however, that these were not consistently dated and some were left open, putting staff and patients at risk.
- Hand hygiene audits were conducted throughout the year and compiled into an annual report. This was reported to the infection, prevention and control group. We were provided with the outcome of the 2015/16 hand decontamination audit report which showed an overall compliance rate of 65%. The trust target for compliance was 90%. The audit also observed compliance with bare below the elbows policy. The audit found out of 88 clinicians who were observed, 79% were compliant with this. Action had been taken to increase the compliance with hand decontamination for example, information had been circulated on the appropriate use of gloves and posters to promote infection prevention and control had been distributed within the trust. Two clinicians we spoke with were unaware of the hand hygiene audits and were unclear how the information had been gathered. However, the audit stated that not all stations had been visited as part of the audit. During our inspection most staff we observed were bare below the elbows which promotes the control of infection by enabling effective hand washing. The trust had provided each member of staff with a fob watch to ensure they did not require a wrist watch. With the exception of one, all members of staff we saw were wearing these. However, two members of staff were seen wearing rings containing stones which did not comply with the trust infection prevention and control policy. We noted that some crews in all divisions wore gloves when this was not clinically indicated, for example, when they handed over to Emergency Department staff and completed documentation. A senior nurse in one of the receiving Emergency Departments also commented on this.
- We observed staff using Personal Protective Equipment (PPE) appropriately when at the scene of an incident. The make ready operatives who were responsible for cleaning, stocking and maintaining vehicles had PPE available to them in the form of gloves, face masks and disposable white coveralls for use when cleaning contaminated vehicles.
- Staff were made aware of known infection and hygiene risks associated with individual patients. Information regarding patients was sent to them via the electronic patient care record and details about infection and hygiene were included. Staff told us if they collected a patient who was known to have an infection, they would request permission to change vehicles so deep cleaning could take place. Staff told us that the control room would inform them if a patient had a known infection, but sometimes this information was not passed on to the control room.
- There were medical device storage rooms at most of the stations we visited. However, the processes, storage and standards for cleaning of equipment varied. In some stations, equipment, which was visibly contaminated, was stored with clean equipment, items were stored on visibly dirty floors and there was not a system to indicate which items were clean or dirty. Medical devices were transported to a central area for repair and maintenance. However, contaminated items were taken in a vehicle with clean equipment and sterile consumables for stocking up the stations. We were informed the vehicle did not undergo any schedule of cleaning or through the deep clean process. We observed clean items on the floor of the vehicle. We were told the central workshop did not have a sink for handwashing and there was one bench on which clean and dirty items are worked on. If items are known to be contaminated they were cleaned, repaired and serviced at the bench. The items were then taken back to the

medical device store and put back into circulation. We were told that due to high demand, some contaminated items could be in the workshop for days before being cleaned. The member of staff we spoke with could not remember having any infection prevention and control training and was not aware of any risk assessments had been performed regarding cross contamination. At Exeter station patient equipment was stored on trolleys which were visibly dirty with dust on the underside and around the base. These trolleys were stored alongside discarded equipment awaiting disposal such as office chairs.

- The trust purchased disposable mop heads for use in all of the ambulance stations. We saw clinicians used these and make ready operatives during our visit. However, some of the mop buckets were contaminated with dust and were visibly dirty. The trust policy was for mop buckets to be stored upside down after use but this procedure had not been followed in all stations.
- Staff raised concerns regarding the length of time it took for cleaning materials to be delivered to their station following the submission of an order form. We were told by some staff that they had been waiting for two weeks for an order of mop heads and paper towels to be delivered.The trust told us that all stations had weekly deliveries staff could arrange for urgent deliveries at any time.
- In the west division at one station we observed a bicycle lock attached to the shelves in the clean equipment / linen store. We asked about the purpose of this lock and were told a member of staff secured their own personal bicycle in the store when they were on shift. This compromised the cleanliness and infection control practices within this clean store area.

Environment and equipment

- The ambulance stations we visited were fit for purpose. Garage areas were tidy and free of clutter. We saw there were designated 'in' and 'out' routes for the ambulances and cars (RRV's) to follow. Décor in some of the older stations was 'tired' but staff facilities were adequate and comfortable
- Between November 2015 and March 2016 the medical directorate, accompanied by the local operations manager or representative and a member of the estates team visited all ambulance stations. Audits were undertaken which included an inspection of premises and up to three vehicles if present. Areas for improvement were highlighted to operations managers and a target date was specified for these actions to be actioned. The operations directorate was managing the completion of actions.
- Staff were mostly happy with the standard of vehicles and equipment provided. Ambulances were well laid out and well equipped. We checked 29 ambulances across the three divisions. Vehicles and equipment appeared well maintained. Sterile supplies were mostly appropriately stored with packages intact and in date. Equipment was labelled to show that they it had been serviced and maintained.
- There was a Standard Vehicle and Equipment Policy (March 2016) which specified the range and quantity of medical devices and consumables carried on all trust vehicles and clarified the minimum standard of equipment that must be taken to the patient. Operational managers were responsible for ensuring that the policy was complied with at their stations and that local monitoring procedures were in place.
- The Standard Vehicle and Equipment Policy stated that clinicians were responsible for ensuring that all vehicles were equipped with appropriate, maintained, charged and functioning medical devices, in accordance with the equipment checklist and for reporting any equipment defects. At the commencement of a shift or at the earliest opportunity, staff were required to complete a vehicle daily inspection. A standing operating procedure required that if staff were unable to complete a full inspection, that they should carry out minimum checks before mobilisation and a full inspection at the earliest opportunity. A vehicle log book was maintained which contained templates for staff to complete vehicle checks prior to commencing their shift. Staff told us that they were not always able to complete vehicle checks before being dispatched and we observed this happening during our inspection with both ambulances and cars. Some staff told us they arrived early for their shift in order to complete the checks. Records of daily vehicle checks were not consistently completed so we could not be assured that the necessary checks had been undertaken. For example, we noted one vehicle at Bournemouth ambulance station had no vehicle checks recorded since 30 April 2016 (39 days).There was a large oxygen cylinder, which had no key to open the valve. We brought this to the crew's attention. There was also a

small oxygen cylinder, which was not securely stored in the vehicle. We saw that a full vehicle check had not been completed for two days on a rapid response vehicle from Torquay station.

- Replenishment of vehicles was managed at the stations between calls. If vehicles required restocking during a shift we were informed this was carried out at local ambulance stations or at acute hospital trusts between patients. Some of the stations we visited were a central store for other stations in the area as they had adequate secure storage space and were centrally located to the stations they supplied. However, in the north division staff told us they were not able to replenish stocks at the acute trust local emergency departments so had to travel back to the main ambulance station taking more time. We inspected the storage areas in one of the central storage stations and the equipment was in date and stored neatly.
- Equipment was being standardised across the trust. At the time of our inspection, the trust was in the process of rolling out a new system for regulating the equipment kept on vehicles. We spoke with a member of staff who was involved in the process. They explained that instead of one large bag containing all equipment crews would carry a set of smaller bags. We were shown two of the bags; one contained a standard set of medicines and the other held emergency equipment. The bags were all packed in the same way so staff knew exactly where to locate equipment they needed. It was the responsibility of the crew to check the contents of the bags at the beginning of their shift. Staff told us the new system had required familiarisation with the contents of each bag to ensure they were able to locate emergency equipment quickly once at the scene of an incident. Most staff we spoke with were pleased with the change and felt they were an improvement on the previous system.
- Vehicle stocks were checked. A full stock check was carried out when vehicles were serviced and deep cleaned. A checklist was in use and we observed this being completed.
- Medical devices were maintained and the service quality was monitored. The make ready operatives were responsible for carrying out a daily stock check on the medical devices stores. The medical devices coordinator used this to make sure supplies were replenished. In the divisions, there was a database which contained a list of all medical devices, their location and date for service. The same system was used for requesting maintenance of equipment. However, though reports could be run from the system they did not get sent to the medical devices coordinators. The medical devices coordinator was also unable to run a report to show how many items of equipment were overdue for service. The majority of repairs and services were carried out by the medical devices team who arranged for external repair or service of any equipment they were not qualified to manage.
- Faulty equipment was reported and replaced. An electronic system was used for reporting defects. These were also logged in daily check book. Workshop staff raised concerns that sometimes clinicians did not report through the electronic system. This potentially caused delays when the vehicle was brought in for routine servicing as the specific parts might not be available and the extra work not factored in. Staff told us this had been raised and highlighted as a risk; however this was not on the risk register.
- At several of the stations we visited we saw a medical device equipment exchange store. These were locked and some were monitored with closed circuit television. Staff we spoke with said if equipment was faulty it was cleaned according to the manufacturer's instructions, a label was attached to identify it was faulty and the nature of the fault. It was then logged in a register and left in the storeroom where it would be picked up by the trust fleet services and returned for repair. Staff reported the system worked well however, we saw variations in practice across the stations we visited. For example, some stores were well organised with specific areas for faulty equipment while others had faulty equipment stored with replacement equipment. We did not see a standard list of equipment stock and excessive items were kept in some stores. Some staff did not clean faulty equipment and placed it in a sealed bag for return.
- Electrical equipment was safe. Most of the electrical equipment we reviewed had a current portable appliance test. However, we saw an air compressor in a shed at Launceston station, which had been due for servicing in September 2015. We could not find evidence this had been completed.
- Servicing and maintenance of vehicles was planned to take place every six weeks. Full services took place at every 18,000 miles as per the manufacturer's recommendation and guidance. Some vehicles were overdue for the service and maintenance timescale. However, staff had followed this up and were able to

provide sound reasons for this delay. Following the servicing and maintenance of each vehicle, a report was sent to the trust to identify the service had been completed. MOTs on each vehicle were carried out by an approved external garage.

- Vehicle servicing schedules were printed out each month. The full history of the vehicle was reviewed on the database prior to the vehicle coming into the workshop. This ensured the staff were fully aware of what work was required and that required parts had been ordered and were available. Staff told us they kept the vehicles in the workshop for up to three days to complete the servicing and deep cleaning. Additional vehicles were available to ensure clinicians were able to respond to incidents.
- Decisions were made for vehicles with faults to be taken off the road. We observed how quickly a vehicle, which had sustained an impact to a rear light cluster, was swapped for a safe and clean vehicle. The faulty vehicle was immediately taken off the road and assessed for safety, time off road and the cost of repair. Staff were required to follow the Vehicle off road guidance or contact the control for assistance. The trust's policy stated that if a vehicle was deemed not roadworthy, according to DVLA standards, it would be removed from service immediately. However, a member of staff in a remote area told us they had reported a vehicle was unsafe, as it had no reversing light. In poorly lit areas, they were forced to use the hazard warning lights for lighting when reversing but this had not been addressed.
- A breakdown service was in place by external providers, which covered tyres as well as mechanical.
- A review/audit of the services provided on the Isles of Scilly was undertaken in June 2015. Health and safety issues were noted in the ambulance station on St Marys due to being either too hot or cold. The only way to reduce the heat in the summer was to leave the windows open which impacted on security when the station was unmanned. The requested update to the review did not provide any information on the action taken to address this issue.
- Staff told us that they had reported to the trust concerns regarding the emergency vehicle used on St Agnes in that the vehicle was not fitted with reversing lights. To transport a patient safely to the medical launch staff were required to reverse this vehicle onto the quay. At times of darkness or reduced visibility, the only lights to guide the driver were the flashing indicator lights. This did not ensure the safety of staff and patient. This was not identified as a risk in the 2015 review/audit of equipment and estates. We asked the trust for further information on this and were told that there had been no incidents reported regarding this matter since the vehicles had been introduced in 2010. A risk assessment had been completed regarding the use of this vehicle and was dated February 2010. The assessment did not identify a risk from a lack of reversing light. A further risk assessment had been completed regarding operating on the quaysides and was dated June 2015. This did not specifically identify the risk of reversing onto the quayside but advised that the clinician and the coxswain had responsibility to abort the operation if deemed too dangerous.
- In the review/audit of the services provided on the Isles of Scilly undertaken in June 2015, the roof of the ambulance station on the off island of St Martins was shown to be leaking and arrangements were made to replace this. The 2016 audit did not provide confirmation this had been carried out as the island was not visited as part of the audit.
- The trust's fleet department carried out service and maintenance of stretcher trolleys and carry chairs. Equipment was labelled with an identifying bar code label, detailing the date of the last service and the date of the next service. When we checked vehicles with staff, they appeared to take no responsibility for checking whether equipment was in date. In Bournemouth we found a stretcher was overdue for servicing by two months. The crew on this ambulance was not aware of this.
- The equipment for Community First Responders was asset tagged and linked to a database. We were told their managers were sent a monthly update showing which equipment had been serviced. However, one of the managers was unable to show us the database and said they did not receive this information.
- There was a standing operating procedure, which set out how bariatric patients were to be transferred and cared for on ambulance vehicles. Bariatric patients are defined as those patients who weigh in excess of 25 stone (158kg) or if they have a body size or shape, which may affect their transport or care. Stretchers, which could carry bariatric patients, and vehicles, which could safely store these stretchers were available at a number

of stations in each locality. All carry chairs were suitable for carrying up to 200 kg and all stretchers were capable of carrying up to 300 kg. This significantly reduced the need for bariatric specific equipment to be dispatched.
- Harnesses were available on ambulances to secure adults and children whilst in transit.
- Vehicles and their contents were not always secure. We entered one ambulance parked at Bournemouth station, while the crew was taking a meal break. The keys were left in the ignition. During our inspection both, announced and unannounced we observed ambulances were left open with door and tail lift down outside emergency departments in all divisions. This meant that unauthorised people had access to equipment that was not locked away.

Medicines

- Not all medicine procedures were safe and followed trust protocol. Medicines were not always stored securely, although a new system of sealed drugs bags was being rolled out at the time of our inspection in order to improve the security of medicines carried on ambulances.
- Medicines were stored in locked cupboards, which were accessible by a key pad. We saw the temperature within the cupboards was monitored to ensure they were kept at a safe temperature and as per the manufacturer's guidelines. The locked medicines cupboards at most stations were located within the clean store room which was secured with a keypad. Intravenous fluids were stored in boxes that were labelled and on shelves in the same room as the medicines. All clinical staff were provided with the code to access the area.
- Medicines were stored in bags on vehicles that were tamper evident. This was achieved by sealing the bag with a single use tag. This meant that it was clear to see if it had been opened. A system was in place, which showed the medicines bag was fully stocked when it was sealed with a white tag. If medicine had been used from the bag and therefore under-stocked a red tag was used to alert staff. The replaced medicines were recorded on a paper log. When the medicine bag was restocked a check was made of the contents and the log showed all had been checked and was in date. If no medicines had been used, the bag was opened each week to routinely check and record the medicines contained within. At Plymouth station staff returned to the station after each patient to restock their medicines bags. This was because there were no red tags available to them to identify their medicines bag was incomplete. They told us this was because the tags were on order but had not arrived. However, there were red tags available at other stations we visited.
- However, on a number of occasions medicines were not stored securely. Examples we saw included, at Torquay station, the door to the storeroom was propped open and at Plymouth station, the door was tied open with a bandage. Following our inspection the trust assured us that locks had been fitted in these locations. We observed vehicles unattended and unlocked and in two cases with the doors or boot wide open when the crew were attending to a patient out of sight of the vehicle. When some ambulances were outside emergency departments these were also left open and the cupboards where the medicines bags were stored were not locked. This meant that the public could access medicines and did not ensure the security of the medicines and intravenous fluids within the vehicles. The trust assured us that staff had been reminded to lock their vehicles when unattended.
- Controlled medicines in the stations we visited were stored safely and according to medicines legislation. We checked the balance of controlled medicines in the register against the stock in the cupboards at the stations we visited and found these to be correct.
- Daily checks were performed on levels of controlled medicines. In Bodmin station controlled medicines were checked each day and reported to the station manager. This helped to maintain stock levels and identify if a medicine was being used more frequently than expected. Where high levels of use were identified, an investigation took place to ensure the medicine was not being misused.Controlled medicines were carried securely by paramedic staff. We were shown belt pouches staff used to carry controlled medicines such as morphine securely; however, some paramedics were carrying them in their pockets. Some staff we spoke with said they had not had any lone working assessments undertaken and sometimes felt vulnerable when carrying controlled medicines on their person.
- Staff were not consistently following the trust's procedures for the administration and disposal of part used syringes of controlled medicines. Crews used controlled medicines during the treatment of patients when necessary. We observed morphine being drawn up into a syringe by one member of staff who handed it

to another member of staff attending the incident to administer. This meant the drug had not been checked by the member of staff administering it. Some staff raised concerns about this as they were administering a medicine they had not drawn up, or witnessed being drawn up. During the inspection we were also told that excess medicines were incorrectly disposed of by either squirting on to the floor or down a sink.

- Different staff groups were permitted by the trust to administered medicines via their professional status as doctors or paramedics, patient group directions for nurses and paramedics or medicines protocols for nurses, paramedics and advanced technicians. A patient group direction is a medicines protocol for specified professional staff groups with a legally specified content and approval route**.** Staff we spoke with either carried paper copies of the these or had downloaded these to their mobile phones to refer to when away from the station. Staff we spoke with demonstrated a good understanding of the patient group directions and were aware they were required to sign copies at the station to say they had read and understood the individual ones. Updates to the them were made known to staff and a lead paramedic we spoke with ensured all staff at the station had seen and read any updated ones. However, ipratropium & salbutamol nebuliser solution and Naloxone intra nasal were accessed by staff including advanced technicians rather than via PGD.
- Most medicines were dispensed in single use containers, however, the Glyceryl trinitrate (GTN) spray for use when people experienced chest pain and / or angina was reused for more than one patient. This raised infection control concerns. However, the trust had completed a risk assessment of its use and compared it to other preparations. They found this was best suited for use with the crews and the risk of cross infection was assessed as being low when administered by paramedics.
- Patients were given information about the medicines they had been given and why. We observed staff giving patients information about medicines and there were leaflets available for some of the more frequently used medicines.
- Staff recorded medicines given to patients. When medicines were used for a patient the staff completed a logbook to identify the patient, the medicine, the dose, the time and incident number as well as the paramedics identifying number and signature. This provided an audit trail of all medicines used by clinicians. Medicines which had been given was also recorded on the electronic patient record form. This system had replaced paper forms and was used by staff when handing over patients to other care provider such as acute hospitals or care homes.
- Ambulances carried “green pharmacy bags” used to transfer patient’s own medicines from home to hospital. This ensured they were safely handled and secure during the transfer.

Records

- Records were made and shared appropriately with staff delivering care and treatment but were not always stored securely.
- All records followed the Joint Royal Colleges Ambulance Liaison Committee and National Institute for Health and Care Excellence guidelines. The trust had also developed their own guidelines for record keeping based on current best practices.
- The trust used an electronic patient record form for most patients, but this had not been rolled out to all divisions at the time of our inspection. Where it was in place, each vehicle had an electronic pad, which was passed on at handover. This was used for accessing and recording patient care records. Staff were positive about the electronic patient record form as it provided useful information about patients with pre-existing conditions and up to date information regarding end of life planning and resuscitation. We saw one member of staff use it to refer to an earlier episode of care and treatment for a patient with complex needs. This provided the member of staff with useful information regarding the patients’ medical history
- We observed several transfers of patients’ records from the crew member who attended the incident first to the crew who were called to the incident and took the patients to hospital. Records were passed to the relevant staff at the receiving provider. We observed staff completed records in detail taking a history, during the treatment period and prior to leaving hospital. We saw staff who used the electronic patient record form print off their notes or where paper records were still being used hand over a duplicate copy to a member of hospital staff. The notes were concise and provided sufficient detail on the care and treatment provided to the patient.

- Confidential information about patients was kept safe. The electronic patient record device was kept with staff or in the vehicle. It was password protected and could not be accessed. However, we found a hand held device on an unmanned ambulance at Bournemouth Station (the crew were taking a meal break). The ambulance was open and we were able to log on to the patient records system and view confidential patient information.
- Paper records of patients care and treatment were kept in the ambulance or car until crews returned to the station. However, at Torquay station we saw log books for recording the use of morphine placed on a desk in the main garage. This did not respect the confidential and personal information of patients, as it was accessible to all staff and visitors to the garage.
- There were arrangements for recording triage decisions for major incidents or mass casualty events. Triage cards were available to staff which were nationally recognised and placed with a casualty to determine their treatment priority during a major incident.
- The trust has a policy for the management of clinical records policy, which stated how and when clinical records are to be destroyed.
- Records were shared appropriately to facilitate the safe onward management of patients. For example, a patient's electrocardiogram was shared with a hospital prior to our arrival as a result, the patient was diverted to theatre rather than the emergency department.
- An annual audit of record keeping was undertaken. The last one was undertaken in April 2015 and looked at records completed between October and December 2014. However, this did not include the north division due to variation in their processes. This looked at completion of key identification fields (incident number, vehicle call sign and date), provisional diagnosis codes, patient and incident details (presenting condition, patient age, gender, clinician details, key observations, medicines administered, conveyance destination). This showed overall an improvement had been achieved since the previous audit. Some areas had highlighted a small decrease by a couple of percent. The plan was to continue with the audits until all stations and crews were transferred over the electronic system for patients' records. The north division had their own audit undertaken in in 2014/15 for requesting of patient records and tracking of these. Recommendations were highlighted in the report and the audits will continue until the north division has electronic patient records.
- Staff did not have access to a designated computer workstation within the ambulance station on St Marys. Staff did however, have local agreement to use an area in the St Marys hospital to access information technology systems and to store records.

Assessing and responding to patient risk

- The majority of patients had their risks assessed and their safety monitored and maintained.
- Staff were able to access guidelines to assess patients. The guidelines used by the trust were based on National Institute for Health and Care Excellence and Joint Royal Colleges Ambulance Liaison Committee guidelines. Guidelines were available on the electronic patient record form and we also saw well organised and up-to-date policy folders in the stations we visited. However, clinicians working within the emergency department of two hospitals in the west division informed us the treatment of patients varied according to individual staff. We were told some crews brought patients in with intravenous fluids in place and oxygen in use whilst others did not. They added that at times the treatment had been unnecessary and inappropriate and at other times completely appropriate. We do not know if this was reported to the trust.
- We observed two separate incidents in the north division where we felt the crews had not recognised and responded to the medical symptoms the patients were displaying. We relayed these incidents to a senior manager for the north division who said they would investigate these. Staff we spoke with were confident in escalation procedures and understood the processes for requesting additional resources through ambulance control and clinical supervisors. We were told that if a team on site or while in transit needed specialist clinical advice, they could obtain this through ambulance control by asking to speak to a clinical supervisor. Staff told us this system worked well and there was always somebody to provide clinical advice when needed.
- Patients were monitored to ensure the early detection of deterioration. All patients were clinically assessed and monitored. We saw this in operation while out with the crews observing practice. On arrival at the scene, the staff all took a detailed history from the patient and their

relative/representative whilst commencing a series of physical tests and examinations. These included blood pressure, pulse, oxygen saturations and blood sugar levels. The physical observations were repeated throughout the course of the treatment and if necessary journey to hospital.

- There was an effective escalation process for deteriorating and seriously ill patients. We heard staff informing and updating acute hospitals of patients who had deteriorated during transit. This enabled the hospital to request additional resources such as staff and equipment. We saw staff request extra resources such as more staff when they were attending a patient. They contacted the operations centre and staff were quickly deployed.
- There was a mechanism to assess and manage risks when transporting patients experiencing a mental health crisis. Staff were aware of the procedures to follow when transporting patients who were experiencing mental health issues. They told us this was based on knowledge gained through their training programme which was included in the conflict resolution training.
- Staff knew how to manage disturbed or unacceptable behaviour. For example, staff we spoke with told us they had been given support from the police when they had experienced challenging behaviour from a patient.

Staffing

- The trust had a staff bank of existing employees who are willing to work extra hours. A texting system was in operation, which sends a message to all staff notifying them of the need for additional cover. A daily email was also sent out to staff regarding the availability of overtime in their area. We were also told that the service offered incentives to staff where necessary to encourage them to cover outstanding shifts. The head of operations informed us the system worked well, they always filled the available shifts, and that agency staff were not used. However, all staff we spoke with informed us there were a considerable number of unfilled shifts each week and during the unannounced inspection in the north division, we met an agency member of staff who told us they had worked a number of shifts recently.
- Actual verses planned staffing levels for April and May 2016 showed the trust was meeting their planned staffing levels 98% of the time with a 1% use of agency staff. The trust did not use a staffing tool as staffing levels were based on the needs of each division.
- Staff were not getting adequate breaks. Clinical staff and managers we spoke with informed us the service was very busy, there was little time in between calls and they did not always get their breaks. Many crews we spoke with said they were not able to take their assigned rest breaks and frequently finished late. They reported that even when they were designated to take their rest break, it was sometimes cancelled and they were called back on duty. A staff member from who contacted us prior to our inspection told us “meal breaks are after six hours on duty and we don’t get another break but finish late a lot of the time.”
- The trust monitored staff access to meal breaks in the east and west division. Historical data was not available for the north division due to different computer systems in place. Data for the period April 2013 to May 2016 showed that less than 50% of meal breaks were provided. In response to this data, and staff feedback, the meal break policy had been reviewed and re-issued on 23 May 2016, two weeks prior to our inspection. Data was not available at the time of our inspection to show if improvements had been made. However, we received mixed feedback about the new system with some staff saying it had improved and others saying it was worse than the previous system.
- Staff did not always get enough time off between shifts. Staff informed us they often worked in excess of their 12 hours shifts. This was due to starting early to check their vehicles and equipment and finishing late completing their work with a specific patient. When staff finished late and were working the following day they did not always have the 11 hour break between shifts as required by law.
- We were told there had been a reduction of mechanics in the workshops. Staff in the west division told us for one station they should have had one and a half full-time equivalent members of staff but this had been reduced to one. We were told this had been worked out on the percentage of vehicles per staff member but the

staff did not know where the figure came from. Despite a reduction in numbers, staff described servicing and maintenance of vehicles as taking increasingly longer due to additional equipment placed on the vehicles.

- Between December 2015 and May 2016, 89% to 92% of crews had a clinical member of staff on board, for example, a paramedic, advanced technician or an ambulance practitioner. This meant they were able to attend to emergency calls and provide treatment to the patients at the scene.
- Staffing was considered the biggest area of risk faced by the east division. At the east division operations meeting held in May 2016 concerns were expressed about staffing levels in North Somerset. It was recorded that the sector was struggling to put out core resources and there were particular concerns in Shepton Mallet. It was also reported that the sector was struggling to retain staff. There was a shortfall of 66 staff across the east division due to vacancies and staff absences due to sickness, maternity and secondments. This represented a shortfall of nearly 10%.
- There have been concerns raised with us about the level of paramedic cover on the Isles of Scilly. St Marys Island at all times who provided support to first responders on the off islands. However, there had been a vacant position, which had resulted in cover being provided from paramedics from stations in Cornwall. At times, the only cover available was a technician. When staff on the rota did not know the off islands, they relied on the community first responder to collect them from the quayside and take them to the casualty.
- The trust is not contracted to provide resident cover on the off islands and when it does so, this is in addition to contractual cover.The trust has informed us that responders are volunteers and as such cannot be guaranteed.Only St Marys has paid staff, all other islands are supported by volunteers when they are available. When they are not available the primary response remains with the paid staff from St Marys to attend.
- The trust acknowledges at times it was hard to cover the Isles of Scilly. A log of incidents raised on the Isles of Scilly identified that on one occasion an accident occurred on one of the off islands when there was no paramedic cover and no first responder available to respond. Another incident occurred in May 2016 on an off island when there was no community first responder to assist. This resulted in the ambulance technician experiencing a delay in accessing the casualty due to the lack of local knowledge of the island and there being no one to collect them from the boat. Concerns were also raised by staff that at times there were no community first responders on duty on some of the islands. This was in due to the reduced numbers of community first responders currently in post to provide cover. Community first responders on the Island of Tresco were on duty they used the messenger alert system so the control hub was alerted when they signed on for duty. The trust assumed the remaining islands were covered with an available community first responder unless they were informed otherwise. However, staff informed us that on two occasions they had informed the control hub there would be no one available on one island but this had not been noted and answer phone messages were left advising the community first responder of an incident. These instances had been incident reported.
- A further incident occurred in May 2016 when there was no paramedic cover on the Islands, which resulted in a casualty experiencing prolonged pain. The member of staff on duty was a technician who was not able to administer sufficient analgesia to alleviate the pain due to the extensive injuries sustained by the patient.
- The north division operations meeting in May 2016 detailed approval to appoint 60 new Emergency Care Assistants (ECA's).

Anticipated resource and capacity risks

- The service had some understanding of foreseeable risk.
- In one of the areas we visited, there had been delays at the hospital receiving patients due to excessive demand. The service had worked closely with the hospital to prevent this reoccurring. Policies and procedures had been agreed and staff reported this had reduced delays at busy times.
- However, when we asked if individual stations had business continuity plans in case of major disruption to the service not all had a documented plan.
- There was a predictable seasonal increase in population during the summer months in the west division. Despite this, staff we spoke with told us it was not routinely planned for. There was no increase in resources such as staff, equipment and vehicles.
- In Weymouth, where tourism in the summer months increased demand for the service, a paramedic was

deployed on a bicycle in order to respond quickly to appropriate emergencies in congested areas. Motorcycles were also used to respond to special events where demand was anticipated to be high.
- In the north division additional resources were put in place to help meet demand, for example, an alcohol recovery area and additional staff. During Cheltenham race week
- There were daily teleconferences held in each division to discuss a range of issues which could affect performance, including staff and vehicle availability, and the escalation status of receiving hospitals. Seasonal factors, including weather conditions were also discussed. We were able to attend the daily team telephone communication at two ambulance stations during our inspection. During one of these it was identified that were at risk of implementation of the Standard Operating Procedure (this is a procedure that is usually followed when dealing with a situation and a number of actions put in place to help rectify the situation) at a local hospital. This would be put in place and it was decided that after this call the senior member of staff would have a face-to-face meeting with the bed manager in the emergency department. We visited the hospital with the senior member of staff and had a discussion with the bed manager about what was in place to help the crews hand over patients.

Response to major incidents

- Staff we spoke with were aware of what their role would be in a major incident. However, not all staff had participated in rehearsals or desktop exercises. A major incident is an event whose impact cannot be handled within routine service arrangements. It requires the implementation of special procedures by one or more of the emergency services, the NHS or a local authority to respond to it. Any incident is considered to be major if the number, severity or type of live casualties; or its location, requires extraordinary response measures. Management staff attended The Joint Emergency Services Interoperability Programme training. This training facilitated the blue light services to work together effectively in response to major or complex incidents. Two senior staff we spoke with had attended a four-day course on responding to major incidents run by the National Resilience Ambulance Unit. However, some staff said they had not received any specific training. Senior staff in the north division told us that the training they were provided with was not sufficient for their role as a bronze commander. They said feedback had been given to the trust but no changes had been made to the training and if they did training by another provider, it was not recognised by the trust. In the event of a major incident specialist teams such as the Hazardous Area Support Team (HART) would be contacted and their role would be to provide additional support and where needed use their skills.
- Vehicles contained a major incident pack. We were shown the pack and it included equipment for trauma management and equipment to be used where a patient had suffered major blood loss. Prompt cards were also contained in the vehicles, which had been produced by the National Ambulance Resilience Unit for staff to use during a major incident.

Are emergency and urgent care services effective?

(for example, treatment is effective)

Requires improvement

We rated the effectiveness of the trust's emergency and urgent care services as requires improvement because:

- Response times for most categories were consistently below the England average. The proportion of Red 2 calls responded to within 8 minutes was worse than the England average from April 2015 to January 2016. The trust had not met the national target of 75% since October 2014. From May 2015 the data provided showed a steady decline in performance against the target from 73.2% to 63.3%.
- From February 2015 to January 2016 the proportion of A19 calls responded to within 19 minutes was mainly worse than the England average. The national standard of 95% was not met for 10 of these 12 months.
- From April to October 2015 the average proportion of patients who received angioplasty (unblocking of a coronary artery) following ST segment elevation myocardial infarction within 150 minutes was worse than the national average.
- The average proportion of patients assessed face to face who received an appropriate stroke or transient ischaemic attack care bundle in April to October 2015 was worse than the national average.

- The rate of annual performance appraisals was variable ranging from 38.4% for specialist paramedics to 87.7% for paramedics. This was below the trust target of 90%. The quality of the appraisals was also variable.
- Not all staff were competent in providing treatment and care to patients with mental health issues.

However:

- The proportion of Red 1 calls responded to within 8 minutes was better than the England average for 16 out of 19 months between July 2014 and January 2016.
- From April to October 2015 the average proportion of patients with ST elevation myocardial infarction who received an appropriate care bundle was better than the national average.
- The service provided evidence based care and treatment in line with national guidelines such as the Joint Royal Colleges Ambulance Liaison Committee and the National Institute for Health and Care Excellence.
- The trust had developed an initiative to reduce the number of patient transfers to hospitals. There were pathways to prevent hospital transfers and staff had received additional training to enable them to treat patients at home. This had reduced the number of hospital transfers.
- We observed good multidisciplinary working. Consent was obtained from patients prior to treatment or care being given.

Evidence-based care and treatment

- The service was provided in line with national guidelines including the National Institute for Health and Care Excellence (NICE) and the Joint Royal Colleges Ambulance Liaison Committee (JRCALC). Clinical staff had access to personal clinical guidance folders. Guidelines included pathways for the assessment and management of patients presenting with acute onset stroke symptoms and suspected transient ischaemic attack. We saw up to date, organised policy folders in stations which were also available on the electronic patient record form. JRCALC was routinely used. However the trust were planning to develop their own guidance and pathways in partnership with hospital trusts which reflected local variations.
- We reviewed four policies on the trust intranet page and found they were all in date. Staff were able to access the system to view the policies and procedures at stations. However, some staff told us they did not always have the time to do this.
- Revised guidance and policies were distributed throughout the trust by email on a Wednesday unless urgent. This was part of the 'Change Wednesday' initiative which aimed to reduce the number of emails throughout the week. Staff said this helped them to focus on the areas where change had been introduced. Some staff told us there had been significant changes and it was sometimes hard to keep up with these as they had to read their emails between busy shifts in their own time which was not always possible.
- Patients were supported at home in accordance with both JRCALC and NICE guidelines when it was safe to do so. For example, paramedics could supply a course of corticosteroids to patients who had recovered following an asthma attack. Suitable patients who had experienced a suspected transient ischaemic attack could be referred directly to an outpatient clinic.
- Treatment was provided to patients following trust policies and nationally recognised guidelines. For example, we saw care given to a patient in accordance with the British Thoracic Society guidelines for people with chronic obstructive pulmonary disease. We also observed a paramedic using NICE guidance for the care of a patient following a seizure.
- There was a policy for patients experiencing mental health issues. This included information for transporting patients appropriately. Staff we spoke with said they had received training and were able to describe the actions they would take in these circumstances. Staff told us patients with mental health problems would be accompanied by their carer or a relative. There was an agreement with local police forces in the east and west divisions which covered all aspects of interagency working however, these were not present in the north division. Here options for mental health patients were more limited and we were informed they were sometimes inappropriately transferred to hospital emergency departments.
- The service ensured patients went to the most appropriate hospital for treatment. In one area the ambulance service was working with the hospital to admit frail elderly patients directly to an appropriate

assessment ward. The trust also had direct access to specialist stroke services and pathways for admitting patients to these were outlined in the trust clinical guidelines.
- Suitable guidelines and protocols were available for children. We saw up-to-date policies for treating children and staff were able to describe how they would care for children.

Assessment and planning of care

- Enhanced clinical advice and support was available to staff. Staff we spoke with told us if specialist clinical advice was needed they would contact the clinical hub and speak with a clinical supervisor. They told us this system worked well and there was usually somebody to provide clinical advice when needed.
- Staff could explain the procedure for not conveying patients to hospital and providing 'see and treat' care instead. There were pathways to reduce the number of unnecessary transfers to hospital. For example, the trust had supported staff to complete additional training regarding wound care. We saw immediate first aid and wound care being provided to a patient in their own home by a paramedic. Further treatment was required and the specialist wound care paramedic was called to attend to the patient rather than transferring them to hospital. Staff and patients we spoke with were positive about this system.
- We observed paramedics liaise with providers of social care services when, following assessment, it was evident patients did not need to be taken to hospital or anywhere else for treatment. We accompanied ambulance crews called to patients in their home. They assessed the patient and suggested alternative treatment, which meant patients were not taken to hospital. For example, a person living with dementia had called an ambulance, the crew spoke with the patient's relative via telephone and with the GP and a decision was made that the patient was safe left in their own environment. In another example a different crew arranged an appointment with the patient's GP and diabetic nurse with the consent of the patient; the crew also informed the patient's relatives/carers and explained treatment options. This meant the patient could stay in their home and did not need to go to hospital. We spoke with some ambulance crews outside hospital emergency departments who said they do not always transfer patients to hospital if clinical need did not indicate this as being necessary.
- Staff were usually alerted through the electronic patient record form of patients with a mental health problem. We observed staff treating a patient with mental health problems and they followed trust policies and guidelines in the delivery of that care.
- Staff we spoke with were knowledgeable regarding stroke pathways which ensured patients received prompt and appropriate treatment. Agreements were in place and patients who were assessed as suffering a stroke were transported directly to the computerised tomography (CT) scanner as opposed to the emergency department. A CT scanner uses a computer to take data from several x-ray images of structures inside the body and converts them into pictures on a monitor. This enables clinicians to monitor the degree and extent of damage potentially caused by a stroke and ensures appropriate treatment could commence without delay.

Response times

- The trust was one of only two trusts nationally piloting a new system of response called the Ambulance Response Programme (ARP). This aimed to improve response times to critically ill patients by allocating resources appropriately when patients initially contacted the service. The impact on patient care and trust performance as a result of these changes was reviewed internally on a daily basis and reviewed nationally within the ARP Working Group on a weekly basis. The data provided by the trust would be used to help inform further national developments. Since the introduction of the ARP the trust was reviewing all areas of resource dispatch and response times to ensure the most appropriate responses were made based on the clinical need of the patient. The results of the project were not known at time of inspection.
- Calls to the service which were immediately life threatening such as cardiac arrest were termed Red 1. Red 1 calls required a nationally agreed response time within eight minutes and the target for compliance was 75% or above. From July 2014 to January 2016, the proportion of Red 1 calls responded to by the trust within eight minutes was better than the England average for 16 out of 19 months. The trust met or exceeded the national compliance target of 75% for six

months in this period. However, since October 2015, the trust data showed there has been a steady decline in performance against the national target from 73.3% to 69.9%.

- Calls which were serious but not the most life threatening such as chest pain were termed Red 2. As for Red 1 calls, these also required a nationally agreed response time within eight minutes and the target for compliance was 75% or above. From April 2015 to January 2016, the proportion of Red 2 calls responded to by the trust within eight minutes was worse than the England average. The trust had not met the national target of 75% since October 2014 and from May 2015, the trust data showed a steady decline in performance against this target from 73.2% to 63.3%. Red 2 performance has been impacted by the introduction of the ARP. The Trust had national agreement that recognised this impact for performance management purposes and the target has been reduced to 70%. However, from August 2015 to January 2016, the trust had not met the new reduced target of 70%.
- If Red 1 or Red 2 calls were initially attended by a single clinician in a rapid response vehicle and onward conveyancing of the patient was required by a double crewed ambulance, the national target states an ambulance should arrive on the scene to undertake the conveyance within 19 minutes in 95% of cases. These were termed A19 calls. From February 2015 to January 2016 the proportion of A19 calls responded to within 19 minutes by the trust was mainly worse than the England average and the national standard of 95% was not met for 10 of the 12 months. From May 2015, the trust data showed a steady decline in performance against this target from 95.3% to 91.1%.
- Calls where presenting conditions were serious but not life threatening were divided into four categories, Green 1, 2, 3 and 4. Green call response times were locally agreed as there were no nationally agreed targets.
- Calls where presenting conditions were serious but not life threatening were termed Green 1 and required a locally agreed emergency response time within 20 minutes. The target for compliance to the response times was 90%. From April 2015 to February 2016, the trust did not meet this target with compliance rates ranging from 75.4% to 82.7%.
- Green 2 calls were classified as serious but with a lesser clinical need than Green 1. These calls had a locally agreed emergency response time of within 30 minutes and the target for compliance was 90%. From April 2015 to February 2016, the trust did not meet this target with compliance rates ranging from 62.6% to 80.9%. From April 2015 to February 2016 there had been a steady decline in performance against the locally agreed target from 77.9% to 62.6%.
- The least serious emergency calls were categorised as Green 3. These calls required a locally agreed emergency response within 60 minutes or a telephone assessment within 30 minutes. The target for compliance was 90%. From April 2015 to February 2016 the trust met or exceeded the target in five months with compliance rates ranging from 88.1% to 95%.
- Green 4 calls were categorised as not requiring an emergency response and would receive a locally agreed clinical response within 60 minutes. The trust target for compliance was 90%. From April 2015 to February 2016 the trust did not meet the target and compliance ranged from 62.9% to 74.2%.
- There was a further Green 4 call category for transport requested by hospitals or other healthcare professionals such as GP's. This category was called Green 4 (HPC) and the locally agreed trust target for compliance for these calls was 70%. However, from April 2015 to February 2016 the trust did not meet the target. Compliance rates ranged from 67.8% to 54% with a steady decline in performance from July 2015 where it was 66.1% to 54% in February 2016.
- The trust introduced a 'Measures to Improve Performance' plan in 2015. This plan aimed to improve performance through a variety of actions including introducing procedures and processes to improve efficiency such as ARP and reducing handover delays at hospitals.
- 'Right care, right place, right time' was introduced to ensure the most appropriate care was given to patients. It ensured patients received the best possible care in the most appropriate place and at the right time. It aimed to deliver more care, where appropriate, closer to home by training staff in aspects of treatment such as wound care and the management of long term conditions. This would reduce the time taken to treat patients by avoiding unnecessary transfers to hospital.
- Handover delays at hospitals were managed locally on a daily basis and there were agreed escalation procedures. In the west division, a standard operating procedure had been agreed with one of the local hospitals and as ambulance staff had been experiencing

delays, this was in effect at the time of our inspection. Staff we spoke with said the operating procedure worked well and reduced delays during the periods it was applied. The trust was also working closely with NHS commissioners and hospitals where long delays were experienced.

Pain relief

- Patients we spoke with told us they were asked about their pain and appropriate pain relief was offered and provided in a timely way.
- The Wong-Baker pain assessment scale was used to assess pain in children. The scale used images of faces to help children communicate their pain. This was printed on the back of every patient clinical record with a pain scoring section in the patient observation box. Advice on the management of pain in children was set out in the trust Paediatric Care Policy (2009). Clinicians were advised they should consider seeking advice, admission or the attendance of a clinician with more advanced skills if the management of a patient was beyond their skills. An audit of pain relief in children was carried out in 2013; however, the status of this audit was unclear and there were no recommendations arising from it.
- There was an appropriate pain assessment tool used for patients with communication difficulties, such as patients living with dementia.
- The trust had Patient Group Directives (PGD's) which increased the range of pain relief available for staff to give to patients. Based on the findings from assessment, pain relief was administered according to the severity of pain. We observed a variety of pain relief being used including glyceryl trinitrate spray for angina, nitrous oxide gas, oral morphine and morphine for injection.
- Nursing staff we spoke with at receiving hospitals were happy with the level of information provided by ambulance crews in relation to pain assessment and the pain relief administered.
- An audit of the management of a sample of patients in the east division with suspected fractured neck of femur who used the service in March 2013 showed of 126 cases where the patient was in pain, 83% had a pre and post intervention pain score recorded and 84% of cases received some form of pain relief. A number of recommendations were made following the audit including conducting a similar audit in other divisions and the trust had also undertaken an awareness campaign. As a result of this audit the clinical guideline 'Pain Management' was issued in October 2014 and the audit and results from it were published on the trust intranet for staff information.

Patient outcomes

- The trust routinely collected information about patient care and treatment. The quality of care and patient outcomes were measured using Ambulance Clinical Quality Indicators. The trust gathered and monitored information on patient care and outcomes from heart attacks and strokes.
- Heart attack or ST segment elevation myocardial infarction (STEMI) is caused by a prolonged period of blocked blood supply within the coronary arteries. Reductions in STEMI mortality and morbidity is influenced by those patients who received the appropriate care bundle, those who have timely delivery to the cardiac catheter lab for intervention, and those who have timely thrombolysis or clot busting medicines.
- The trust average proportion of patients with STEMI who received an appropriate care bundle from April to October 2015 was 83%. This was worse than the locally agreed performance threshold of 90% and better than the national average of 78.3%.
- Between April and October 2015, the trust average proportion of patients who received angioplasty (unblocking of a coronary artery) within 150 minutes was 75.8%. This was worse than the locally agreed performance threshold of 84% and worse than the national average of 86.7%.
- Following a cardiac arrest, the return of spontaneous circulation (ROSC) (for example signs of breathing, coughing or movement and a palpable pulse or measurable blood pressure) is a main objective for all out of hospital cardiac arrests and can be achieved through immediate and effective treatment at the scene.
- From April to October 2015, the trust average proportion of cardiac arrest patients with ROSC at the time of arrival at hospital was 25%. This was better than the locally agreed threshold of 24%.
- The Utstein comparator group provides a more comparable and specific measure of the management of cardiac arrests for the subset of patients where timely and effective emergency care can particularly improve survival. For example, 999 calls where the arrest was not

witnessed, and the patient may have gone into arrest several hours before the 999 call are included in the figures for all patients, but are excluded from the Utstein comparator group figure.

- Using the Utstein comparator group, from April to October 2015 at the time of arrival at hospital the trust average number of patients with ROSC following cardiac arrest was 50.2%. This was better than the locally agreed threshold of 45%.
- Coronary heart disease (CHD) is the single most common cause of death in the UK today, and the most common underlying condition that causes patients to die as a result of this is cardiac arrest. The presence of a paramedic (or doctor) significantly improves response to, and outcome from, a cardiac arrest, as the paramedic or doctor on scene can begin Advanced Life Support. By including both out of hospital and in-hospital periods of care, this measure reflects the effectiveness of the whole acute healthcare system in managing out of hospital cardiac arrest, reflecting the care delivered by both ambulance services and acute trusts. Survival to discharge is calculated for two patient groups; the overall group, and the same Utstein comparator group.
- For this trust, the average proportion of all patients from April to October 2015 discharged alive from hospital following cardiac arrest was 9.1%. This was slightly better than the national average of 9.0% and the locally agreed threshold of 9%. However, the trust average proportion of the Utstein comparator group who were discharged alive in the same period was 27.7%. This was worse than the national average of 29.1% but better than the locally agreed threshold of 27%.
- As set out in the National Institute for Health and Care Excellence national quality standard, the health outcomes of patients can be improved by recognising the symptoms of a stroke or transient ischaemic attack, making a diagnosis quickly, and early transport of a patient to a stroke centre capable of conducting further definitive care including brain scans and thrombolysis. The proportion of patients in this trust who were transported to a stroke centre capable of delivering thrombolysis within 60 minutes from April to October 2015 was 45.7%. This was worse than the locally agreed threshold of 57%. The trust reported performance against this threshold was challenging due to the rurality of the area it covered and longer travelling distances to stroke centres.
- The trust average proportion of patients assessed face to face who received an appropriate stroke or transient ischaemic attack care bundle in April to October 2015 was 96.8%. This was worse than the national average of 97.7% and worse than the locally agreed performance threshold of 97%.
- The trust informed the inspection team that their research and audit team were working with ambulance staff to improve pre-hospital care for a range of medical emergencies including STEMI, stroke and cardiac arrest. They had recruited a full time lead quality improvement paramedic and two part time quality improvement paramedics into their research, audit and quality improvement team. In addition, three clinical development officers had been allocated one day each to assist with clinical quality improvement activities. The research, audit and quality improvement team used established quality improvement methods which aimed to engage ambulance staff in identifying barriers to achieving targets and developing interventions to overcome them.

Competent staff

- New staff were provided with a corporate trust and local induction prior to working alone or as part of a double crew. We were told the local induction consisted of a day in the station, three days observing on shifts and one month working with another paramedic. Following this staff were considered to be fully operational however, a member of staff we spoke with said they did not feel confident to be fully operational following the induction period.
- We observed a trainer providing a teaching and learning session for a crew member of staff regarding the electronic patient record. This was delivered on a one to one basis as the member of staff had missed their initial training due to annual leave. We observed part of the training and found the trainer to be enthusiastic and positive about the subject matter which transferred to the student
- Staff were required to complete an annual performance appraisal (re-named career conversations in 2016). We received varied comments regarding the quality of these. One member of staff commented they had not had an appraisal for three years and when they had discussed this with their line manager they were told it had been done. This did not demonstrate a two way discussion between the staff member and their

manager regarding their training and development needs. Another member of staff showed us the booklet they completed as part of their appraisal. This had been completed by the member of staff and their manager but there was no specified training or career development pathways identified. The appraisal system was not role specific and some staff felt there was no training or career development available for their role.

- The rate of appraisals across the range of staff we spoke with was variable. Some staff appraisals were up-to-date however others reported they had not had an appraisal for between two and six years. Data provided by the trust showed from April 2015 to March 2016 compliance ranged from 38.4% for specialist paramedics to 87.4% for paramedics. Administration and managerial staff compliance was 41.6%.
- Staff working in small or remote teams were supported. Staff we spoke with who worked in smaller rural stations said they were well supported by their managers and had received an appraisal in the last year. They were kept informed of training opportunities and knew members of staff who had accessed these.
- A nurse revalidation policy was introduced by the head of nursing in 2015 to manage revalidation for the nurses and midwives employed across the trust. The trust was also holding revalidation workshops to provide support for nurses and midwives and we saw these advertised in the trust weekly newsletter.
- Training facilities were available. Staff from all stations had access to a fully equipped training room in one of the larger ambulance stations in their area. They were able to book a session with a learning development officer in the training room to update their skills. Themed workshops were also available to all staff at the training centre for example, life support for children and airway management.
- Additional role specific training was available. The trust told us there was a range of educational and developmental opportunities provided for staff as part of the 'GROW' element of the trust's 'Aspire' initiative. Part of the Aspire initiative was an intranet website designed to help staff develop their career by providing them with information and tools. In 2015 sixty five paramedics devoted eight days of their own time to achieve degree level accredited module on patient assessment and 270 paramedics attended a one day course on wound management. Other courses attended included emergency obstetrics, advanced life support, cancer and end of life care. All courses were publicised on the trust website and some were available as part of normal working hours. We also saw courses were publicised on staff noticeboards in ambulance stations. Emergency care assistants (ECA) were able to gain a level three diploma award during their first year of employment. The trust was the first to offer ECAs a nationally accredited award as a standard. There were also two ECA to paramedic conversion courses, one full time and a second undertaken by distance learning.
- Opportunities to access professional development training was variable. Some staff raised concerns about the lack of additional role specific training which was available to them. Some staff we spoke with acknowledged the educational opportunities available but many were unhappy they had to complete training in their own time and some courses were not funded. However, other staff we spoke with said they were offered extra training courses which were paid for by the trust and attended in work time.
- In the 2015 NHS staff survey 76% of respondents reported that the organisation provided equal opportunities for career progression or promotion. This was better than the national average for ambulance trusts. However, a number of staff we spoke with told us that they were prevented from accessing continuing professional development because they would have to part-fund their training or undertake it in their own time. One paramedic told us they had been made aware of educational opportunities during their career conversation but their personal circumstances did not allow them to access these opportunities because they had to be pursued in their own time. A technician told us that although they worked as the lead clinician on 40% of their shifts their role was not recognised in the same way as a paramedic. They told us they were unable to progress to become a paramedic because they would have to undertake the conversion course in their own time.
- Staff received training to support a patient with mental health problems including legal powers relating to transporting these patients. Staff we spoke with had attended the training sessions and were able to describe how they would manage patients with mental health problems. However, some staff said they would benefit from more training in this.
- The trust provided training to community first responders regarding the equipment they would be

expected to use during the course of their duties. A learning log was provided for each piece of equipment to identify that the responder was deemed competent in its use. For example, moving and handling equipment and the use of Nitrous Oxide.
- A weekly meeting / training session was available to community first responders on the Isles of Scilly. We were provided with a programme of available dates for responders to attend on St Marys Island.
- Staff commented that when they attended the weekly training sessions they were useful and a range of topics covered. Electronic training materials were used to deliver information during these sessions.

Coordination with other providers

- Staff were very clear about acute pathways, such as cardiac and stroke care. However, staff told us there were limited options available to them in relation to mental health patients, especially at night and at weekends.
- Patients were transported to the appropriate service based on their needs. We were told when a patient had suspected stroke they were transported directly to the CT scanner to reduce a delay in treatment through waiting at the emergency department.
- The trust had taken steps to reduce unnecessary journeys to the emergency department. In 2010 the trust developed the 'Right care, right place, right time' initiative. This was a commissioner funded agreement which committed the trust to reduce admissions by 10%. Paramedics were provided with education to enhance their skills in patient examination and diagnosis. The proportion of 999 calls managed without emergency department attendance increased from 50.8% in 20110/11 to 56.8% in March 2016. This equated to a reduction in emergency department attendances of 15,523 in this period despite an increase in demand of 9.7%.
- There were right care champions appointed throughout the service. All staff were encouraged to report issues which prevented them delivering the right care in the right place at the right time. Feedback could be submitted via email, via the hand held electronic patient care record form devices or using feedback cards available on stations. Emergency department staff were also encouraged to provide feedback, for example when a patient was brought into the department because no appropriate alternative pathways were accessible.
- There were arrangements with independent providers to support the emergency and urgent care service. Contracts for third party providers outlined their roles and responsibilities for supporting the emergency and urgent care service. A member of staff we spoke with told us they regularly worked with a third party provider and had not experienced any problems with their service.
- The trust regularly met with other stakeholders such as clinical commissioning groups, commissioning support units, patient representatives and local acute hospitals. They discussed performance including patient handover times at local hospitals and new systems and improvements which were being implemented by the trust.
- There were arrangements for the service to work with other agencies such as the police, acute hospitals, coastguard, RNLI and fire and rescue service. Staff we spoke with were very positive about their professional working relationships and links with other agencies. Two members of staff told us they attended a monthly Local Safety Advisory Group meeting with local police and fire and rescue service. This had helped with team building across the services.
- The trust was part of the national memorandum of understanding in the provision of mutual aid. This is a framework through which NHS Ambulance Trusts jointly agree to provide assistance on a national scale in the event of a major incident.

Multidisciplinary working

- We saw effective handovers between ambulance and hospital staff. The trust policy was for clinical staff to handover care to emergency departments using a specified model called ATMIST. The initials stood for age, time, mechanisms, injuries, signs, treatment and ensured information relevant to the patient was passed on. We observed a number of handovers at emergency departments. We saw these provided emergency departments staff with detailed information regarding the patient when the trust policy was followed. However, on two handovers the model was not followed and the staff had to ask further questions to receive the full information about the patient. Most of the

emergency department's staff we spoke with at the hospitals told us the handovers were appropriate for the level of need of the patient. There were good cooperative relationships with the ambulance service and the two services provided mutual support when operational pressures affected patient flow. Ambulance staff were described by a member of emergency department's staff as "polite, helpful and professional".

- At one station, staff reported there had been a reduction in handover time at the acute hospital due to the work the services had carried out together. A standard operating procedure had been agreed to reduce delays at busy times and ambulance crews reported this had worked well.

Access to information

- The trust used electronic patient care records. Clinical control rooms took the initial emergency telephone call and sent the information from the call electronically to the ambulance crews which they received on a handheld, password protected device. Staff told us the quality of information provided to them by the clinical control room was improving and they acknowledged it was mostly as good as the information provided by the caller. Staff we spoke with said they would ask the patient or their relatives to confirm any advanced care plans or 'do not attempt cardio pulmonary resuscitation' orders on arrival even if they had received this through the electronic patient care record system.
- The electronic patient record system allowed staff to view patients' previous history in terms of their engagement with the ambulance service and special notes about their presenting condition. The system also allowed them to transmit real time information about a patient's condition to receiving hospitals. However, it was reported there were sometimes signal problems which affected the transmission of information to and from the system. A staff member also told us the devices had a poor battery life and there had been occasions when the system had crashed. There was also an issue where they could not make a diagnosis due to being unable to obtain an electrocardiogram. This issue was not on the trust risk register. However, the electronic patient record system was managed and any deficiencies were reported and action was taken to resolve them. The issues around connectivity were being investigated. Information could still be added when there was no signal and the record was updated when the signal returned. Further resilience had been provided by linking into all acute trust internal wifi systems so any national failure of mobile communications could still be overcome.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were clear about their responsibility to obtain consent for care and treatment. We witnessed ambulance crews explaining care and treatment and obtaining consent. Some staff were less clear about assessing mental capacity to provide consent and the requirements of the Mental Capacity Act 2005. The trust had a policy regarding the Mental Capacity Act and there was guidance for staff in the form of a leaflet 'assessing capacity' which set out the requirements of the Mental Capacity Act 2005. The leaflet also had information to help crews decide if a patient lacked capacity to give consent. Guidance could also be accessed via the hand held electronic patient care record device. An ambulance crew in one station spoke very knowledgably about the process; however, a staff member we accompanied in another area did not use this tool when it was indicated. All patients we spoke with said their consent had been gained prior to any treatment.
- Staff received training to support a patient with mental health problems including legal powers relating to transporting these patients. There was guidance and training available for staff however, training records showed that only 79% of all trust staff had completed mental capacity training. Some staff we spoke with had attended training sessions and were able to describe how they would manage patients with mental health problems. They told us patients with mental health problems would be accompanied by their carer or a relative and the police could be called for any situations where further assistance was required. Two members of staff told us about an incident where they had transported a patient with mental health issues to a place of safety with support from the police. The actions they had taken followed the trust guidelines, however, some staff said they would benefit from more training in this.
- For unaccompanied patients or those who were unconscious staff we spoke with said they acted in the patients' best interest and were able to explain the

process. When a patient was unable to give consent due to confusion a mental capacity assessment was completed and recorded on the electronic patient record form. Some staff we spoke with were able to describe an assessment tool they used called CURE (communicate, understand, response, evaluate) to assess a patients capacity. An ambulance crew in one station spoke very knowledgably about the assessment process; however, a staff member we accompanied in another area did not use this assessment when it was indicated. Most staff said they would assess capacity using the approved Mental Capacity Act 2005 and were able to explain this.

- Some staff we spoke with were knowledgeable about Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act (MCA). They said they had received training at their induction and yearly mandatory training updates however, others said they had not received any training in DoLS and MCA.

Are emergency and urgent care services caring?

Outstanding ☆

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

We rated caring for the emergency and urgent care service as outstanding because:

- Feedback from patients and those close to them was consistently very positive. We accompanied crews on emergency and urgent calls and spoke with patients and relatives in emergency departments. Without exception, patients, relatives and other healthcare professionals told us that ambulance staff acted with care and compassion.
- Staff were passionate about their patients' care and wellbeing. We saw numerous examples where staff 'went the extra mile' to ensure their patients' comfort and wellbeing.
- Staff adopted a person-centred approach when attending to patients and supporting those close to them. Staff considered the needs of the individual and took actions to promote their dignity, showed consideration for individual preferences and promoted independence by actively involving patients in decisions about their care and treatment.
- Staff demonstrated their commitment to working in partnership with patients and those close to them. By working with patients staff sought to empower and encourage patients to make decisions about their care and when appropriate patient were supported to manage their own health by using non-emergency services, such as their GP.
- Staff took time to interact with patients; they were friendly and used appropriate humour to ease patients' anxiety.
- Relatives and people close to patients were not forgotten. They told us that they were kept well informed, and were involved in decisions about their loved ones' care. They told us they received emotional support and reassurance.
- Staff treated patients with compassion and respect, whatever their circumstances. Staff showed a non-judgemental approach to patients and those close to them.
- Staff always considered patients' privacy and dignity. They showed creativity in some difficult circumstances, to ensure that privacy and dignity were maintained at all times.
- Regard for patients emotional and social needs were embedded in the way staff cared for all patients regardless of their circumstances.

Compassionate care

- Staff were kind and caring and showed empathy and understanding to both patients and their relatives or representatives. We observed staff delivering compassionate care in ambulances, patients' homes and in the hospital emergency departments. Staff were polite and courteous to patients and their relatives or carers. We spoke with patients and relatives. They consistently gave positive feedback and spoke very highly of the ambulance staff, and the care and treatment they had received. Comments included,
  - "Extremely kind, efficient and supportive. Very, very thorough. Couldn't have been better to me and my mum".
  - "Brilliant service, everyone kind, sympathetic, gentle and friendly".
  - "Excellent five star service"

  - "I was treated with respect and dignity, just like last time, amazing service – couldn't have done more".
- Handovers were conducted in a way that supported patient confidentiality and privacy, and where possible, involved patients and their relatives.
- Staff took time to interact with patients and their relatives/carers and frequently 'went the extra mile' to ensure patients' wellbeing. We accompanied a crew called to a patient's home. The patient lived on their own and conveyance to an emergency department was not required. Staff spent a considerable amount of time reassuring the patient, who was anxious, and arranged for appropriate support from the GP surgery. Staff made the patient a sandwich because they had not eaten, before they left.
- Staff showed an encouraging, sensitive and supportive attitude to patients and their relatives/carer. We saw many examples of this. One patient, who had used the service twice in the last six months, described the ambulance crew as "brilliant". They said both crews were "warm and friendly and also professional". They told us one of the ambulance crew had made an effort to find them in the emergency department cubicle to say goodbye and to wish them well. A further patient described an ambulance crew as "smashing". They told us "They were friendly and well mannered. They explained everything".
- In Wiltshire, we observed outstanding and non-judgemental care and treatment provided to a homeless person. Staff were professional, yet compassionate, in the manner they applied appropriate levels of assessment for the location and the condition of the patient. The crew excelled in the way they obtained consent for treatment and to transport the patient to a hospital facility. The staff delivered outstanding care, despite a recent encounter with the same person when a conflict had occurred.
- Staff treated patients with dignity and respect. Staff introduced themselves and checked how people wished to be addressed. Staff closed the rear doors of the ambulance while emergency treatment and tests were taking place prior to leaving the scene of the incident. This prevented passers by being able to see inside the vehicle.
- Staff used blankets to cover patients at the scene of incidents and when removing or disturbing clothing to carry out tests. Staff covered patients with a blanket, while transferring them to hospital, to maintain their dignity and keep them warm. We observed ambulance staff maintaining the dignity of patients when they transferred them from a stretcher or a wheelchair to a hospital bed.
- We saw examples of staff taking creative steps to preserve patients' dignity. At the scene of an accident in a public place, staff used mobile screens that a school provided, to maintain the patient's dignity, as far as possible.
- A patient, who had an electrocardiogram (a test which measures the electrical activity of the heart and entails sensors being attached to the skin) performed in the ambulance, was asked if they would prefer a staff member of the same gender to perform the test.
- The trust had a standard operating procedure with information about additional support and additional equipment to help staff care for bariatric patients (patients who are very overweight). At ambulance stations, we saw designated stretchers to help staff convey bariatric patients to hospital. We accompanied a crew attending to a patient who had fallen in the shower. The crew called for backup staff to help safely move the patient into the ambulance. Staff took care to uphold the patient's dignity at all times and reassured the patient.
- A nurse at a hospital in North Somerset told us that ambulance staff were attentive and caring. They told us ambulance staff often asked about the well-being of patients they had brought into the emergency department earlier in their shift.
- Staff responded to patients experiencing pain, discomfort and emotional distress in a compassionate, timely and appropriate manner in most cases. However, we accompanied one crew attending a patient with a suspected back injury. The crew did not offer any additional pain relief to the patient as they had already taken their own painkillers, despite signs that they were was in pain.
- Staff attended to patients, in the presence of a relative or carer, with compassion and professionalism. A crew responded to a 999 call and introduced themselves to the patient and their family. Staff assessed the patient after gaining consent. They spoke with the patient about what they were doing. Staff noted the patient's level of confusion and ensured this did not prevent them from explaining what they were doing and checking that the patient understood. Staff used appropriate humour to

help put the patient at ease. They encouraged the patient to mobilise and manage independently, where possible and appropriate, and reassured the patient throughout.
- A patient told us the care they had received was very good. They told us the staff had explained everything and "even made sure the dog was ok before leaving the house".

Understanding and involvement of patients and those close to

- Staff recognised when patients and their relatives needed additional support to help them be involved in their care and treatment. Staff took time to support patients, relatives and other parties during distressing events. A patient who had used the service three times recently told us that all of the staff were "lovely". Their relative told us the ambulance staff were "caring and courteous". They said the crew took time to reassure them as well as the patient. They said, "I would give them 20 out of 10."
- We saw ambulance crews took time and care to explain proposed treatment and options to patients and their relatives. Patients told us that ambulance staff explained things in a way they could understand.
- In North Somerset, we accompanied a crew to attend a patient who did not speak English, which meant the crew had to communicate through a family member. The family member travelled with the patient to the hospital to ensure effective communication during the journey. The crew demonstrated excellent communication and compassion.
- Friends and family test results for the month of December 2015 were largely positive, with 40 out of 46 respondents saying they were likely or extremely likely to recommend the service. Three respondents indicated they were unlikely or extremely unlikely to recommend the service and one respondent said they did not know. However, the number of responses represented a very small sample (0.4% of patients who used the service during that month).
- NHS England reported data for the 'see and treat' service as part of the emergency and urgent care services. Friends and family results for October 2015 to April 2016 showed the majority of patients would recommend the service to friends and family (range 70% & to 94%). However, the response rate again was very low, the average was less than 0.1%.
- Ambulance crews spoke to patients in a kind and supportive manner while treating them. We overheard crews interacting with patients on a personal level and chatting to them in a reassuring way. We observed staff talking to patients and relatives while waiting to give handover in a calm, unhurried way, answering questions where they could and providing reassurance.
- We spoke with two police officers in an emergency department in Devon, who had accompanied a patient detained under the Mental Health Act. They said they were impressed with the care and treatment given to the detained patient on the way to the hospital. The police officers stated the ambulance crew were professional and treated the patient with equal compassion, dignity and respect. They told us earlier that day they had accompanied another patient with significant mental health needs. They had been impressed with the care and treatment given to the patient by the ambulance crew. The crew cared for the patient in a manner that was not influenced by any preconceived prejudice. They told us their experiences with ambulance crews were usually positive.
- We observed staff conduct handovers to other health professionals in a way that supported patient confidentiality and privacy, and where possible, they involved the patient and their relatives.
- Staff considered patients' views and obtained consent. We consistently observed patients being involved in decisions about their care and treatment. Staff gave clear explanations of treatments and procedures to patients and ensured patients understood information by using gentle questioning.
- Friends and family were involved and invited to accompany patients transferring to a hospital. We observed staff taking time to explain to patients and their relatives or representatives what was happening and what care and treatment they proposed.
- We attended one emergency call to a patient who was unable to communicate verbally. The staff member clearly explained the treatment to the patient and sought non-verbal responses and consent from the patient.

Emotional support

Emergency and urgent care services

- Staff gave appropriate and timely support and information to help patients and their relatives cope emotionally. They supported patients, relatives and other parties during distressing events. One patient told us that the ambulance crew, who had attended them, "took time to reassure both me and my relative." A patient's friend, who was with them when they collapsed in a public place, told us how the ambulance crew had cared for them too.
- Some staff used appropriate humour to reduce people's anxiety levels and we witnessed friendly banter between patients and ambulance staff.
- A patient in Dorset told us they had been very frightened and the ambulance crew talked to them all the way to hospital, constantly reassuring them. We saw staff speak appropriately with a child who had been involved in an accident; they used a teddy bear to build a rapport with them.
- Staff supported patients, relatives and other parties during distressing events. We accompanied an ambulance crew to an incident at a school. We observed the crew providing reassurance and support to the school staff, while attending to the patient, both at the school, on the journey to hospital and prior to leaving the hospital.
- Ambulance staff supported distressed, anxious and confused patients. We observed staff provide practical support to an older person, who lived alone, by cleaning the floors where blood had stained following an accident. They made a cup of tea for the patient, who did not have to go to hospital, prior to them leaving.
- The service had policies and protocols to guide frontline staff when caring for patients who died and their relatives. The service also had provision for supporting staff affected by incidents including caring for deceased patients of all ages.
- We observed staff providing care and support to relatives following a sudden bereavement. At one incident we attended, where a patient had passed away, we saw staff provide kind and considerate care to relatives and others who had been involved. Staff maintained the privacy and dignity of the patient and treated patients with compassion and consideration. Staff ensured relatives had an opportunity to ask any questions and had somebody with them before they left if appropriate.

Supporting people to manage their own health

- The trust had a frequent caller policy, which was designed to support patients with complex needs to access other services where the attendance of an ambulance may not be necessary. Operations officers attended multidisciplinary meetings to discuss how individuals' needs might be better met in the community.
- The service worked with an acute hospital in the north division to review frequent attenders to ensure best care and use of resources. There were shared plans of care, which included, for example, working with psychology and review of medicines to reduce calls and conveyance to hospital.
- In Cornwall we saw a care pathway for a frequent patient with a long-term condition. Patients and local healthcare professional agreed clear management plans.
- Some patients received a 'see and treat' service from ambulance staff. Staff supported patients safely at home or referred them to a more appropriate health service. This helped to avoid hospital admissions and reduced travelling for patients as they could access the appropriate treatment locally.

Are emergency and urgent care services responsive to people's needs?
(for example, to feedback?)

Good

We rated responsive as good because:

- We saw evidence of South Western Ambulance Service NHS Foundation Trust services planning to meet the immediate emergency and urgent care care needs of local people. There was flexibility, choice and continuity of care which was reflected in the types of services we saw. For example services that enabled patients to either stay at home after assessment by telephone or go to different providers of non-emergency healthcare. Most patients had timely access to initial assessment, diagnosis or urgent treatment. When an ambulance was requested, control staff employed a method called hear and treat. This was advice by telephone and enabled the proportion of patients supported at home to increase from 7.35% in 2013-14 to 12.7% in 2015-16.

Other examples include services such as 'right care' a commissioner-funded agreement to reduce unnecessary admissions to emergency departments by 10% from 2010 through face to face assessment and treatment of patients at home. This reduced the numbers of admissions to hospital from long term conditions and acute illness or injury and enabled patients to stay at home accessing care or treatment at times and in places more convenient and appropriate for them.

- Staff feedback on issues which prevented 'right care' from being delivered was captured with over 5,000 incidents highlighted up to the date June 2016. This was used to identify further changes required to improve patient care.
- The ambulance response project or ARP started 19 April 2016. The expected outcome of ARP was to ensure that the most appropriate response vehicle was sent to each patient's correct location rather than just meeting a time target by sending the nearest vehicle. Call centre staff would provide additional time to triage patients on the phone when it was clinically safe and appropriate to do so, and this helped them to decide on the best vehicle to send. The full impact of the ARP project was not known during the inspection period, as it was still in pilot phase.
- The trust used a network of volunteer community first responders, responders such as fire co responders, doctors and others including trust staff that could supplement core ambulance resources.
- The trust consistently had the highest rate of appropriate hospital admission for patients who were conveyed to an emergency department (62.5%) 2014 2015.
- Reasonable adjustments were in place for some patients. Action was taken to remove barriers to patients with physical disability, those with reduced mobility or those who had bariatric needs who found it physically hard to use or access services. The trust also ran blue light days where people with a learning disability could familiarise themselves with ambulance vehicles, equipment and staff to understand the service better. This also enabled staff to better understand the needs of people with learning disabilities.
- Complaints and concerns were taken seriously and listened to. The trust had also consistently achieved their 100% target for acknowledging complaints and concerns raised through the patient advice and liaison service. While not all complaints were responded to in a timely way patients and others were treated compassionately when they did raise complaints. There was openness and transparency in how complaints were dealt with.
- Translation services were available and were used.

However:

- Complaints and concerns were not always responded to in a timely way. It wasn't easy for patients or people close to them to know how to complain or raise a concern. Staff gave a variety of responses of how patients could make a complaint describing that patients could telephone or submit their concerns online on the trust website. Not all vehicles had complaints forms or information for patients to read or take away with them.
- Not all of the needs of the local population were taken into account when planning emergency and urgent care services. Ambulance staff were not always able to tell us how they met diverse needs in practice for example those who were hearing or sight impaired. Other shortfalls were in how the needs of different patients needing emergency and urgent care were known to the trust and ambulance staff and how that might affect assessment and treatment. For example, knowledge about learning and other disability, gender reassignment, race, religion or belief and sexual orientation was not collected for the purposes of planning for the diverse needs in the population. So services were not always delivered in a way that focused on patients' holistic needs.

Service planning and delivery to meet the needs of local people

- South Western Ambulance Service NHS Foundation Trust (the trust) worked with commissioners and other providers so that services were planned to reflect the immediate needs of the population and to promote flexibility, choice and continuity of care.
- The trust planned staff and vehicle levels using different methods. For example the trust used computer software to identify demand for emergency and urgent care staff, vehicles and their locations.
- Variations to core staff and vehicle needs were discussed at a divisional and local level via the weekly resource management group meetings held and chaired by heads of operations. Any demand issues

were dealt with through the meeting. Demand and resource availability planning to meet the needs of local people was also seen in documents such as South Western Ambulance Service NHS Foundation Trust winter plan document 2015/16, integrated business plan 2014/15 to 2018/19, operational plan 2016/17 and resource escalation action plan November 2015. We also saw evidence of planning to meet patient's needs in minutes of meetings. The minutes also mentioned development of clinical pathways and projects such as right care. They also mentioned engagement with other stakeholders in the health and social care community such as the council of governors of the trust. Improvements as a result of this planning had included helping more patients to stay at home or access care away from emergency departments.

- Commissioners, other providers and relevant stakeholders were involved with South Western Ambulance Service NHS Foundation Trust planning services. For example the trust liaised with organisations such as Healthwatch for Cornwall, isles of Scilly, Dorset, Gloucestershire and other areas seen in South Western Ambulance Service NHS Foundation Trust Quality Account and Report 2015/16.
- Divisional leads told us about local operational issues affecting service delivery. For example in the north we were told about plans for ambulance response during a busy time with a horse race meeting. Another example was university fresher's week which influenced resources and deployment of vehicles. The trust put in place more resources like an alcohol recovery area and extra staff, offered overtime and used private ambulance firms when needed.
- Between December 2015 and May 2016, all but December had over 90% of emergency and urgent care vehicles with a paramedic, specialist paramedic, advanced technician or ambulance practitioner as a crew member. This was equivalent to over 9209 vehicles. December had the lowest with 88.67% or 9489 vehicles across the trust. The trust also had emergency and community first responder schemes to respond to life threatening emergencies in rural areas where ambulances might take longer to arrive.
- Information about the immediate needs of the local population was used to inform how services were delivered on the mainland and the Isles of Scilly. We saw evidence of this in the change from the single responder and rapid response vehicle model with one ambulance person in cars or on motorcycles to more vehicles with two ambulance staff that could transport patients for mainland services. There was also a network of community first responders that met needs on the Isles of Scilly. Meetings also took place between staff on the isle of Scilly and the mainland to identify issues with the provision of emergency and urgent care on the islands.
- The trust used the national ambulance quality indicators to review the safe level of care that was provided. The trust had also been key to the development of the dispatch on disposition pilot (now called the ambulance response project or ARP). The ambulance response programme was started 19 April 2016 for a 12 week trial. The expected outcome was to ensure that the most appropriate response was sent to each patient's correct location rather than just meeting a time target by sending the nearest vehicle which may not have been the most appropriate. Call centre staff would provide additional time to triage patients on the phone when it was clinically safe and appropriate to do so. The ARP was run alongside the Yorkshire ambulance service pilot and monitored by NHS England and commissioners. Some staff told us that since the implementation of ARP the single crewed responses with ambulance cars were less busy but there had initially been more late finishes. We were also told since the implementation of ARP, the numbers of general radio broadcasts had reduced. General broadcasts happened when all crews were contacted during times when resource was short and demand high. Often crews would respond while still tidying or cleaning vehicles. Some staff described their levels of stress as lower and that ARP had made a difference in types and appropriateness of calls they responded to. Some staff said red calls seemed to be proper red calls or genuine emergencies needing two crew members
- There were a range of clinical pathways planned to meet the needs of patients with longer term conditions. The trust told us it was committed to continually improving the pathways and care options available to patients. This met patient's needs by reducing the need to be transported to an emergency department when it was safe to do so by use of more appropriate clinical pathways and delivering patient care closer to home. Patients were also supported at home through the right care project, in accordance with Joint Royal Colleges Ambulance Liaison Committee or JRCALC and National Institute for Health and Care Excellence or NICE

guidelines. Guidelines included pathways for the assessment and management of patients presenting with for example the onset of acute stroke symptoms and suspected transient ischaemic attack (TIAs or 'mini strokes'). The pathways had been planned and developed in partnership with hospital trusts and reflected local variations. Around 14.5% of patients that call 999 for an ambulance could be safely managed over the phone, without sending an emergency ambulance.

- Where an ambulance was despatched the trust told us over half of patients could be managed by ambulance staff in their own home which was called 'see and treat'. In 2010, the trust developed the 'Right Care, Right Place, Right Time' initiative, a commissioner-funded agreement that committed the trust to reducing unnecessary admissions to emergency departments by 10%. The right care strategy was supported by further development for paramedics to help them make the right clinical decisions. There had been 4,600 staff comments since its launch and 112 champions had been appointed across the service to promote the scheme. Staff were encouraged to provide comments as feedback when they felt that ambulance resources were used inappropriately. We saw the scheme publicised in ambulance stations and the trust told us of regular bulletins and roadshows to increase staff awareness. Some staff we spoke with were not aware of the scheme. The right care programme also focusses on developing non-emergency department pathways within community and acute hospitals. Examples included minor injury units, medical admission units and GP assessment units. During April 2015 to March 2016, 7.7% of incidents were conveyed to non-emergency departments, enabling patients to access quicker more appropriate care, whilst reducing the strain on Emergency Departments.
- Basic patient management was covered by JRCALC guidelines. The management of long terms conditions in the community was key to the right care programme. The long term conditions (LTC) lead focussed on the management of pathways to support patients with LTCs. The trust provided clinicians with a range of enhanced clinical guidelines, which used the latest evidence base and learning from other incidents to deliver additional support. Under the guidelines, trust clinicians are supported to ensure that all patients with LTC's received care at home when it was safe to do so.
- The trust worked with other providers of care to reduce the numbers of patients transported to emergency departments in other ways. For example, in Plymouth the ambulance staff worked closely with the community health trust to transfer appropriate patients to an assessment unit that was staffed by GPs. This enabled patients to stay nearer their homes and reduced waiting times in the ED. There were appropriate standard operating procedures, flow charts and protocols for staff to follow regarding the use of this service. A paramedic was located within the assessment unit to assist ambulance staff with identifying patients suitable for the unit as opposed to ED. Also a working group at Staverton Station had been set up with the Police and the Fire service to respond differently to road traffic collisions in Gloucestershire. Time had been allocated for staff to attend a Road Traffic Collision Conference. The aim was to improve responsiveness and working relations across the emergency services which would better meet the needs of patients in road traffic collisions.
- As an indirect measure of appropriate care during 2014-15, the trust consistently had the highest rate of admission (62.5%) for patients who were conveyed to an emergency department according to Hospital Episode Statistics.
- During 2015, the trust commissioned an 18-month specialist paramedic in urgent care programme. Graduates of the programme would be available in their new role as specialist paramedics from July 2016. The trust planned this to meet both need of patients and other health and social care providers by being able to treat patients in a more responsive way.
- The Electronic Patient Record (ePCR) system which was being implemented across the trust during 2015-16 had been designed to bring a number of key benefits to long term condition management including the provision of scoring tools to assist with safe patient assessment at home. The trust was also working towards an electronic means of being able to inform each patient's GP following an episode of care involving ambulance staff.
- The trust worked with commissioners and other providers to provide commitments to ensure that the service provided met the needs of local and regional networks. There were systems and processes in place to assist the management of day to day variations in demand across the health and social care system as well as procedures for managing significant surges in

demand. The trust also worked with commissioners and other providers to meet the needs of patients who needed to be transferred to national centres. We saw a framework for this in NHS ambulance service national mutual aid memorandum of understanding 2016 and other documents such as NHS England (south) surge management framework.

- The trust also recorded information relating to frequent callers and had a policy to support patients and the service response. The trust also worked with people on de-escalation plans which enabled people to understand how to manage their contact to the ambulance service better if it had been judged to be inappropriate. Patients, who rang the service regularly for an ambulance response that was not required, had care plans in place to suit their needs.
- In planning services for people with learning disabilities the trust told us their electronic system could record information highlighting issues like this for ambulance staff responding to calls. The system had 'flags' to highlight to operators what the relevant issue might be for example communication difficulties The trust was unable to tell us how many times patients with learning disabilities had used the service in the last year as trust data would not contain an accurate record of the number of patients seen with a learning disability. This was because the diagnosis of learning disability would not be recorded unless directly related to the reason for the incident or call. For example a patient with a urine infection would be recorded as a urine infection but if the patient had a learning disability this would not be recorded. There were 66 patients flagged on the control system with a special message containing the phrase 'learning disability'; this did exclude numbers of cases relating to terms such as Asperger's. Some staff members told us that control did not always share information for a previous ambulance call to an address – they said they had raised this with control.
- The trust had also recently held two learning events in Dorset on palliative and end of life care to support ambulance staff working with this patient group. The event had external speakers, including a palliative care consultant and Macmillan GP and hospice doctor.

Meeting people's individual needs

- Services delivered took account of the needs of patients and callers living with dementia or learning disability or those who didn't speak English as a first language. The trust had developed a range of resources to help staff to support patients with different and sometimes complex needs. We saw examples on station notice boards and electronic resources relating to different people's needs and how to meet them. For example for patients who lacked capacity to make specific decisions and how to assess for this. However not all staff we spoke with were clear or consistent on how to assess mental capacity.
- Staff could explain how they assessed mental capacity through the mnemonic CURE, could the patient - communicate, understand, how did the patient respond and how did they employ information to make a decision. Although some staff were not sure what options were available for patients once they had established the lack of specific decision making capacity and felt that often this resulted in a visit to the emergency department. The trust had made available information for assessing decision making capacity in a leaflet for crews. It was also available on electronic devices on trial. Vehicles we inspected did not have the leaflets on but we did see training documents that covered the MCA2005 and MHA1983.
- Staff said they had updates for dementia training on line and during development days. There were learning resources on the intranet to help staff support patients living with dementia, including an e-learning package. There was clinical guidance to support staff in understanding the application of the Mental Health Act and the Mental Capacity Act. However, staff and managers in the east and north divisions did not direct us to these resources when we asked about the steps taken to support this patient group. Some staff told us they had received dementia awareness training "a few years ago".
- The Trust had made some adjustments for patients and people living with learning disabilities. Trust representatives had met with people with learning disability, through Learning Disability partnership boards. They had also set up 'Blue Light Days' where patients with learning disability had the opportunity to meet staff and spend time exploring and familiarising themselves with emergency ambulances. The Trust told us it had provided ambulance staff with learning material through the intranet learning zone. They had also produced easy read versions of some trust communications for example frequent caller letters.
- No staff we spoke with knew how to use sign language and there were no communication aids on vehicles for

patients with significant or total hearing loss or sight loss. We asked staff about how they supported patients with complex needs, including communication difficulties, such as patients with learning disability, patients living with dementia or patients who did not speak English. They were not able to describe any communication tools, except that they had access to a telephone interpreter service for patients who did not speak English. We did see Wong Baker pain score tool on vehicles designed for children and older patients with some difficulty in communicating and understanding. Most staff felt that the training they had received in supporting communication with vulnerable patient groups was inadequate.

- For patients whose first language was not English staff could use a telephone translation service which they commented was easy to use and access. It was used by trust staff to assist patients who could not, or found it difficult to communicate in English. In the period January 2016 June 2016, the service had been used 980 times across the Trust. In frontline emergency and urgent settings the service had been used 734 times for 45 different languages as diverse as Polish (215 occasions) to Oromo and Ukrainian (once). We did not see the service in use during our inspection. We saw an example of care for someone who did not speak English at all and relatives were used to translate in the assessment and treatment of care given. The ambulance crew were aware of language line for translation but did not use it. An operations manager for north Wiltshire said translation services for staff were available, they also told us that there was a high population of Polish people and that some staff that could speak polish. Using staff and relatives to translate can lead to errors in communication where patients do not want to share intimate details with relatives. Also translation is a specialist skill and staff assessing and treating may not always be able to be objective while assessing, translating and treating. We were told communication aid cards were available on some ambulances for staff to use with patients. However, these were not available on all vehicles.
- We asked staff how they supported communication with patients who had a learning disability or dementia. They said they would encourage their carers to travel with them to help alleviate any stress and would explain procedures in a manner they thought they would understand. Some staff we spoke with could give us examples of how they would communicate with patients with communication difficulties such as being clear and speaking in a straightforward language avoiding technical terms.
- We observed examples of practice by ambulance staff in engaging with patients who were in vulnerable circumstances. We saw patients seen and treated and left at home who had a diagnosis of dementia or other cognitive difficulties for example. This was done with discussion with other professionals including the general practitioner and the patient's relatives.
- Bariatric patients are those with excessive body weight which is dangerous to health (over 25 stone or 158 kilograms) or a size and shape which may impact on their transport care. For most patients in this group, the first crew on the scene would provide immediate support for the patient's physical needs and request further support following the trust policy. They said that they might call the fire service or hazardous area rescue team who had specialist lifting equipment available and were usually summoned to give assistance in moving patients. Staff told us of a range of locations of stretchers across the trust. The majority of new vehicles and stretchers in the trust's fleet were able to transport patients up to 50 stone or 318 kilograms. Staff told us that control would know when specialist equipment had been used in the past for a patient and inform crews.
- One crew showed us how the stretchers are able to accommodate bariatric patients at the sides and they were aware of weight limits. Child transport needs were also met with different size restraints and equipment and wheelchair transport for people with mobility issues.
- Overall we saw that patients were treated as individuals in the way staff used basic interpersonal skills with children, older patients and those living with dementia or with a learning disability. However their understanding of other needs and preferences were not usually fully known. For example ambulance staff did not always understand the communication implications of learning disabilities, or ethnicity, language, religious and cultural backgrounds in the time patients were with them.
- When we spoke with staff some said that the delivery of service was no different whether the patient was old, young or disabled. The treatment was based on maintaining an airway so that breathing and circulation

of blood could occur. The trust told us ambulance services were delivered on the basis of life saving or immediate treatments or other urgent interventions in response to how needs were met. We were told that the ambulance service had a limited role in meeting patient's spiritual needs. Where a spiritual need was identified and the patient was being conveyed to hospital, the ambulance clinician would manage any issue identified before highlighting to the hospital nursing staff during handover that a spiritual need may require support from the any chaplaincy team. Where a patient was managed on scene ambulance staff told us they would contact an individual identified by the patient for example a local vicar, Imam etc. Such individuals might also be contacted to provide support to relatives following the death of a patient.

- Mental health advice for staff was available through the clinical hub of the service. The trust told us that ambulances were arranged for patients experiencing a mental health crisis and there was an agreement with local police forces which covered all aspects of interagency working with mental health.
- We were told that patients who needed mental health support were also transferred with a carer to support them when available. Crews told us the safety and well-being of the patient was a priority and if they felt the patient was at risk to themselves or others the police were called on for further assistance. They did not have direct contact with a mental health team unless patient was already known to mental health services. Sometimes there was a mental health nurse available in the clinical hub for advice and guidance but staff said this service was not available all the time and finished at midnight. In a safeguarding and mental health group report that covered 1106 incidents 1 April to 30 April for the trust, there were 41 incident reports associated with patients experiencing mental ill health. Eleven of the incidents reported difficulties accessing assistance from other services. Four of the incidents described communication issues between the clinical hubs and attending crews. For example, details of warning flags attached to the address were not passed to the attending crews. In one instance a community first responder was inappropriately sent to attend a suicidal and violent patient.
- We saw ambulance staff working with potentially violent or aggressive patients. Staff had received breakaway training and training to deal with violent or aggressive patients to enable them to remove themselves from physical harm but had not had training on physical restraint of a violent patient. Some staff told us they did not feel equipped to deal with violent or aggressive patients. The trust had a restraint policy in place with a link to May 2015 guidelines from NICE for appropriate restraint.

Access and flow

- Actions were taken to minimise the time people had to wait for treatment. We saw evidence that care and treatment was only delayed when it was absolutely necessary. For example when there were not enough ambulance staff or vehicles in the immediate area and resources were sometime diverted to other calls as priorities changed. We observed the daily telephone conversation with all of the north division operations officers where response times were discussed and if an emergency or red call time was missed they acted to find out the reason for this.
- Most patients had timely access to initial assessment, diagnosis or urgent treatment. When an ambulance was requested, control staff employed a method called hear and treat. This was advice by telephone and enabled the proportion of patients supported at home to increase from 7.35% in 2013-14 to 12.7% in 2015-16. This meant patients could have either appropriate care at home or access to a range of more appropriate local services which are likely to be more responsive to their needs. Staff sent ambulance vehicles and prioritised the care and treatment for patients with the most urgent needs. Dependent upon the symptoms described in the call made to the emergency operations centre, this determined how quickly and what type of ambulance resource was dispatched.
- Community first responders who were volunteers and responders such as fire co responders, doctors and others including trust staff were staff that could supplement core ambulance resources. The community first responders were volunteers who had been trained to attend medical emergencies and deliver basic life support, oxygen therapy and defibrillation using an automated external defibrillator. In rural areas when ambulance crews were not always nearby the trust used community first responders (CFR) where available if the incident was appropriate for them to attend. Dispatchers could send CFRs to cardiac arrests and work place incidents. Community First Responders were

alerted by pagers that the trust had issued them with. CFR liaison officers told us that there were plans to change to a dedicated landline number that CFRs could use instead of them using 999 when attending scenes, this would improve communication and reduce 999 calls where appropriate. The CFR personnel were available on the Isle of Scilly and across the trust mainland locations. Between May and July 2016 responders were needed for less than 4% of emergency calls for the trust (312 in total). This meant that CFRs were supplementing frontline ambulances and staff when necessary, not overstretched and being used inappropriately.

- In 2010, the trust developed the 'right care, right place, right time' initiative, a commissioner-funded agreement to reduce unnecessary admissions to emergency departments by 10%. The ambulance crews did not always transport patients to hospital but attended to them and treated them at the scene when possible. This reduced the numbers of admissions to hospital and enabled patients to stay at home accessing care or treatment at times and in places more convenient and appropriate. However, while at times it took crews longer to see and treat than to transfer the patient to hospital a better outcome for the patient was achieved. The proportion of 999 calls managed without emergency department attendance through see and treat increased from 50.84% in 2010/11 to 56.82% in March 2016. During 2014-15 the initiative successfully reduced the number of patients conveyed to an emergency department across the South West by 15,523 despite a 9.75% increase in 999 demand. As an indirect measure of appropriateness, figures from the hospital episode statistics which measure a number of key hospital admission data demonstrated that the trust consistently had the highest rate of appropriate admission for patients who were conveyed to an emergency department (62.5%). Staff feedback on issues which prevented the right care from being delivered was captured with over 5,000 incidents highlighted to date. This was used to identify further changes required to improve patient care.
- We saw some patients assessed and appropriately advised to seek support or further treatment from other professionals such as GPs or walk in centres. Patients discharged, after treatment at the scene or onward referral to other professionals and those with a patient journey to a destination other than an emergency department was better than the England average. The proportion of patients who re-contacted the service following treatment and discharge at the scene, within 24 hours was mainly worse than the England average between July 2014 and November 2015. It had improved between December 2015 and March 2016 and was above the England average.
- The single point of access was operated by the trust. It was a contact point which health and social care professionals could use to arrange the right care for urgent and non-urgent patient needs. It was available to ambulance staff and allowed paramedics direct clinician to clinician contact. Paramedics could gain access to out of hours GPs to support clinical care at home or via a walk in centre. All staff we spoke with thought this process was beneficial to patient care but sometimes there could be a wait to get advice and this affected response and transport times.
- Staff in the east division used electronic patient records. This system allowed them to view patients' previous history in terms of their engagement with the ambulance service and special notes about their presenting condition. The system also allowed them to transmit information about a patient's condition to receiving hospitals. There were plans to be able to share information with patients GPs when they had used the ambulance service.
- We saw information terminals in emergency departments provided by South Western Ambulance Service NHS Foundation Trust. Hospital staff could see details of patients arriving by ambulance, their estimated time of arrival and condition. This helped hospital staff be prepared to take a handover of care and for patients to be better supported and managed. This also helped the ambulance crew to be released quicker to respond to other work.
- Sometimes crews were needed to respond to other calls but were delayed in handing over patients to emergency department staff in acute hospitals. In such circumstances, a general broadcast call would go out to all available crews in the area to assist. The trust also used operational managers and operational officers to work with acute hospital trust staff in the emergency department to alleviate the situation when ambulances were held up outside emergency departments waiting to hand over their patients. We saw this process in action.

- We observed a daily team telephone communication between the ambulance trust and hospital staff which identified areas that were at risk of needing additional support which would trigger acute hospital trust staff to increase resources into the emergency departments. We also observed situations where the policy for managing delays in handover between ambulance and hospital trust staff was implemented. An operations officer would have a face to face meeting with the bed manager in the emergency department to ensure optimum communication between agencies. At one hospital we visited we discussed with the bed manager what was in place to help the crews handover patients. We could see that additional nurses were assessing patients who were placed on trolleys in the corridor until a trolley space was vacated or, a ward bed became available. We witnessed good working relationships with the hospital staff bed managers and the operational officers at the hospitals we visited. Staff at one Hospital felt that there were very few delays in patient handover which was supported by ambulance officers. Sometimes the problem solving between ambulance and hospital trust staff meant that implementation of the formal escalation policy was not needed.
- Ambulance service managerial and operational staff and the hospital trusts where delays were more frequent or longer were trying to resolve the situation with daily joint working and we saw minutes of meetings and discussions where processes and solutions had been discussed between the hospital trusts emergency departments and ambulance service.
- The trust used private ambulance services to transfer some patients when there were no the trust ambulances available.

Learning from complaints and concerns

- The service learned through engagement with patients and communities using feedback through the friends and family test. The Trust was unable to report on friends and family test results by station or division as they only had one contact point for receipt of feedback. Patients could only report by emergency service or patient transport service and Community Services as general headings. The friends and family questionnaire was on a printed leaflet left with patients, and also on the trust website for those with internet access. It was also available to patients who visited the treatment centres where out of hours services were located. The trust said that the ambulance sector did not find the friends and family test a useful form of patient feedback and that there was no viable alternative choice available to patients for emergency and urgent services. The trust were required to make the test available by the department of health. The trust had not yet devised an alternative to the friends and family test that reflected the needs they had identified.
- Staff were able to describe the information they provided to patients or their carers if they wanted to make a complaint. Managers across divisions we spoke with informed us staff were encouraged to resolve complaints and concerns at a local level as soon as possible. Ambulance staff we spoke with said they would attempt to resolve a complaint at the time it was made if it was appropriate to do so. At some of the stations we visited we were shown a leaflet given to patients and their relatives on how to raise a concern or comment about the service. However, at other stations staff informed us they were not routinely given to patients. They told us they would refer patients who wished to complain to trust headquarters or they would contact the clinical hub for advice.
- We did not see the complaints leaflets in all the vehicles we inspected or travelled in and we did not observe them being handed out.
- Staff we spoke with said they encouraged patients go on line to make complaints. Some staff said they encouraged patients to raise a complaint through using a telephone number, going online to the trust website or when they had leaflets - giving them to patients. The patient advocacy liaison service team was contactable through the trust website; it offered an email address and a telephone contact number. Patients we spoke with were not aware how to make a complaint or raise concerns.
- Complaints were investigated according to pre-set levels, with the lowest levels concerning negligible or low level harm being dealt with at a local operational level. Moderate harm complaints were investigated by quality leads or operational managers. Investigation outcomes were included within the trust bi-monthly patient safety and experience reports to the Board. The trust recorded all actions from level three moderate harm complaints on an action register. These were monitored centrally and followed up by the patient

experience team. Actions were only closed on receipt of appropriate evidence, thus ensuring learning has taken place. The trust recorded all actions from complaints that were escalated to Serious Incidents.

- However some complaints were not always handled effectively. The trust told us that they struggled to meet target response times for the completion of complaint investigations (25 days for level two- negligible or low level harm and 35 days- moderate harm).
- Ambulance staff who had direct patient contact described what happened if a complaint was made and the information they provided to patients or carers that wished to complain. An investigation officer was identified who had responsibility to investigate the complaint, provide staff support, take staff and patient statements and process the information. The operations officer reviewed the investigation and corresponded with the patient. If staff had three complaints made about them in any three month period a review of themes took place to identify what could be done to prevent them reoccurring.
- Crews we spoke with said they were then made aware of any investigation and outcome. If there were learning outcomes the information went to the learning and development team who then worked with operational managers and operational officers to address any issues.
- Staff we spoke with said when a complaint was made about them they were supported. One member of staff showed us correspondence they had received from the trust following a complaint. They told us they had been offered support throughout the process and with improving practice. Staff told us learning from complaints was usually shared by email.
- The urgent care service GP lead for Gloucestershire held regular development days and shared learning from complaints to ensure wider trust learning for all sectors. The trust also shared detailed learning on a regular basis, via the Chief Executive's Bulletin, to ensure wider Trust learning.
- The trust also produced a 'you said we did' poster which provided an 'at a glance' view of the impact of some of the feedback on service development and this was displayed on the trust website.
- We saw minutes of a quality development forum which was a new group which had been established by the trust to ensure an integrated approach to the management of risks arising from themes and trends across the Trust. This was a patient focused group and produced recommendations and actions by using feedback from all areas across the trust, including complaints, claims, incidents and right care feedback to ensure continuous service improvements. The wider learning from this group informed the trust's statutory mandatory education days and changes to guidelines. The trust had received a number of complaints from patients regarding attitude. Low emotional resilience could negatively affect staff's behaviour with colleagues and communication with patients. The forum had reviewed how to develop greater emotional resilience in staff. The outcome of the review included the recommendation to develop an accredited Emotional Resilience course for staff.
- Divisional leaders, operational managers and operational officers we spoke with were aware of what duty of candour was in relation to complaints but could not quote the regulations. They said it was about the level of harm that had occurred and being open and transparent to patients about it. We heard examples of how staff had implemented this. By the time complaints got to divisional lead level the complaint was advanced and had not been able to be resolved. We spoke with a divisional lead who described three dismissals the trust had carried out. Before this stage the trust had tried to resolve the issues identified in complaints by supporting staff through additional training packages and final written warnings.
- The trust's patient experience team had oversight of complaints management across the trust. Their details were publicised on the trust's website. The trust also used social media and liaised closely with patient advocacy and liaison departments at local hospitals. The trust had consistently achieved their 100% target for acknowledging complaints and concerns raised through the patient advice and liaison service.
- The trust had revised its process for the sharing of learning from patient feedback in recent months following feedback from staff. The Trust were in the process of reviewing how they shared patient feedback for learning. They planned to share at least one piece of detailed learning on a weekly basis, via the chief executive's Bulletin.
- The trust had had two complaints upheld by the Parliamentary and Health Service Ombudsman 2014/15 and two partially upheld 2015/16.

Emergency and urgent care services

Are emergency and urgent care services well-led?

Requires improvement

We have rated well-led as requires improvement because:

- Although the management team at service line, division and sector levels was very focussed on resource management and ambulance response times, quality, in terms of patient outcomes and experience, did not feature highly at operations meetings.
- Risks to quality and safety were well understood at a local level but were not locally recorded and accountability for managing these risks was not defined. Risk registers maintained at directorate and corporate levels did not align with the risks and worries described to us by staff and managers. Notably, the risks identified by the 2015 staff survey did not appear on either risk register. We saw little evidence that the risk register was regularly discussed at service line or division, or actions to mitigate risks reviewed.
- We were concerned about a lack of local oversight in respect of infection control. This highlighted a disconnection between different reporting lines.
- Whilst the trust had made significant efforts to support staff wellbeing, their efforts were somewhat overshadowed by the intensity of work, due to relentless and increasing demand on the service and the pressures this placed on staff. Staff morale and motivation was mixed. Some worrying messages had emerged from the 2015 staff survey in relation to frontline ambulance staff. Staff dissatisfaction was reflected by results which showed that a significant proportion of staff felt unwell due to work related stress, felt pressurised to work despite not feeling well enough to perform duties, and had experienced musculoskeletal problems as a result of work activities. The survey also highlighted that a significant proportion of staff suffered physical violence and/or harassment, bullying or abuse from patients, their relatives or other members of the public. Local action plans had recently been developed but this was work in progress.
- These messages were consistent with feedback we received from staff, who complained about work intensity and fatigue. There was a culture in which there was an unspoken expectation that staff would work longer hours than they were contracted to work. Staff told us they regularly finished their shifts late, missed their meal breaks, arrived early for work to undertake vehicle checks and undertook activities such as reading email updates and bulletins and undertaking training in their own time.
- The intensity of work undoubtedly contributed to staff absenteeism and high levels of staff turnover.
- There was a limited approach to obtaining the views of patients and staff were not engaged in this process.

However:

- There was a well-publicised mission statement and a set of core values. Whilst not all staff could articulate these, they consistently demonstrated their commitment to delivering high quality care to patients.
- Staff enjoyed their work and there was a strong sense of teamwork, shared purpose and camaraderie.
- Leaders, both locally and trust-wide, were respected and provided good role models, promoting and practising the trust's shared values.
- Local managers were visible, accessible and supportive to staff. Staff appreciated their supportive leadership style, as well as their practical clinical support at difficult incidents.
- Staff felt valued and supported by operations officers. Staff wellbeing and welfare was a high priority. The trust recognised the physical and emotional strain associated with frontline ambulance roles and supported staff to maintain their physical and mental health. A range of staff support services had been introduced. The Staying Well service, launched in December 2015, provided access to counselling, advice, peer support and signposting to other services, for staff experiencing a wide variety of problems which may be affecting their work.
- There was a "no blame culture" where staff felt they could be open when things went wrong.

Vision and strategy for this service

- The trust had developed a mission statement, a vision and a set of values. These were prominently displayed in ambulance stations and had been widely publicised in preparation for our visit. Staff we spoke with, whilst not able to clearly articulate these aims and values, were able to demonstrate their commitment to consistently provide safe and high quality patient-centred care. One staff member summed it up. We asked them to give an

example of exceptional care that they had provided. They told us "I can't really give an example as I give everybody the same high level of care; I am just doing the job".

- In the 2015 staff survey (published in January 2016) 68% of respondents said that the values of the organisation were discussed (definitely or to some extent) at their appraisal. 32% said that they were not. Sixty-three per cent of respondents agreed or strongly agreed that the team they worked in had a set of shared objectives
- A series of leadership away days had been held in the last year. These enabled the service line to brief all operational managers on developments within the Ambulance Response Programme and update all staff on the modernisation programmes being taken forward across the trust, including the implementation of a single CAD. These events enabled the leadership of the trust to directly engage with operational managers and 0perational officers and set the work programme and priorities for the emergency and urgent service for the year.
- It was not clear however, how key messages from the day were cascaded to staff. Two staff members (in the east division) told us that they thought that communication from the top of the organisation was poor and that the direction of the trust was unknown.

Governance, risk management and quality measurement

- At trust level, integrated performance reports provided a holistic understanding of performance, which included operational performance, clinical quality, patient experience and finance. Governance arrangements at service line and by division focussed on resource management and the achievement of ambulance response times, with little attention to clinical quality and patient experience. There appeared to be a disconnection between two parallel reporting lines, the A&E service line, and the groups reporting to the trust-wide quality committee.
- At station, sector and divisional levels there were daily teleconferences to discuss resources and other factors affecting operational performance.
- At sector level, operations officers met regularly with their operations manager to discuss operational performance issues. Operations managers regularly discussed and monitored sickness management and resourcing. A weekly absence report was produced and there was a weekly telephone call with the head of operations.
- At divisional level, there were operations team meetings held in the three divisions approximately every six weeks. These meetings reported to the A&E service line meetings, which, in turn, reported to directorate and ultimately, to the director level quality committee.
- Operations meetings were chaired by the head of operations and attended by operations managers for each sector, along with representatives from human resources, training, health and safety and the divisional quality lead. The format and content of these meetings varied across the three divisions; however, they were primarily business meetings. Items discussed included operational performance, staffing, training, fleet and logistics. In the east division there were standing agenda items on health and safety, new risks, new legislation and clinical effectiveness; although minutes did not demonstrate that these areas were regularly discussed. A health and safety report was produced for operations managers in December 2015 and February 2016 with advice on fire safety and asbestos management, two issues which had been identified during health and safety inspections.
- Quality did not feature highly in operations meetings. We noted that there was little discussion recorded in these meetings about emerging themes in patient feedback, including friends and family test results, complaints and compliments. There was also little evidence of discussion in relation to patient outcomes.
- Quality leads, who reported to the head of operations in each division, had recently started to produce quarterly quality reports, although the frequency of these reports varied from division to division. Reports summarised complaints, plaudits and incidents and identified emerging themes. We did not see any discussion recorded around any identified risks or management plans to reduce those risks. For example, in the north division there were clear trends, with significant numbers of incidents reported under the category of missing or faulty equipment (the highest reported incident category) and crew safety (second highest category). Neither of these issues was regularly discussed at operations meetings.
- There was little discussion of infection control issues at operations meetings, suggesting a lack of local oversight

and accountability. This was despite the fact that audits had demonstrated poor compliance in some areas and some stations had not submitted audit data regularly. One of the operations managers we spoke with in the east division, was unaware that infection control data had not been submitted for one station for three consecutive months. Another manager in the east division acknowledged that, although they undertook spot checks of infection control at their stations, they did not have an overview of compliance in this area because they did not see the results of infection control audits, which were sent to infection control team. The trust held regular infection prevention and control meetings which reported to the board through the quality committee. Regular audits, including an annual station audit were reported through this committee structure. The infection control audit reports provided to us for May 2016 showed that trust-wide, overall compliance for station cleanliness was 83% (amber) and for vehicle cleanliness 82% (amber). Only 89 out 105 stations (85%) submitted data during this month. This data was reported to the board via the integrated performance report in May 2016 and compliance was rated green because it exceeded the local target of 75%. This assurance was not qualified by the fact that 16 ambulance stations did not submit data and was therefore misleading.

- There were monthly A&E service line meetings, chaired by the director of operations. The meetings were attended by the head of operations for each division and managers from other arms of the service and supporting functions, including human resources, training and logistics. We reviewed the minutes for meetings held in January and February 2016. Items discussed included financial and contractual information, operational performance, human resources and training updates, a clinical update, project updates, such as 'right care', approval of new policies, station quality audits, and safeguarding. Again, there was little discussion in relation to patient outcomes, patient experience or any shared learning from complaints and incidents.
- Running in parallel, there were trust-wide groups overseeing clinical effectiveness, health and safety and quality development, all reporting to the trust's quality committee, which in turn reported to the board. It was not clear how this information was shared to operations managers or cascaded to staff.
- Integrated performance reports to the board reported performance against response time targets, ambulance national quality indicators covering patient safety, effectiveness and experience against five domains. These were:
  - Preventing people from dying prematurely
  - Enhancing the quality of life for people with long term conditions
  - Helping people to recover from periods of ill health or following Injury;
  - Ensuring that people have a positive experience of care;
  - Treating and caring for people in a safe environment and protecting them from avoidable harm.
- The corporate risk register highlighted a number of risks which were relevant to the emergency and urgent care service, including infection control, and compliance with mandatory training. However, these risks were not identified at service line, division or sector level and accountability for managing these risks at a local level was not defined. Local managers did not identify that mandatory training or infection control were issues of high risk.
- We saw no evidence of discussion in relation to existing or new risks within the divisions. There was a trust-wide risk register for the operations directorate. Risks were allocated to the director of operations. Risk registers were not maintained at station, sector, division or service line (with the exception of North Somerset) and accountability for managing local risks, or corporate risks at a local level, was not clear. For example, there was little discussion recorded at operations meetings in relation to meal break management and staff working beyond their contracted hours, despite the fact that staff and managers acknowledged this was a serious and ongoing risk. There was little discussion in relation to compliance with mandatory training compliance and appraisal take up.
- We were told that the operations risk register was discussed at, and monitored by the monthly A&E service line meeting, chaired by the director of operations. We saw that this was a standing agenda item; however, we reviewed minutes of meetings held in January and February 2016 and there was no discussion recorded, other than a reminder in February to update the risk register.
- There was little alignment between the risks identified in the risk registers and the concerns and risks

highlighted to us by staff and managers during our inspection, including those risks identified in the 2015 staff survey. For example, many staff and managers were concerned about staff safety, intensity of work, the resilience of staff, levels of staff absenteeism due to sickness, and staff turnover. The 2015 staff survey (Locality report; Delivery) had identified some worrying staff feedback. Thirty-eight per cent of respondents reported that they had experienced musculoskeletal problems as a result of work activities, 46% had reported that they felt unwell due to work related stress in the last 12 months and 65% reported that they had come to work in the last three months, despite not feeling well enough to perform duties. Other issues raised by staff, such as lack of alternative pathways for mental health patients, were similarly not identified on the risk register.

- We were provided with the action plans which had been developed in response to the staff survey findings in each division. The documents stated that the trust-wide quality committee would monitor progress against the action plans and updated action plans would be posted on the intranet quarterly so that staff could also monitor progress. Action plans had only been developed in April and May 2016 so it was too early to see any progress. We were told that the human resources department conducted a series of roadshows during May and June 2016. They shared information about new developments, including a peer support network, learning and development and staff survey results. Results and action plans were publicised on the intranet and "You said, we did" messages were delivered via bulletins.
- In the west division, it was reported at the operations meeting in April 2016, that every station had been visited and given a rating, with a number of actions to be completed. There were some areas which were found to be rated 'red' and managers were requested to put action plans in place to correct these issues. The minutes of the following meeting held in May 2016 did not demonstrate that actions had been progressed.

Leadership of service

- In each division there was a head of operations, supported by operational managers in each of the geographical sectors within that division. Operations managers were based at a hub station and were supported by operations officers, who were responsible for day-to-day staff and station management. Not all ambulance stations had manager presence but operations officers were required to visit each station in their patch regularly. An operations manager in north Devon had introduced a system whereby they met with operations officers on the last Thursday of every month and spent the last Friday of every month at different stations in their patch to allow staff to speak with them on any matter. They reported that this had been well received by staff and some staff had attended meetings in their own time.
- A staff member from a small rural station in the west division, told us they saw their manager each week. Bronze commanders were allocated from the pool of operations officers each day and night shift to support staff operationally, while station-based officers dealt with station and staff management and welfare issues. A rota was sent to all staff each week so that they knew who the duty officer was on each shift.
- In the 2015 staff survey (Delivery) 58% of staff said they were satisfied or very satisfied with the support they got from their immediate manager. During our inspection, staff universally praised the operations officers and operations managers. They told us that operations officers were visible and accessible, although this was more so at the larger stations.
- One staff member in the east division told us "the managers are all lovely people and they support us well". They told us about the emotional and practical support they had received when one of their relatives was unwell. Another staff member told us they had been "well looked after" on their return to work following a period of extended absence. Staff told us they felt able to approach any of the operations officers or operations managers; they did not feel the need to contact managers above this level but believed they could do so if they had concerns and that they would be listened to and supported. A staff member told us that there were always opportunities for de-briefing after difficult incidents such as road traffic accidents. Staff told us they were given time to reflect and come to terms with difficult outcomes for patients.
- A staff member who contacted us prior to our inspection told us "Management is approachable, lead well and understand the roles very well as the majority of them were paramedics before advancing in their careers. This

is to be praised." A staff member in the east division told us that the support they received from managers was "amazing" and that they thought it was a very well run organisation.

- Managers and staff in the east division told us that the head of operations, although rarely seen at ambulance stations, was accessible and approachable if they needed support. There was a weekly teleconference with the head of operations to discuss issues such as sickness management. One manager told us however, that they felt the division worked in silos, with little interaction between the sectors.
- Operations managers told us they felt well supported by executive management, particularly the director of operations and each operations manager had an executive mentor who they met with regularly. They had recently attended an away day with executive directors.
- At some ambulance stations, there were lead paramedics, who undertook a range of station administration duties, such as ordering of stock, and who were awarded small pay uplift. The lead paramedic role was seen as a 'stepping stone' to an operational officer role. Staff were given training in incident management and they had opportunities to cover gaps in the duty officer role. These staff were not given protected time to undertake these duties. One lead paramedic in the east division told us that they undertook most of their additional duties on their days off as there was not time during a normal shift. They were paid overtime for this.
- An operations manager in Dorset told us they had spent one month last year working alongside ambulance crews in order to "stay in touch with the job" and to ensure their own currency of clinical practice.
- We heard mixed views about the visibility of executive directors. They regularly attended meetings and social events across the trust. This included station visits. A number of road shows had recently been held at hospital emergency departments to publicise new ways of working. This had been well received by staff. There were posters displayed in ambulance stations, identifying board members with photographs. A number of staff in the east division told us they had emailed the chief executive directly and had received a prompt response. A staff member in the west division told us they approached the chief executive directly with a suggestion for service improvement and the chief executive had acted upon this.
- In the 2015 NHS staff survey, only 23% of respondents reported good communication between senior management of staff. However, this was better than the national average for ambulance trusts.

Culture within the service

- Staff morale and motivation in the emergency and urgent care service was mixed. In the 2015 staff survey (Delivery) 45% of respondents indicated they were dissatisfied with the extent that the organisation valued their work.
- The trust used the friends and family test to gauge staff opinion about the quality of service and how likely they were to recommend the service to friends and family as a place to work. In March 2016, out of 659 respondents, 43% indicated that they were unlikely or extremely unlikely to recommend the service as a place to work, whilst 40% said they were likely or extremely likely to recommend the service. Seventeen percent indicated they were neither likely nor unlikely or they did not know.
- Most of the staff we spoke with told us they felt valued and respected by the service. When asked to explain this many staff referred to the support they received from their immediate managers and peers. Many cited teamwork as the one of the best things about working for the service. Staff told us there was good camaraderie within the service, with "everybody pulling in the same direction". A staff member told us that that the director of operations had attended a colleague's funeral, which they thought, was "a nice touch".
- Staff received recognition for their work. Letters of praise and thanks from patients were shared with staff by email with an accompanying note from their manager. We saw "thank you" cards displayed in many of the ambulance stations we visited.
- In Taunton ambulance station there was a plaque displayed, recognising the contribution of all staff who had been involved in a local major incident in 2011. Staff had also been presented with individual plaques at a memorial service held after the incident.
- A staff member in the east division told us they had been presented with a chief executive's award in recognition of their actions, which were above and beyond the call of duty. The trust's Our People Awards Policy set out a range of awards presented to staff at an annual awards ceremony. This included awards for long service, retirement awards and achievement awards.

Recipients of achievement awards could be nominated by colleagues or members of the public. There were also awards for employee of the year, mentor of the year, apprentice of the year and special recognition award to recognise the implementation of a trust project, innovation or outstanding teamwork.

- However, many staff told us that intensity of work and fatigue affected morale and motivation . Sickness absence levels in emergency and urgent care were higher than the trust's target of 4%, although they were reducing as a result of focused management and staff support schemes. Sickness absence levels by division in 2015/16 were;
  - East 5.84%
  - West 5.85%
  - North 4.94%
- The top three reasons for sickness absence were: injury/ fracture, anxiety/stress/depression/other psychiatric illness and back problems.
- Staff turnover in emergency and urgent care was high. The average turnover rate in 2015/16 was 10.75% and, split by division:
  - East: 9.24%
  - West: 6.64%
  - North: 11.68%
- Staff safety and wellbeing was a priority but this was in the context of a service that was experiencing high and increasing demand, which staff and managers described as relentless. Most staff reported they were happy with their shift patterns but many staff told us that their work was exhausting and that they frequently worked in excess of their contracted hours. The trust did not routinely report on shift overruns. They told us that historically, the process for recording hours did not allow for analysis of this information. However, in March 2016, the trust began to implement an electronic timesheet and this allowed for analysis of extra hours worked. Although this system was only partially implemented, the trust was able to provide us with information, which showed that 29% of shifts in April and May 2016 resulted in an incidental claim for additional hours
- The trust recognised the risks associated with increasing demand and had taken a number of steps to mitigate the impact of this on staff safety. These included the 'dispatch on disposition' trial and the Ambulance Response Programme, both of which aimed to reduce the inappropriate dispatch of an ambulance. The trust was also undertaking a review of rotas, with the aim of better managing peaks in demand and improving staff welfare and wellbeing
- Staff told us that they frequently went for long periods without a meal break. The trust accepted that this was a problem, which was driven by demand on the service, although, with the introduction of a new meal break policy, this was improving. The standing operating procedure which had been introduced, following staff consultation, meant that some staff could choose to respond to group broadcast calls while on their break.
- Some staff told us there was an expectation that that staff arrived early for their shift in order to undertake their daily vehicle checks; others told us they did it willingly. Staff (in Taunton and Poole) complained that it was difficult to book annual leave and felt there was little flexibility or contingency to cover gaps in the rota, resulting in staff feeling obliged to pick up extra shifts on overtime. One staff member in the east division told us that leave was mostly imposed.
- Bronze commanders attended incidents such as entrapments and serious trauma to support staff. Bronze commanders offered debriefing to staff who had been affected emotionally. Staff told us that they received welfare checks from the clinical hub if they had attended difficult incidents. We observed an example of this in the west division when a crew had attended an incident involving a child. The clinical hub contacted the crew to check whether they needed any support or 'down time' following the incident. A staff member in the north division told us that there was good support provided for staff who had attended incidents where a child had died. However, three staff in the north division told us that welfare calls did not always take place for staff working in volatile situations. One staff member described the welfare check as a "hurry up check".
- A number of staff told us about how they had been supported during periods of absence through illness or injury and their return to work. A staff member (in Poole) told us that their rota pattern had been adapted to fit in with their caring responsibilities at home. However, a staff member in Taunton told us that they had not been supported to reduce the amount of unsocial hours they worked for family and health reasons. Another member of staff told us that it was becoming more difficult to negotiate flexible working conditions due to staff shortage and a lack of experienced staff. They told us

that fatigue and lack of flexible working was leading to staff burnout and higher levels of sickness. It was felt by many staff that this negatively impacted on staff retention. In the 2015 staff survey (Delivery), 38% of respondents indicated they were dissatisfied with opportunities for flexible working patterns.

- The trust launched the 'Staying well' service in December 2015. This was a confidential service, which provided access to counselling, advice, peer support and signposting to other services, for staff experiencing a wide variety of problems which may be affecting their work. This included support following a traumatic incident at work, access to fast track physiotherapy, as well as issues not related to employment. An intranet page included a range of self-help and health promotion resources. A report to the A&E service line meeting in February 2016 stated that 166 staff members had been supported by the service since its launch. The "headline" reported reason for using the service was stress.
- Staff we spoke with were positive about this service and the peer support they received from local champions. There was a team of 38 trained peer supporters. One staff member told us that had sustained a back injury at work and they were immediately referred to a physiotherapist, who they saw within 48 hours. They returned to work after two weeks, following a lifting and handling assessment. The trust told us that since the introduction of this fast track service, sickness absence due to musculoskeletal injury had decreased.
- Staff we spoke with described a "no blame culture" where staff felt they could be open when things went wrong. A staff member told us they had been involved in adverse incident which had identified some learning needs. Their clinical practice was restricted while they undertook some supported reflection and learning. They told us they felt supported, as opposed to blamed for the incident.
- Staff worked collaboratively to deliver good quality care. A number of staff members told us however, that there were tensions between the clinical hubs and frontline staff, particularly when staff were not able to take their breaks or when they were asked to work beyond the end of their shift. They said that it was difficult when some hub staff did not acknowledge they were working over and above what was required of them.
- An Operations manager in the east division acknowledged there were ongoing tensions between front line staff and the clinical hubs and they were taking steps to resolve these. They told us that operations officers in their sector had been set an objective to work a shift in the hub to help them to understand the challenges staff in the clinical hub faced. Some hub staff had also accompanied ambulance crews on shifts to foster good working relationships. Another manager in the east division told us that they had invited staff from the clinical hub to a showcase evening to meet and speak with staff. They also told us that they had arranged for a member of staff, who had been the subject of complaints from hub staff, to spend a shift in the clinical hub to help rectify the relationship issues. In the west division an operations officer had recently spent time in a clinical hub to focus on crew down time and welfare. It was reported at an operations meeting that this had been well received by staff.

Public engagement

- The trust held a number of public open days at ambulance stations and road shows in community settings during 2015. The trust engaged with Healtwatch and had recently started to hear patient stories at board meetings.
- The trust, in common with other ambulance services, found it challenging to capture patient feedback to allow it to assess the quality of care provided. The trust used the friends and family test to capture patient feedback. The surveys were sent to patients in paper format to their home address and some patients were contacted by telephone, text or online. Feedback cards were carried on some ambulances but some staff were not able to produce these cards and did not seem to be engaged in the process.
- A number of staff were very clear with us that it was not appropriate to give out feedback cards to patients who very unwell or seriously injured. Whilst we acknowledged this, we saw a number of missed opportunities. All of the patients we spoke with in emergency departments in the east division were able and willing to complete comments cards but had not been asked to do so.
- When we accompanied ambulance staff in the west division, we observed that patients, who were treated at home and not conveyed to hospital, were not offered feedback cards. The friends and family test yielded 46 responses from patients who used the service during December 2015. This represented only 0.4% of patients

who accessed the service during the month. In the 2015 NHS staff survey the trust scored 3.3 out of five in relation to effective use of patient/service user feedback.

Staff engagement

- The trust used a range of communication tools to ensure that staff were kept informed about news, service developments and policy changes. However, these were not fully effective and we heard mixed views about how well informed staff were.
- All staff had an email account and they told us that many communications were sent by email. This included a weekly bulletin from the chief executive. Some staff told us they received too many emails and they did not have time to read them. They said that there was an expectation that they would read these in their own time because they had little 'down time' during their shift. In the west division staff told us that the trust had recently introduced a communication strategy known as "Change Wednesday". This was in response to feedback from staff that they received too many communications and did not have time to read them all. All changes to systems and practices, except those which were urgent, were now communicated on a Wednesday so that staff knew when to check their emails. We did not hear about this in the east or north divisions.
- Managers also used noticeboards and printed material to supplement email communication. In Yeovil and Weston-s-Mare ambulance stations there were a number of well-presented and well stocked notice boards, providing information about key performance indicators, referral pathways, the role of the emergency care practitioner and the 'right care' scheme. A sector-wide bulletin and a bulletin from the chief executive were also displayed. In East Dorset a quarterly newsletter and an annual performance summary was shared with staff. In Torbay, staff who attended a focus group felt that they were kept well informed by a variety of communication methods. In Plymouth staff described good sharing of information via meetings, noticeboards (pin board and electronic) and emails.
- During our inspection, we overheard an ambulance crew in the east division discussing the new meal break policy, which they were not familiar with. They told us they thought the clinical hubs were not applying it consistently and they wanted to seek some clarity on the terms of the policy. They acknowledged to us that they had probably been sent a communication about this but they had not had time to read it.
- Some staff complained that they had not been given the opportunity to familiarise themselves with new equipment bags. For example, in the west division a staff member told us they had recently returned from leave and the new bag, which they were not familiar with, was in use. We overheard a conversation between this staff member and the clinical hub staff, where the staff member appeared to be berated by hub staff for taking too long to check their equipment prior to beginning their shift because they needed to familiarise themselves with the new bag. The roll out of the new bag was being managed differently in different parts of the service. In Taunton station for example, a bag had been placed in the crew room so that staff could familiarise themselves with it before it was put into use.
- Operations managers acknowledged that communication with a mobile workforce was challenging, particularly with those staff who were based at smaller stations. In the east Somerset sector, weekly updates were sent out to staff. Managers told us that they tried to catch up with staff either in their stations or at emergency departments. The service had recently started to use social media to communicate with staff. In north Somerset there were informal station meetings led by operations officers every six months.
- A series of road shows had recently taken place at local emergency departments, led by the chief executive and the director of operations.
- The chief executive issued a weekly bulletin, which was sent electronically to staff and we saw this displayed in some ambulance stations.
- There was a Staff Suggestion Policy, which allowed staff to identify new or improved ways of working. This was publicised on the trust's intranet and invited staff to comment on suggestions made by their colleagues. If a suggestion was implemented the staff member responsible received a certificate from the chief executive and, in some cases, a small financial reward.
- Minutes from an A&E service line meeting reported that a suggestion had been submitted via the staff survey to appoint lead emergency care assistants/mentors. The suggestion was discussed and supported by the group and a manager was tasked with producing a proposal for further consideration by the group.

Emergency and urgent care services

Innovation, improvement and sustainability

- At the time of our inspection the service had just embarked on a trial, known as the Ambulance Response Programme. This 12-week pilot aimed to improve response times to critically ill patients, making sure the best response was sent to each incident first time and with the appropriate degree of urgency. The trust was one of two ambulance services nationally participating in this trial.
- The trust was working with commissioners to develop and support alternative pathways for patients in order to prevent inappropriate ambulance conveyance to hospitals. The introduction of Right Care had resulted in 56.8% of patients, who called for an ambulance, being treated at the scene or referred to other services, rather than being conveyed to hospital emergency department. Staff and healthcare partners were engaged in providing feedback and identifying instances where alternative sources of support did not respond appropriately.
- The trust was working with commissioners on a plan, Measures to Improve Performance, to improve ambulance response times. Quarterly reports to CCGs monitored progress against the agreed trajectories.
- A local induction programme had been developed in east Dorset, shared and adopted by the rest of the east division.
- A learning and development officer had recently undertaken a piece of work, as part of their master's degree, looking at how to support staff returning to work following a period of absence. They had recognised that there was a lack of a consistent approach in the management of this across the trust. The staff member presented their findings to the chief executive who then requested that the recommendations were developed into a trust-wide policy. At the time of our inspection, this was in draft and was to be developed and implemented by the human resources department.

Patient transport services (PTS)

Safe	Requires improvement
Effective	Requires improvement
Caring	Good
Responsive	Good
Well-led	Inadequate
Overall	Requires improvement

Information about the service

Patient transport services (PTS) provided non-emergency transport for adults and children in Bristol, North Somerset and South Gloucestershire, who were unable to use public or other transport due to their medical condition. Eligibility criteria were applied by the healthcare professionals who made the referral to the PTS control centre.

This was non-emergency work involving admissions to hospital or attendance at outpatient

departments, renal dialysis centres, oncology and hospice centres, day units, children centres, inter hospital transfers and a range of care centres. The service also discharged patients back to their place of residence. This included a '24/7' crew that were available from 6pm to 6am every day.

There were 120 members of staff working in PTS. Patient transport vehicles were crewed by Ambulance Care Assistants (ACAs) and Intermediate Care Assistants (ICAs). The ACAs were responsible for the welfare of their patients, both throughout the journey and during transfer to and from the ambulance. Their role was to ensure all patients were transported both safely and in comfort and that the medical needs of their patients are met.

During April 2015 to March 2016, the service provided 105,317 patient journeys. PTS vehicles were based at six sites: Bristol, Almondsbury, Yate, Nailsea, Soundwell and Weston Super mare. The trust also utilised a boat to facilitate patient transport services in the Isles of Scilly.

The service accounted for 2% of the budget held by the operations team, and was responsible for 5.0% of the patient contacts by the trust.

In the eighteen months prior to our inspection, the contract for Patient Transport Services had been extended twice. One week prior to our inspection, staff were informed that the trust had decided not to bid for the contract due for renewal in September 2016. At the time of our inspection, staff did not know which provider would be taking over the provision of the PTS.

During our inspection we spoke with 27 members of staff including six managers, plus 14 patients, three carers and two nurses at a local acute hospital and the manager of a care home. We observed staff transporting patients to and from appointments and listened to staff attending to the needs of staff and patients over the telephone.

Patient transport services (PTS)

Summary of findings

We gave an overall rating of requires improvement for the patient transport services. This was because:

- There was a lack of consistency around incident reporting. There was no evidence of feedback or learning from incidents during the 12 months preceding our inspection.
- There were infection control risks caused by vehicle defects such as ripped seat covers and punctured internal walls.
- Vehicle daily inspections (VDI) were not consistently completed on a daily basis. VDI checklists were not reviewed or audited leading to a lack of assurance regarding vehicle safety.
- Staff administered 'Entenox' (a medical gas mixture of nitrous oxide and oxygen that is used to relieve pain) to patients. There were no clinical pathways or set protocols to guide the clinical reasoning of staff using this gas. Staff did not record when they gave this treatment to patients. Leaders of PTS could not provide assurance that this gas was administered safely. Immediately following our inspection, the trust withdrew this treatment from PTS.
- Staff administered oxygen to patients to patients who had been prescribed oxygen as part of their treatment regime and adjusted oxygen levels according to their assessment of the patients need during their journey. There was a flowchart for staff to guide their clinical reasoning, but this was insufficiently comprehensive. Staff did not record their interventions.
- Staff did not participate in the learning development review process and compliance with appraisals was poor.
- The process of gaining patient consent for treatment was not documented.
- There was very limited oversight of quality in the PTS other than performance against key performance indicators. Some aspects of governance related to safety issues were unclear and were not monitored effectively.
- Local leaders in the patient transport service were demotivated to make improvements. Staff were unaware of their role in the strategy for the service.
- Staff told us they did not feel supported or valued by their local management team or their employer. Staff told us their concerns were not treated with respect.
- Staff described the culture as insensitive and poor communication was frequently highlighted by staff as a concern. Leaders were aware of communication concerns but had not attempted to address these.
- Meetings were infrequent and irregular and were not minuted. This meant that staff did not feel included in decision making and there was a lack of clarity about how individuals were held to account.

However:

- The service had performed well against the key performance indicators set by commissioners. These related to patient and commissioner satisfaction, timeliness and responsiveness of journeys and management reporting.
- Managers were working closely with local hospitals to improve turnaround time when dropping off and collecting patients.
- Compliance with mandatory training was good at 95.9%
- There were high levels of patient satisfaction and low numbers of complaints reported.
- Staff showed compassion and understanding toward patients and carers.

Patient transport services (PTS)

Are patient transport services safe?

Requires improvement

We rated the patient transport service (PTS) as requires improvement for safe. This was because:

- Staff did not receive feedback regarding incidents they reported. Staff were unable to identify learning from incidents that had occurred during the twelve months preceding our inspection.
- **When incidents occurred, staff informed the dispatch team who logged these onto the electronic management system which was particular to the patient transport services. Managers of the service then decided which of these incidents to report onto the trust electronic reporting system. The trust told us that this decision was based upon whether the incident generated learning. In this way managers were informed daily regarding incidents that had occurred. However this process meant that not all incidents were visible to the trust wide governance system, and trends involving incidents within the patient transport service might not be identified or monitored effectively.**
- There were several vehicles with ripped seat covers and one with a hole in the internal wall. These defects meant that the vehicle could not be cleaned adequately to prevent infection.
- Not all staff were completing vehicle daily inspection checklists. Checklists were not reviewed effectively to enable the safety of vehicles to be assured.
- At the time of our inspection the trust was in the process of swopping non-serviced fire extinguishers with serviced ones. As this process was not complete, it meant there were some vehicles that contained fire extinguishers with no recent check recorded.
- Some staff provided treatment for patients but no records of these interventions were completed. These treatments included administering Entenox (nitrous oxide and oxygen gas mixture) and adjusting oxygen for patients who had been prescribed oxygen therapy as part of their treatment regime.
- At two stations we saw that vehicles were left unsecured with engines running.
- Only 18% of patient transport vehicles had been consistently deep cleaned every eight weeks or less during the twelve months during the period of March 2015 to March 2016.
- At the time of our inspection, emergency preparedness drills had not been completed on the patient transport boat on the Isles of Scilly.However, the emergency preparedness drills are part of the Domestic Safety Management Plan for the Star of Life that went live in June 2016. The first drill is scheduled for September 2016.

However:

- Staff compliance with mandatory training including safeguarding level two training was 95.9%
- We saw that staff regularly cleaned their hands and we observed staff cleaning their vehicles at the end of shifts. The vehicles we checked were visibly clean.
- Business continuity plans had been recently tested.

Incidents

- Staff understood their responsibility to raise concerns, but told us when they did raise concerns, action was not always taken.
- **When incidents occurred, staff informed the dispatch team who logged these onto the electronic management system which was particular to the patient transport services. Managers of the service then decided which of these incidents to report onto the trust electronic reporting system. The trust told us that this decision was based upon whether the incident generated learning. In this way managers were informed daily regarding incidents that had occurred. However this process meant that not all incidents were visible to the trust wide governance system, and trends involving incidents within the patient transport service might not be identified or monitored effectively.**
  For example, staff told us that the electronic communication system used in the vehicles frequently failed, causing delays to patients. We witnessed one such failure occurring during our inspection. These failures were not reported as incidents on the trust wide incident reporting system but were logged separately with the logistics department for resolution.

Patient transport services (PTS)

- **The trust provided guidance regarding incident reporting in their incident reporting policy and in the mandatory training workbook that all staff were required to complete. However, staff demonstrated some confusion regarding when to log incidents solely with the control room and when to complete an incident report. We were told by several staff that incident reports were used for vehicle collisions and not for circumstances such as moving and handling incidents.**
- There were only six incidents reported during November 2015 to February 2016. This was less than 1% of the incidents reported trust wide, and equated to 0.2 incidents per 1000 patient contacts in PTS. Most of these incidents related to minor vehicle collisions and there were no serious incidents reported, which met the commissioners key performance indicator.
- Where reported, incidents and complaints were investigated by team leaders. Investigations were included within the Trust Patient Safety and Experience Report presented to the Board every two months.
- Leaders used emails and a notice board to inform road crew staff about changes in policy or procedure following safety incidents or safety alerts. Staff were unable to give examples of learning from other department within the trust. Staff told us there was limited time in their working day to access information on notice boards or emails.
- One member of staff gave an example of feedback from a driving incident. However most staff told us they were not given feedback regarding learning from incidents and were unable to identify changes to their practice that had been made as a result of learning from incidents.

Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation which was introduced in November 2014. This Regulation requires the provider to be open and transparent with a patient when things go wrong in relation to their care and the patient suffered harm or could suffer harm which falls into defined thresholds.
- There had been no requirement to apply the duty of candour during the twelve months prior to our inspection. Patient transport staff demonstrated an understanding of the need to be open and transparent with patients but had limited understanding of the requirements of the duty of candour.

Mandatory training

- The service had provided a series of one day development workshops for operational staff during 2015-2016. These workshops had included topics such as: level 2 safeguarding, key performance indicators, manual handling, barriers to communication, and oxygen delivery and 'prevent' training. Prevent training was designed to teach staff to recognise and redirect individuals at risk of being radicalised or drawn into a terrorist activities and to share concerns and make referrals as necessary. Compliance with attendance at this training was 97%.
- Staff also completed the trust wide mandatory training workbook. This workbook covered topics such as: Health, Safety & Security, Well-Being, Moving and Handling (Level 1), Equality & Diversity and human rights, Bullying & Harassment, Governance & Information Governance, Safeguarding, Infection Prevention Control (Level 1), Mental Capacity Act, Emergency Preparedness, Response and Resilience, Medicines Management, Risk management, Fire safety.
- Overall compliance with completion of this workbook, including non-operational staff, was 95.9% during 2015-2016.

Safeguarding

- The trust target for safeguarding training compliance was 95%. Level 2 safeguarding awareness for vulnerable adults was included in the one day development workshop attended by 97% of operational staff during 2015-2016. The patient transport service primarily transported adults but on occasion transported children. This equated to less than 0.5% of the overall activity of the patient transport services. The patient transport service specification stipulated that children were required to be accompanied by a carer. PTS staff did not complete a separate course for safeguarding children but the safeguarding adults' workshop included some discussion regarding the identification of safeguarding concerns in children.
- Staff gave appropriate examples of safeguarding concerns they had reported and knew who to contact

for advice. The trust informed us that feedback from local authorities regarding safeguarding events was not always readily available to pass on to employees of the patient transport service.

Cleanliness, infection control and hygiene

- The systems in place to prevent and protect people from healthcare associated infections were not reliable. Staff consistently complied with trust infection control policies such as hand hygiene and were bare below the elbows Personal protective equipment including gloves and aprons were easily accessible on the vehicles and antibacterial hand gel was available on all the vehicles we checked. Managers told us that infection control spot checks were completed by team leaders. However these were not recorded and managers were unaware of any learning that had occurred from these checks.
- The trust standard required vehicle 'deep cleans' to be completed every 8 weeks. Only 18% of PTS vehicles had consistently achieved this standard during March 2015 to March 2016. However, during our inspection we noted that all the vehicles we checked were uncluttered and visibly clean and had been deep cleaned within the preceding eight weeks. Road staff were given time at the end of their shift to clean their vehicle.
- Some internal vehicle defects caused a risk to infection control. We observed several vehicles with ripped fabric on seats with exposed foam padding. This meant that staff were unable to decontaminate these seats effectively. On one vehicle, there was a hole in the internal wall, which caused a breach of the smooth sheet material designed to facilitate cleaning.
- Crews were made aware of specific infection and hygiene risks associated with individual patients, for example patients carrying methicillin-resistant staphylococcus aureus. Staff contacted the control centre for advice and support regarding infection control issues.

Environment and equipment

- Not all staff were completing vehicle daily inspection (VDI) checklists every day. At one station, staff told us they completed a VDI checklist at the beginning of the week and then did not repeat this process unless they noticed a fault or their vehicle changed. At another station, staff told us they were sometimes instructed by control room staff to not complete the VDI checklist because there was insufficient time before their first patient collection.
- There is a statutory responsibility to ensure that daily vehicle inspections take place. We looked for records of these checks at four stations and were shown less than ten at each station, dating back to January 2016.Operations managers were unclear where these checklists were stored and suggested they may have been shredded. The lack of processes for completion, review, and retention of these checklists was evidence that the checklists were not used to give assurance of vehicle safety.
- We saw on one vehicle that there was a loose bumper and a plastic seam cover was missing revealing a sharp edge on the side of the vehicle. These defects had potential to cause injury to patients, staff or members of the public. Staff told us they had not reported these defects because vehicles were rarely repaired. However, if staff did report defects, we saw there was a system in place that ensured the fleet was maintained to an acceptable level. The exception to this were the ripped seat covers evident in several vehicles.
- We saw that fire extinguishers did not display check dates or expiry dates. This meant that staff could not be assured that this equipment was fully functional. The trust was in the process of swopping all fire extinguishers with newly serviced extinguishers. This process was due for completion within the two weeks following our inspection.
- In two ambulance stations we observed that ambulances were left unattended with engines running. There was an expectation that local managers monitored vehicle security and challenged any non-compliance. However, there were no formally recorded spot checks.
- All vehicle tail lifts had been checked and serviced regularly as required by the Lifting Operations and Lifting Equipment Regulations 1998.
- Resuscitation equipment was consistently in date for maintenance. First aid kits were available and were in date. Equipment was labelled and stored in the cupboards provided. All staff were familiar with how to use the equipment carried in their vehicles.
- Seatbelts were consistently used appropriately for patients. We observed that staff secured patients' wheelchairs within vehicles and staff were familiar with

the process and equipment used to do this. When young children were transported they usually sat on their own child seat or booster seat for the duration of the journey, but the patient transport services also held a stock of child seats at the Bristol station. Children travelling by stretcher were safely secured using a specialist paediatric restraint system.

- In June 2015, there had been a review of health and safety procedures on board the 'Star of Life'. This was the boat used for PTS on the Isles of Scilly. There was a domestic safety management system for the boat and this formed part of a self-assessment procedure to ensure compliance with the Maritime Coastguard Agency. This included a local operating procedure. The local operations officer completed a compliance check immediately after our inspection and noted there was no non-compliance with this procedure.
- There were risk assessments in place for eight high risk operations on board the Star of Life, such as refuelling and use of the carry stretcher. Staff had raised concerns regarding the inaccessibility of the life raft on board the Star of Life. At the time of our inspection, the fleet department were fabricating a new bracket to enable the raft to be relocated.

Medicines

- PTS vehicles did not carry any medicines other than oxygen and Entenox (nitrous oxide and oxygen mixture). Patients or their escorts were responsible for their own medicines whilst in transit.
- The patient transport service administered Entenox (medical nitrous oxide and oxygen mixture) to patients on journeys. We were not given assurance that the administration of this gas was governed safely or effectively. Although this gas does not require a prescription to be administered, there are risks to patients if used more frequently than every four days without monitoring the patient's haematology. Use of medical nitrous oxide and oxygen mixture is designated as 'minimal sedation' however if used in combination with other sedatives or potent analgesia there is an increased risk of sedation. There were no clear protocols to guide staff in the safe use of this gas. Staff did not complete a patient care record when this gas had been administered. This resulted in a risk to the accountability of the staff carrying out these interventions, and a risk to the continuity of care for the patient receiving the treatment. Managers of the service did not have a clear understanding of the circumstances or the frequency of occurrences when staff administered medical nitrous oxide and oxygen mixture and the risks associated with this clinical practice had not been assessed or mitigated. We raised our concerns with the managers of the service during our inspection and immediately following the inspection the service withdrew medical nitrous oxide and oxygen mixture from patient transport service vehicles.
- The patient transport service gave oxygen to patients when oxygen had been prescribed as part of their treatment regime and adjusted oxygen to meet patient need. Staff we spoke with demonstrated understanding of the risks and contraindications for adjustment of oxygen and could apply this understanding to patient examples. However, we were not given assurance that there were systems in place to ensure consistent best practice and adequate governance. Ninety-seven per cent of staff had participated in training in oxygen therapy however this training lasted only thirty minutes. The flowchart staff used to guide their interventions was not comprehensive and in particular, this flowchart did not advise regarding the initial assessment needed prior to adjustment of oxygen and did not stipulate the need for follow up of low risk patients. Staff did not complete patient care records when they administered oxygen. This resulted in a risk to the accountability of the staff carrying out these interventions, and a risk to the continuity of care for the patient receiving the treatment. There was a risk to patients who, as a result of their medical condition, tended to retain carbon dioxide during respiration, because oxygen does not result in more efficient breathing for these patients.

Records

- The PTS did not routinely use Patient Clinical Records (PCR). If a PTS crew had a patient that needed clinical assessment or intervention staff contacted the emergency service via the Clinical Hub. An emergency crew then completed a patient assessment and Patient Clinical Record.
- For complex patients, staff sometimes completed a risk assessment of the access to patient's property and a moving and handling plan was determined as a result of this assessment. A note summarising the plan was documented on the booking form, but the assessment process was not recorded. This resulted in a risk to the accountability of the staff completing the assessment.

- Managers told us that they were unaware when the patient care record had ceased to be used, the reasons why this had been stopped, or the method by which staff now recorded these interventions.
- We raised these concerns at the time of the inspection and as a result, managers told us they planned to develop a new standard operating procedure that detailed when and how staff should complete patient care records.

Assessing and responding to patient risk

- Within PTS, there was a service for transporting patients from a local acute hospital to the cardiac centre at a neighbouring acute hospital. Some staff had been trained with additional skills to meet the needs of these patients, including administering Entenox (nitrous oxide and oxygen gas mixture) and adjusting oxygen therapy doses for patients who had been prescribed oxygen as part of their treatment regime, use of the spinal board and a five day first responder course. These staff were called 'intermediate care assistants' (ICA). Booking staff ensured that ICA staff were available for all journeys that required use of these extra skills
- When patients became ill during their journey, staff responded by calling 999 to summon help via the clinical hub. However, there was no standard operating procedure for staff to follow in this situation
- All voluntary car drivers told us they felt confident to dial 999 if a patient became critically ill during their journey.
- Sometimes information on referrals was not accurate regarding patients moving and handling status or the access difficulties present in the patients home environment. In these circumstances, PTS staff completed an assessment of the moving and handling risk prior to the control centre allocating resources.
- Control centre staff used mobility criteria to identify the mobility status of the patient and therefore to allocate appropriate resources for their transportation, i.e. type of vehicle, number of crew. When a ward referred a patient who required to be transported on a stretcher, staff completed a pre discharge questionnaire. This enabled staff to identify appropriate resources to meet those patient's needs.
- Staff covering the '24/7' service could access the 'silver' on call commander and the duty accident and emergency manager for advice if needed.
- Staff in the patient transport services were not required to manage the risks and extra care needs of patients in a mental health crisis because these patients were routinely transported by the urgent and emergency care teams
- Managers checked regularly to ensure that all staff held valid driving licences. Managers ensured that all voluntary car drivers held valid driving licences plus current MOT and insurance for their vehicle.

Staffing

- Managers told us that they reviewed staffing levels in the PTS every twelve months. However, this process was not recorded. No adjustments to staffing levels had been made as a result of these reviews.
- In March 2016, there was a high vacancy rate of 26.1% amongst call advisors but this represented a shortfall of just 1.74 whole time equivalent due to the small team size. There was a low vacancy rate amongst ambulance care assistants at 1.5%
- Agency and bank staff were used to fill staffing gaps and to meet additional demand. During 2015-2016, the use of agency staff was 5%. The trust did not have a target against which they measured the use of agency or bank staff in the patient transport services
- Managers did not monitor the frequency of occasions when staff were required to work longer than their shift. Staff were always given time to take breaks during their shifts, and there was always adequate break between shifts to rest.

Anticipated resource and capacity risks

- Fire evacuation plans were tested in October 2015. This exercise identified a number of required actions that were completed including training of more fire wardens at the Bristol base, review of the door release system, review of the process for resetting of the alarm, and a fault on the alarm system to be resolved.
- In January 2016, the PTS tested the connectivity and functionality of the Gloucester hub. As a result of this exercise some contact details were updated on the plan.
- A self-assessment of emergency preparedness was completed for the Star of Life patient transport services boat on the Isles of Scilly in June 2016. This identified that preparation for emergency situations had not been tested and exercised on board the Star of Life. There

were no records of exercises or drills. The search and rescue drills were anticipated to be scheduled during the summer months when sea conditions were less hazardous.

Response to major incidents

- Managers of the service were aware of their role in the major incident plan for the trust.
- Contingency plans were in place for emergency situations on board the Star of Life PTS boat on the Isles of Scilly.

Are patient transport services effective?

Requires improvement

We rated the PTS as requires improvement for effective. This was because:

- Some of the competencies of intermediate care assistants such as oxygen therapy were reviewed as part of the1-day development workshop attended by 97% of all staff. However, the trust did not provide evidence that other competencies, such as 'Entenox' (nitrous oxide and oxygen gas mixture) administration and cardiac monitoring were refreshed.
- Staff did not participate in the learning development review process and compliance with appraisals was low.
- Standard operating procedures were not accessible to staff when they were out and about transporting patients.
- Staff were not informed when patients were diabetic and this meant that staff did not have access to important information that may be needed by emergency crews attending to assist.
- The process of gaining consent was not recorded.
- The service did not monitor response times for renal patients requiring transportation on a stretcher or trained ambulance crew. This meant that the service could not monitor compliance with The National Institute for Health and Care Excellence (NICE) Quality Standard QS72 Renal Replacement Therapy services for Adults.

However:

- The PTS was achieving the targets identified in key performance indicators for commissioner satisfaction and patient satisfaction.
- Staff attended to patients needs for nutrition and hydration.
- The service was working well with local acute hospitals to provide useful information that enabled wards to plan better for patient arrivals and departures.

Evidence-based care and treatment

- Seven of the key performance indicators set by commissioners were related to the responsiveness of the service. Five of these were achieved in May 2016. These included:
  - 'telephone answering' achieved 95.6% against a target of 95%,
  - 'Patients living less than 10 miles away were in transit no more than 60 minutes' achieved 91.8% against a target of 90%,
  - 'Patients living over ten miles away were in transit for less than 90 minutes' scored 93.5% against a target of 90%,
  - 'transport arriving within 45 minutes of booked outward journey' achieved 91% against a target of 90%,
  - 'Patients were collected within 75 minutes of the booked departure time' achieved 96.6% against a target of 90%.
- However, outcomes in PTS had fallen below the target for two of these key performance indicators. The percentage of patients not arriving more than 45 minutes before their booked arrival time in May 2016 was 87.3% against a target of 90%. Similarly the percentage of patients not arriving after their arrival time was 92.4% against a target of 97%. These metrics had been below target for most of the twelve months prior to our inspection.
- There were 23 standard operating procedures used in PTS to clarify the manager's expectations of staff completing various tasks in their day to day work. These included topics such as rest break management, assisting wheelchair users and wheelchair stability, contacting the operations centre, vehicle daily inspection, cancelling or aborting appointments, use of bus lanes. However, there were no copies accessible to staff in their vehicles or means for staff to access the standard operating procedures when out of the office.

Patient transport services (PTS)

- The trust was not contracted to provide patient transport services for renal therapy patients, except for those who required a stretcher or support from a trained ambulance crew. Monitoring of response times for renal patients transported on a stretcher was included within the standard key performance indicators and was not specifically measured. This meant that the service did not monitor performance against guidelines for collection response times within 30 minutes as outlined in The National Institute for Health and Care Excellence (NICE) Quality Standard QS72 Renal Replacement Therapy services for Adults.

Assessment and planning of care

- An assessment of eligibility was completed by the referring agency. Staff in the control centre checked these details to allocate the correct type of vehicle and crew to meet the patients need for assistance with mobility and/or requirement for escort.
- We observed PTS staff assessing patients' needs at the point of pick-up and offering assistance to board the vehicle as appropriate.

Nutrition and hydration

- Staff attended to patients needs for hydration and nutrition. There was a small supply of drinking water available on the vehicles in sealed disposable cups.
- Ward staff at the local acute hospital told us that PTS staff generally waited for patients to finish their meal if they arrived during mealtime.

Pain

- Patients told us that staff were attentive to their pain levels. Staff were careful when assisting patients to move so as not to exacerbate their pain.
- Staff understood how to assess pain levels of the patients in their care; however we saw no evidence of a standardised pain assessment tool in use and no documentation of the outcomes of pain assessments.

Patient outcomes

- The PTS was required to monitor performance against a set of key performance indicators (KPIs), set by commissioners and based on national guidance.
- The service had consistently succeeded in achieving 100% compliance for the performance indicator related to NHS commissioner satisfaction and had achieved 97.8% compliance against a target of 85% for the key performance indicator related to patient satisfaction.
- PTS was not part of the Trust's Annual Internal Audit Plan and no local audits were completed. Staff in the PTS did not participate in national audits and no external reviews were carried out into the service in 2015/16. This meant the service was unable to benchmark itself against similar services.

Competent staff

- PTS staff were offered adequate support during their induction. As part of their induction, ambulance care assistants attended a one week clinical foundation course covering subjects such as basic life support, cardiac disease and chest pain, management of the choking patient, end of life care, mental health, consent and capacity, dementia, dignity and respect, disability, seizures, wounds, musculoskeletal injuries and stroke.
- The voluntary car drivers gave a mixed evaluation of the quality of the induction they received. There was a volunteer driver handbook containing useful information and advice. This had been updated in September 2015 and reissued to all voluntary car drivers in the service. All voluntary car drivers had attended a training update in November 2015 covering topics such as key performance indicators, safe movement of patients, patient confidentiality and safeguarding.
- However, not all staff felt that their ongoing learning needs were met. Staff did not participate in the trust Learning Development and Review process (LDR). At the time of our inspection, 32.4% of staff were overdue for their appraisal. Staff told us that online training had to be completed in their own. However managers told us that staff were given time to complete training during periods of inactivity.
- In August 2015, following a banding review, the Ambulance Care Assistant role was upgraded from Band 2 to Band 3. At this time, existing Ambulance Care Assistants were trained in competencies specific to the role of Intermediate Care Assistant (ICA) such as Oxygen Therapy and the use of Stretcher equipment.
- "Some of the competencies of intermediate care assistants such as oxygen therapy were reviewed as part of the1-day development workshop attended by 97% of

all staff. However, the trust did not provide evidence that other competencies, such as 'Entenox' (nitrous oxide and oxygen gas mixture) administration and cardiac monitoring were not refreshed.This meant that staff may not have been up to date with the clinical knowledge and skills required to administer these clinical interventions. This posed a risk to the safety of patient care.

Coordination with other providers

- At times of high demand, an independent ambulance service was sub contracted to transport patients. The trust was required to ensure continual and ongoing monitoring of standards of these providers.
- Managers told us that they visited this provider twice a year to check records of MOT, driving licenses and insurance. However, we were unable to corroborate this as these checks were not documented. An audit of this service was undertaken in May 2016 on behalf of the accident and emergency service line which included the patient transport services.

Multidisciplinary working

- The service worked closely with two of the local acute hospitals to provide information that assisted the ward staff to prepare for patients imminent arrival or departure. This included a list the night before of expected patients and their anticipated time of arrival at the hospital. The resource managers in PTS provided a list of patients who would be arriving for outpatient clinic on a stretcher and this enabled hospital staff to ensure a suitable clinic room was available for those patients. Hospital staff at a transport office in one local acute hospital were able to view the booking screen which showed when crews were scheduled to arrive and depart. Managers of the patient transport service had visited ward sisters and matrons to explain the service they provided.
- We observed staff discretely handing over a DNACPR form to the staff receiving a patient at a care home.
- We observed staff handing over a patient to staff at a receiving care home, explaining how the patient preferred to be called, how she needed help with moving and handling and what leisure activities she enjoyed.

Access to information

- The electronic information management system used in patient transport services contained a field to store relevant patient information. However, staff told us they were not always given the relevant information needed to deliver care safely. For example, they were not informed if a patient was diabetic and so were reliant on patients to inform them of any special care they might require, for example food when journeys were delayed. This also meant that if the patient needed emergency assistance during their journey, the crew would not have the relevant information to communicate to the emergency crews when they arrived to assist. The local management team confirmed their decision that information regarding diabetes was not relevant for patient transport service crews to access.
- Staff told us that the electronic communications system used in patient transport vehicles was subject to frequent breakdown. In these circumstances, patients were sometimes delayed as staff in vehicles were not updated with information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- All staff demonstrated a practical understanding of the relevant factors to consider when gaining a patients consent to travel.
- There were trust leaflets available that guided staff through the process of assessing consent and outlined the key requirements of the Mental Capacity Act. However this leaflet was not routinely used by staff within the service.
- PTS staff did not complete patient care records; therefore consent to treatment was not recorded for adults or children. Of particular concern was the lack of documentation of consent for interventions such as use of specialised equipment, provision of and adjustment of oxygen, administering of Entenox (nitrous oxide and oxygen gas mixture).

Are patient transport services caring?

Good

We rated the PTS as good for caring. This was because:

- There were high levels of patient satisfaction reported in a recent survey.

Patient transport services (PTS)

- Staff showed understanding of the challenges faced by patients and their carers.
- There was a good rapport between patients and the staff.
- Patients were encouraged to be independent with their mobility and supported to manage their anxiety.

Compassionate care

- Throughout our inspection, we observed staff treating patients with dignity, courtesy and respect.
- We observed patients being collected from their own homes, care homes and hospital settings. Every effort was made to ensure that they were comfortable, secure and warm during the journey.
- Patients and carers reported high levels of satisfaction with the PTS. They told us they felt safe and cared for during their journeys.
- Patient surveys were carried out annually. In December 2015, 89% of respondents indicated they would recommend the PTS.
- 89% of respondents to the survey confirmed that they were escorted across the threshold of their home and this made them feel 'good and safe', 'pleased' and 'that I was being looked after properly'.
- Staff demonstrated that they knew the patients individually and remembered important details about their preferences.

Understanding and involvement of patients and those close to them

- We heard control centre staff carefully explaining to patients the reasons for their journey and what to expect on their journey.
- We spoke to three carers of patients who reported staff always kept them informed and involved them in decisions regarding the transport of their relatives.
- We observed conversations between patients and patient transport services staff during journeys. Patients were reassured about arrival times for their appointments and kept informed if there were any delays due to traffic conditions.

Emotional support

- Service staff showed understanding of the difficulties faced by patients and their families. For example, one staff member had personally telephoned an anxious patient to reassure them regarding their journey that morning.
- One ambulance care assistant explained the impact of the unfamiliar environment of the vehicle for patients with dementia or anxiety and described how teams supported patients to feel safe in those circumstances.
- We observed good rapport between staff and their patients and carers.

Supporting people to manage their own health

- Not all patients were contacted by the patient transport service prior to their journey. In the last patient survey, completed in December 2015, 79% of patients confirmed they were contacted by phone two working days prior to their appointment and 74% of patients confirmed they were contacted on the day of travel. This enabled patients to prepare for their journey. There was no key performance indicator for contacting patients prior to travel.
- Patients were asked if they required assistance with sitting or standing and were encouraged wherever possible to use their own mobility aids when entering or leaving the vehicle.
- All patients were accompanied to their destination after leaving the vehicle and assisted with booking-in at reception.

Are patient transport services responsive to people's needs?

(for example, to feedback?)

We rated the patient transport services as good for responsive because:

- Two new Patient Transport Service bases had been opened at Weston Super Mare and Soundwell ambulance stations to meet local need. There was a '24/7' service which consisted of one vehicle and a crew available between 6pm and 6am.
- Escorts were encouraged to accompany patients living with dementia or learning disability or for patients whose first language was not English. This enabled staff to meet the patient's individual needs
- There was an intention to make the service more responsive by crews telephoning ahead of arrival times; however, this practice was not yet embedded.

Patient transport services (PTS)

- There were low numbers of complaints and there was some evidence of learning from complaints.

However:

- .There were no communication aids or hearing loops within patient transport vehicles. However, staff could access the language line for translation services whilst at the ambulance base.
- Between 16-18% of planned journeys did not occur for reasons such as cancellation by the hospital or patient being unavailable.

Service planning and delivery to meet the needs of local people

- Information about the local population was used to plan how services were delivered. For example, in January 2016, two new ambulance bases were opened. Provision of a new base at Weston Super Mare enabled teams to be more responsive for patients travelling to and from the local acute hospital. Provision of a new base at Soundwell meant that teams could be more responsive to patients attending the renal dialysis unit at Cossham.
- There had been a recent drive to improve responsiveness by crews phoning ahead to patients or their carers approximately ten minutes prior to their expected time of arrival. The purpose of this call was to alert patients make last minute preparations and also to pre warn crew of potential wasted journeys if patients were unable to attend their appointment. However, staff in PTS and at the hospital told us these telephone calls did not always happen. Managers completed occasional spot checks but did not record these.
- Routing data for the computer aided dispatch system had been introduced in December 2015. Managers told us this enabled more accurate scheduling of collection times and more efficient use of available resources.
- There was a '24/7'service which consisted of one vehicle and a crew available between 6pm and 6am.

Meeting people's individual needs

- Staff encouraged patients living with dementia or learning disability to be escorted by a carer who was able to meet their individual needs in a way that they were more familiar with.
- Patients who used a wheelchair for mobility accessed service vehicles using the vehicle ramp.
- The service had equipment available to meet the needs of bariatric patients including three wheelchairs suitable for patients weighing over 35 stone and one bariatric stretcher.
- However, there were no communication aids or hearing loops inside the patient transport vehicles. This meant that patients with hearing impairment were not well supported to communicate on their journey.
-
- Staff did not use interpretation facilities when patients did not speak English as their first language. Instead they relied upon patients bringing an escort for the journey. However, staff could access the language line for translation services whilst at the ambulance base.

Access and flow

- The Patient Transport Service control centre maintained regular contact with the staff in the vehicles, updating them on any changes to their work schedule and taking on additional work throughout their shift
- Control room staff prioritised the service for patients with the most urgent needs, which were informally determined as oncology patients and dialysis patients. In periods of high demand, patient transport staff asked the hospital teams to prioritise their patients.
- The percentage of planned journeys that did not occur varied across the three geographical regions served. In North Somerset, the year to date figure was 14%, in Gloucestershire, this figure was 16% and in Bristol this figure was 17%. Across the whole patch this figure had reduced from 17.2% in 2012/2013 to 15.8% in 2015/2016. The trust told us they did not benchmark this figure against similar services because there was no national definition of 'aborted journeys'. The most common reasons for journeys not going ahead were cancellation by the hospital, patient not available or not ready, patient too ill to travel or patient used own transport.
- Vehicle servicing was completed in the evenings and weekends in order to ensure that as many vehicles were available during peak transport hours as possible.
- A system of automatic scheduling had been recently introduced in order to provide more accurate and objective prediction of journey times. Managers felt this was effective during quieter periods but less effective during busy times.

Learning from complaints and concerns

Patient transport services (PTS)

- There had been 16 complaints during November 2015 to February 2016. This accounted for 3% of the total complaints received by the trust. This equated to 0.4 complaints per 1000 patient contacts in the Patient Transport Service. The patients transport services did not benchmark their complaints data against other similar services.
- Complaints were investigated by team leaders. Investigations of complaints were included within the Trust Patient Safety and Experience Report that was submitted to the Board every two months.
- One of the key performance indicators for the PTS related to the handling of complaints in line with trust complaints procedure. The service achieved 100% compliance with this measure.
- Posters were displayed inside vehicles explaining how patients could make a complaint. Staff carried credit card sized information cards to give to patients who requested information regarding how to make a complaint.
- Managers gave an example of a recent complaint that had been amicably resolved when they had given careful explanation to the complainant. As a result, the service planned to introduce more information to patients at the time of booking their transport in order to provide realistic expectations of journey times.

Are patient transport services well-led?

Inadequate

We rated the Patient transport services as Inadequate for well led. This was because:

- Some aspects of governance related to safety issues were not adequately monitored, for example, infection control. Risk registers did not capture all known risks, including clinical risks. Identified training needs were not acted upon.
- There was very limited oversight of quality in the Patient Transport Service other than performance against key performance indicators. Some aspects of governance related to safety issues were unclear and were not monitored effectively.
- Local leaders in the patient transport service were demotivated to make improvements. Staff were unaware of their role in the strategy for the service.
- Corporate objectives and trust strategic goals placed a value on supporting staff. Subsequent to our inspection, a trust level retention initiative invited Patient Transport Service staff to retrain as emergency care practitioners and transfer to the urgent and emergency service. However, at the time of our inspection staff told us they did not feel supported or valued by their management team or their employer. Staff told us their operational concerns were not treated with respect.
- Staff described the culture as insensitive and poor communication was frequently highlighted by staff as a concern. Leaders were aware of communication concerns but had not attempted to address these.
- Meetings were infrequent and irregular and were not minuted. This meant that staff did not feel included in decision making and there was a lack of clarity about how individuals were held to account.
- The 2013/2014 integrated business plan included was some evidence of forward planning for service improvement. However at a local level, leaders appeared demotivated to effect improvement.

However:

- Leaders of the service had ensured that all staff were fully informed about the outcome of the tendering process.
- Performance of the service against the key performance indicators was monitored effectively.

Vision and strategy for this service

- The Trust had one PTS contract in the North division (covering Bath, North Somerset, and South Gloucestershire). There had been five extensions to the contract since 2013. This had led to uncertainty about the future of the service. One week prior to our inspection, staff were informed that the trust did not intend to submit a bid for the contract when it was due for renewal in September 2016.
- Within the context of uncertainty of the contract, there was some evidence of forward planning to improve the quality of the service provided. The trust integrated business plan for 2013/2014 outlined an intention for the patient transport services to improve the information provided to the public on how to contact the service directly and how to provide feedback in relation to patient experience. In addition the Trust planned to improve the call-to confirm service to include text messaging features.

Patient transport services (PTS)

- Over the period of the contract extensions the service made some attempts to improve. For example during 2015/16 the Trust presented the Commissioners with an option to test out a service improvement linked to quicker turnaround times for patients in hospital. However this was not taken up.
- A senior trust manager told us that prior to the decision not to tender, future plans had included the relocation of the service within the new control room which would have facilitated access to administrative support and potentially better integration with the Emergency and Urgent Care service, and a more consistent approach to systems of assurance. However, at a local level, leaders appeared demotivated to effect improvement. One manager described feeling as if "the writing had been on the wall for a year and a half".
- Uncertainties regarding the contract had resulted in a lack of investment in the vehicles which were now in their 7th year of use.
- Two and a half years prior to our inspection, a substantial portion of the service contract was lost. Many staff left the service including the deputy manager. At this point administrative support was withdrawn from the service. The lack of administrative support had impacted upon the recording of key governance processes such as minutes of meetings.
- Staff told us they felt disconnected from the trust. The mission statement for the trust focussed entirely on emergency care. Managers of the service told us that due to the uncertainty of its future, the Patient Transport Service had to be seen as a self-sufficient service that operated without any requirement for further investment from the trust. Performance against the key performance indicators was prioritised because this was fundamental to the financial viability of the service.

Governance, risk management and quality measurement

- The Service was part of the Operations Directorate under the leadership of the Director of Operations.
- The majority of Patient Transport Service staff were Band 3 staff who were supervised by four band 4 team leaders. Band 4 team leaders were responsible for investigating incidents, managing the roster, annual leave, sickness reviews, probation reviews and ordering uniform.
- There were two operations managers, one of whom was responsible for all road crew staff and one was responsible for the management of the control centre. These managers reported to the Head of Patient Transport Services who in turn reported to the Director of Operations. The service reported into the 'A&E Service Line' Group which included the heads of operational teams across the trust plus the head of resource management, the head of urgent care services, the head of service development the staff officer and the deputy clinical director. This group reported to the Directors' Group. All staff were clear about their roles and responsibilities.
- Senior managers were kept informed regarding issues of concern within the service. These communications occurred within a weekly conference call, a monthly governance meeting and a weekly individual telephone call plus informal access via telephone when required. Issues relating to the Patient Transport Service contract ending were discussed at the accident and emergency service line meeting in May 2016 Plans for redeployment of staff within the urgent and emergency care teams was discussed and this included training applicants with emergency driving skills if required. However this discussion did not include any plans to support staff into the new host organisation. The need for a risk assessment regarding the impact of staff leaving to find secure employment elsewhere was not identified at this meeting.
- Mobilisation plans and the annual work plan were agreed with commissioners and were discussed at monthly contract board meetings, attended by the head of the service, a patient representative, and representatives from three clinical commissioning groups, two local acute trusts and the clinical support unit. A scorecard for the service communicated performance against key performance indicators plus levels of activity, patient flow, and any resulting actions. Every month the service also reported to the board on the 16 key performance indicator metrics.
- Three of the key performance indicators related specifically to governance, all of which achieved 100% compliance in May 2016. These were: provision of activity reports, provision of summary of reasons for journeys outside of Key Performance Indicators, and finance queries resolved within specified timeframes.

- Managers told us that team meetings occurred. However, these were not held regularly, there were no agendas and meetings were not minuted. There was a Patient Transport Services Working Group with representation from staff and unions that had facilitated discussion of key changes such as the new contract. However, this meeting was also not minuted. As a result there was no means of ensuring actions were carried out or how individuals were held to account.
- Risks associated with the service were held on the operations directorate risk register. However, this did not contain all the service risks we identified during the inspection as there were only two specific Patient Transport Services risks on it. Firstly, the potential for the trust to not create a service model that could meet commissioner expectations was rated as a moderate risk. Secondly, the computer aided dispatch system operating on very old servers was rated as a minor risk. The risk register did not include risks such as loss of service due to inclement weather, vehicles nearing the end of service life, and staff leaving employment with the trust due to the patient transport services contract not being renewed.
- Within the service, governance was not focussed on safety issues. The governance process did not identify a lack of incident reporting or a failure to identify risks. Managerial oversight of quality was focussed on the service performance against the key performance indicators which primarily measured the responsiveness of the service. This meant that important safety concerns were not monitored, for example infection control or service level risks. Safety procedures were not standardised, for example the completion of vehicle daily inspections. Managers could not give assurance that important procedures were taking place, for example, vehicle security spot checks. The service did not have an audit program to support assurance. As a result, routine audits failed to be completed and a lack of governance failed to identify this.
- Managers were not aware of some clinical risks. For example, there was no current risk assessment for the administering of Entenox (nitrous oxide and oxygen gas mixture) by Patient Transport Services staff. The management team had no oversight of the frequency by which staff administered this medical gas. We raised these concerns during the inspection. As a result, immediate action was taken to prohibit staff from administering nitrous oxide and oxygen mixture on the vehicles.

Leadership of service

- Staff felt supported by their peers and the unions. Staff felt well supported by their band 4 team leaders who were perceived to be separate from the management team. Team leaders described their role as a conduit between the staff and the management team.
- However, not all leaders had the necessary leadership skills to lead effectively and promote supportive relationships. Above band 4 level, some managers were described as unapproachable and insensitive. Managers were felt to be out of touch with what was happening on the front line. We saw that the door to the manager's office was routinely shut during our inspection and managers were not observed to greet staff.
- The trust executive team were based approximately 90 miles from the Patient Transport Services base and this lack of proximity represented a challenge for visibility. We were told by staff that senior managers were "invisible unless there was a problem."
- Both operations managers had commenced externally accredited leadership training but this had been interrupted because the manager who was leading the coordination of the training left the trust. The trust informed us there was no current plan to resolve the non-completion of these leadership courses for managers in the patient transport services because the future of the service was unknown.

Culture within the service

- Corporate objectives and trust strategic goals placed a value on supporting staff. Subsequent to our inspection, a trust level retention initiative invited PTS staff to retrain as emergency care practitioners and transfer to the urgent and emergency service.
- However, at the time of our inspection staff told us they did not feel supported or valued by their management team or their employer**. One staff member told us they felt 'only valued as a resource'. Several staff told us they were never thanked by their managers for their work.**
- Staff told us that the managers of the service did not communicate with them in a respectful or supportive

way. We were told by staff that managers frequently shouted at them and spoke to them in a discourteous manner. Fifteen members of staff from different ambulance stations used words to imply that the communication from some managers and other staff was insensitive or disrespectful. On one occasion we observed a member of staff in the control room undermining and dismissing the judgment of a road crew that had alerted the control room to a moving and handling concern.

- Team meetings were irregular and no minutes were taken. This meant that staff unable to attend could not update themselves of matters arising at these meetings. We were told that team meetings were difficult to arrange due to the logistical requirement to keep vehicles manned and the service running. However there were no plans to arrange these meetings differently to meet the needs of staff and the service.
- There were some tensions and conflict evident between staff in the control centre and staff in vehicles. We witnessed one example of staff responding to requests for help in a negative way. Staff told us they felt there was limited understanding of the pressures for staff in the control room as well as the pressures for staff on the road. Managers had some awareness of the tensions between dispatch staff and road crew but had not addressed this in a proactive way.
- There was a high turnover of staff in the service. For 2015/6 this was 13.2% for managers and administrative staff, 11.7% for ambulance care assistants and intermediate care assistants, and 33% for call advisors. Managers did not conduct or record exit interviews to determine the reasons for staff leaving their posts in the patient transport services. Managers estimated that several staff moved across to the accident and emergency teams because these offered more career prospects and job security. Managers felt this was unavoidable and were not using proactive strategies to retain staff.
- Staff told us there was not a strong emphasis on promoting their well-being. For example, leaders had identified that staff in the control centre should be offered conflict resolution training because they were frequently dealing with abusive telephone calls. However, at the time of our inspection this had not occurred because the need to continue the service without interruption was prioritised. As a result staff continued to receive abusive calls without the training or the skills to manage them appropriately.
- There was a lone working policy for the trust but managers of the PTS service identified that they had not been involved in the development of the policy and it did not meet the needs of PTS their staff. Managers were not motivated to make improvements. No action had been taken to raise the issue or amend or adapt the policy to better suit the needs of the staff working in patient transport services.

Public and staff engagement

- The leaders of the service gathered the views and experiences of patients who used the service. There was a patient representative who attended contract meetings for the PTS.
- In November and December 2015, a patient survey sampled 212 patients. There was a 43% response rate to this survey. However the response rate for the friends and families test was very low at 0.4% during December 2015 to February 2016. There was no plan to improve the response rate to the friends and families test.
- Leaders of the service facilitated several meetings with staff representatives and union representatives regarding the bidding process. However these meetings were not minuted and this meant that staff not attending were less able to feel engaged in the process. Staff did not feel actively involved in the shaping of the culture within the service. The week prior to our inspection, trust executives held a meeting with all Patient Transport Services staff to notify staff and explain the trust decision not to bid for the contract. This was attended by approximately 70 staff. The following day the management team and human resources staff telephoned all staff who was unable to attend the meeting. All voluntary car drivers were contacted by telephone by one of the operations managers.

Innovation, improvement and sustainability

- The rosters of the operational centre staff had been recently changed. This measure was introduced for the well-being of staff because management were concerned that long shifts were affecting the

concentration of staff in that environment. Although we were told this change management process had involved several engagement meetings, we were not able to corroborate this as these had not been minuted.

- Staff told us they had suggested ideas for improvement, such as developing a guidebook for new staff working in the control room, but managers had not supported staff to develop these ideas.
- At a local level, the service had failed to develop any innovation. There was minimal evidence of learning or reflection to support improvement.

Emergency operations centre

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

Information about the service

South Western Ambulance Service NHS Foundation Trust and the emergency operation centres (EOCs) serve a population of 5.3 million people. The area it covers extends for around 10,000 square miles from the tip of Cornwall, including the Isles of Scilly, to the top of Gloucestershire, and across the south west of England to include Wiltshire and Dorset. During the year from 1 April 2014 to 31 March 2015, the trust responded to 867,505 emergency and urgent incidents. This required the EOCs to handle around 2,400 calls each day from people dialling 999 for an ambulance service. This included healthcare professionals making requests for urgent transport. The EOCs employed around 430 of the trust's staff, of which 370 had direct patient contact.

The role of the EOCs is to receive 999 ambulance calls from members of the public and other emergency services. Staff assess caller's needs, take decisions, provide advice, and dispatch ambulances to the scene as appropriate. Staff also provide assessment and treatment advice to callers who do not need an ambulance to respond: a service known as 'hear and treat'. This involves staff giving advice to callers including self-care, making an appointment to see their GP, or directing them to other services. Staff in the EOCs manage requests from healthcare professionals, such as GPs and hospital staff, to convey patients from the community into hospital, or transfer between different hospitals.

South Western Ambulance Service has two primary EOCs and a third for ambulance dispatch only. The first is at trust headquarters in Exeter, and second in the north of Bristol, adjacent to the M5 motorway. The third is located in St Leonards in Dorset. The Exeter and Bristol EOCs work as one 'virtual' EOC with 999 calls routed to the next available operator, and vehicles dispatched from the centre responsible for the local area (which also involved St Leonards). The Exeter and Bristol bases have both emergency medical advisors (staff trained to take and triage emergency calls) and trained clinicians (nurses and paramedics) assessing patients and giving clinical advice to the patient or their carer.

We inspected the Bristol (North) and Exeter (South) EOCs with announced visits on 7 and 8 June and 9 and 10 June 2016 respectively. We visited the site of the new Bristol EOC with senior management on 20 June 2016. This was an office building, close to the current location, undergoing an extensive upgrade, and was due to be ready for staff to move into in November 2016. We visited both EOCs again on an unannounced visit on the evening of 22 June 2016. We spoke with around 60 members of staff including emergency medical advisors, emergency medical dispatch officers, clinicians, team leaders, supervisors, duty managers, the quality and complaints team, a safeguarding named professional, frequent caller lead, and senior managers. We listened to around 120 emergency calls and heard how callers were treated and responded to over the phone. We looked at and analysed public data about the organisation, and information provided to us by the trust.

Emergency operations centre

Summary of findings

We rated the emergency operation centres overall as good because:

- There was a good system for reporting incidents, carrying out investigations, providing feedback to staff, and learning and making improvements.
- There were reliable practices for safeguarding people from abuse.
- Patients' risks were well assessed and monitored and good records maintained.
- The service was able to respond to major incidents and change priorities in times of extreme pressure. There were protocols for staff to follow in high-risk situations to keep staff and the public safe.
- The service had recognised the growth in call volumes and was responding by increasing staffing levels above establishment levels.
- Staff had the skills and knowledge to deliver effective advice and guidance. Evidenced-based systems were well integrated. There were internal and external development opportunities and training available for staff.
- There was multidisciplinary work between teams in the EOC and partner organisations.
- All staff demonstrated outstanding compassion, kindness, and respect towards callers and patients often under a high level of pressure. In 120 calls we listened to, this was consistently demonstrated.
- There was a strong and visible patient-centred culture with all staff wanting to help people by showing them kindness and respect.
- The caring of all staff was outstanding, despite them not knowing who they were going to be speaking with next, and how they would be required to respond. This was notable particularly with a significant crisis for a patient with mental health needs, and how staff acted promptly to give them strong and compassionate support.
- The needs of local people were met by good planning and delivery of services.
- There were procedures and protocols for supporting people in vulnerable circumstances.
- Resources were used where they were most needed. The trust had been commended for its service to reduce and respond to frequent callers
- The trust was prioritising resources with a good 'hear and treat' service.
- There was learning and improvements made when people complained about the service they received. Complaints were handled with sensitivity and time taken to provide a considered response.
- There was a clear vision and credible strategy for the service. The leadership reflected the values of the service and were open, approachable and supportive.
- The governance framework had clear responsibilities and most risks were understood and managed.
- There was a strong wellbeing and support service for staff and good engagement with staff and the public.

However:

- The service was significantly below the trust's target for updating mandatory training.
- The levels of staffing were not sufficient to provide relief at all times when staff were training, on holiday, off sick, or taking special leave.
- Staff were not being assessed for their competency and performance and the service was significantly below the trust's target for completing these appraisals each year.
- There was a lack of quality review at local level.
- The leadership was not aware of when the levels of professional support given to staff were failing.
- There were missed opportunities for better integration with the staff working in the different EOCs.

Emergency operations centre

Is emergency operations centre safe?

Good

We rated safety overall as good because:

- There was a good system for reporting incidents, carrying out investigations, providing feedback to staff, learning and making improvements.
- There were reliable practices for safeguarding people from abuse.
- Patients' records were held securely on electronic systems and special notes were available to help support and protect patients and staff.
- The risks to patients were assessed with approved triage systems. Decisions were monitored and revised by clinicians when appropriate, or risks changed.
- There had been a good implementation of the pilot for the ambulance response programme. This triage system was being trialled by the service to assess the safety, effectiveness, and responsiveness of the service should it move away from time-target based responses to sending the right response, first time.
- The service was able to respond to major incidents and change priorities in times of extreme pressure. There were protocols for staff to follow in high-risk situations to keep staff and the public safe.
- The service had recognised the growth in call volumes and was responding by increasing staffing levels above establishment levels in the emergency operation centres.
- There was a good skill-mix among the staff, and plans to broaden the experience in future.
- Staff being able to take their breaks and leave on time was improving.

However:

- The service was significantly below the trust's target for updating mandatory training.
- Not all staff were reporting incidents, particularly when they were verbally abused by callers.
- The levels of staffing were not sufficient to provide relief at all times when staff were training, on holiday, off sick, or taking special leave.

Incidents

- The trust had a straightforward incident reporting policy approved through its governance processes and in date. The policy required staff to report all adverse incidents so they could be investigated and controls arranged to avoid the incident reoccurring. The policy also required learning from near misses or minor incidents without harm. The policy went on to describe what events should be reportable incidents, and then how to report them. The responsibilities for ensuring incidents were properly investigated; findings fed back, and learning shared and implemented, lay with appropriate senior management.
- Staff we met in the EOCs were aware of the duty to report incidents, and how to report an event falling into that category. The trust had an electronic incident reporting system which all staff had access to, although some had to find an available computer to make reports. Staff we spoke with were familiar with the electronic reporting system, and how to use it. They explained how incidents were categorised. They described how some calls could have more than one issue, so these would be reported separately in different categories. Some EOC staff, however, said they had not often reported an incident, and felt they did not happen that much in their particular role. Some staff said they reported issues on to their duty manager, as they did not have time factored into their responsibilities to report incidents themselves. Others said they had reported incidents, and we had good examples, particularly from the clinicians. There were over a thousand incidents reported by the EOCs in six-months, which was indicative of a high-level of reporting and good reporting culture.
- Not all staff were reporting some of the things classed as an incident by the trust. Staff were well aware of delays, patients being given the wrong advice, and accidents in the workplace. We asked staff if, for example, they would report being verbally abused by a caller. Most described this as part of the job, and they did not see this as an incident, unless it stood out as exceptionally bad. Trust policy required staff to report security incidents, including verbal abuse, described as the use of "inappropriate words or behaviour causing distress and/or constituting harassment." The incident report supplied by the trust for the EOCs contained 1,108 incidents reported between 1 October 2015 and 31

March 2016. We looked at incidents reported in this six-month period under the category "abuse from persons external to the trust" and "verbal abuse or disruption" and there were only nine examples.

- There was a reduction in serious incidents between the years 2014/15 and 2015/16. The division in which the EOCs sat (A&E service line) reported 40 serious incidents in 2014/15 and 27 in 2015/16. This was a fall of around 30%. The incidents in 2015/16 represented 0.002% of patient contacts.
- Not all incidents were being investigated in the time required. The trust, however, had not closed all these incident investigations within the 60 days granted by the NHS National Serious Incident Framework. There were 27 out of the 51 overall being closed in the time period allowed, or had granted an extension by the trust's lead commissioner. This was, we were told, due to what had now been recognised by the trust as not enough staff working in this area. New staff were being recruited to increase the team looking at quality, which included review of serious incidents.
- There was a formal structure for reviewing, investigating and reporting on adverse incidents dependent upon their severity. The way incidents were reviewed was determined by a 'risk matrix' and showed who was responsible for investigating the incident, and signing off any reports. The trust had a 'quality team' who took the lead for investigating incidents. Serious incidents were subject to root-cause analysis investigation, and reports to show how the incident arose and what could be changed to avoid it in future. We saw evidence of reports being presented to local management teams and onwards to senior staff through governance reviews. Some of the quality team had attended a two-day training course in root-case analysis and reporting. We reviewed a serious incident from late 2015 relating to capacity to cope with increasing call volumes in the EOCs. Following this incident, a revised standard operating procedure was implemented to work alongside the trial of the ambulance response programme. The programme is described in more detail later in this report. It was seen alongside the new standard operating procedure as one part of the changes being implemented to manage increasing call volumes. Another included recruiting more staff, which was underway.
- There was feedback to staff about serious incident reviews and the learning associated with those, although a number of staff we spoke with were not able to describe how more general feedback was received. A board paper from May 2016 stated that learning from incidents was now being presented to staff in the trust's weekly staff bulletin. This bulletin had started in April 2016 and replaced reporting through the previous newsletter. Despite publicity to staff about incident feedback, a number of frontline staff we asked were not sure as to how this feedback was being currently presented to them. They were not aware of this being part of the staff newsletter. However, the trust told us there had been positive feedback from staff about the newsletter, although the learning and reviews were still not reaching everyone. Individual staff members involved in serious incidents gained feedback from review meetings.
- There was a summary and review of incidents and themes in the annual patient safety and quality report 2015/16. A number of themes had been identified throughout the year. Actions to address these themes and avoid reoccurrence included: work for the clinical team on 'confirmation bias' (other factors in situations potentially clouding judgements); training to avoid producing incomplete patient records; an article about improving spinal care; and the production of sepsis assessment and management leaflets. A number of staff referred to these actions in general conversations, and it appeared the learning had been received and was ongoing.

Duty of Candour

- The trust and EOC staff were aware of and had implemented the duty of candour. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was introduced in November 2014. This regulation requires the trust to notify the relevant person that an incident has occurred, provide reasonable support to the relevant person in relation to the incident, and offer an apology. Managerial staff we met knew about the duty of candour, and it had been referred to with its own section in the patient safety and quality report for 2015/16. Staff in the complaints team referred to using duty of candour in the appropriate circumstances. They said involving the relevant person and making an apology was at the top of their priority

list. We were told the outcome of a complaint had been clearly improved in all circumstances by making a genuine apology and learning from how it felt for the people involved.

Mandatory training

- There was a varied but mostly poor compliance from EOC staff in updating their mandatory training. The trust had a programme of mandatory training requiring staff to update some training every year, and others every three years. The main set of courses was to be updated every three years. This included infection control, emergency resilience and response, safeguarding training, patient experience, the Mental Capacity Act 2005, and medicines management among 24 different topics (a few of which were not relevant to all staff). Courses to be updated annually were information governance and fire training. Clinical staff were required to undertake subject-matter expert training each year. The results for the EOCs against the trust's target of 95% compliance were as follows:
  - Infection control (three yearly) had been completed by 49% of staff;
  - Mandatory training (three yearly) had been completed by 49% of staff;
  - Information governance (annually) had been completed by 100% of staff;
  - Fire training (annually) had been completed by 80% of staff;
  - Emergency preparedness, resilience and response awareness (three yearly) had been completed by 48% of staff;
  - Subject-matter expert (annually for clinical supervisors) had been completed by 53% of staff;
  - Mental Capacity Act (three yearly) had been completed by 50% of staff.

Safeguarding

- The organisation had staff trained and specifically responsible for safeguarding and liaising with other agencies and professionals. We met with the safeguarding named professional for the area designated as 'North' and discussed their role. This involved liaising with other safeguarding professionals external to the organisation and internal staff with concerns and information to escalate. Staff from the EOCs could contact their named professional at any time for advice or guidance.
- Staff were trained on induction to recognise and act upon any concerns in relation to safeguarding. Staff were told what made a person vulnerable, and what they had to do if they suspected any abuse of a person described in this way. Those we spoke with knew what things should concern them from a call to EOC staff. This included, for example: a child being alone or in a potentially unsafe situation; a call being terminated when there was a known or possibly vulnerable person in the situation; and noise in the background (such as shouting or crying) giving cause for concern. Staff taking 999 ambulance calls said they would alert the duty manager or their team leader if they had any safeguarding concerns. The duty manager we met said they would ask for a debrief from the member of staff. They were also able to listen back to the recording of the call – which was available for all staff, including the safeguarding team. Concerns were then escalated to the trust safeguarding lead for evaluation and referral. If this person was not available (such as out-of-hours) the contact details for the local authority escalation team, who had the statutory responsibility for safeguarding, were all on the trust's internal website (which we saw).
- Not enough staff had received the latest training to update them in safeguarding. The trust had a refresher course to be updated every three years for some of their mandatory training. This included safeguarding. Only 49% of EOC staff had updated their mandatory skill set, and this included safeguarding children and vulnerable adults. This was well below the trust's target of 95%.
- There were multidisciplinary reviews into serious issues where safeguarding was involved, or those where there were multiple concerns. The safeguarding lead was involved with local safeguarding boards (to review and discuss policy and performance) and with the local authority teams (to discuss specific investigations). Joint meetings involved relevant agencies, including the local authority safeguarding team, the police, and any other healthcare professionals, such as the local acute hospital or community services. They could extend to include social workers, the fire service, and other appropriate persons, such as teachers and GPs.
- There were internal links with trust safeguarding personnel for other potentially vulnerable people. The team who managed frequent callers to the service sat under the umbrella of the safeguarding team within the

trust, as frequent callers were often recognised as vulnerable. Referrals were made to the safeguarding lead for people identified as frequent callers, which included both adults and children.

- There was valuable feedback to staff making safeguarding referrals. Feedback to a member of staff had provided confidence and reassurance of her knowledge and understanding around safeguarding children. We were shown electronic feedback provided to a member of staff by the safeguarding team as to the outcome of the referral. The staff member told us it was good to get feedback and to know there had been a positive outcome.

Cleanliness, infection control and hygiene

- There were procedures for EOC staff to handle incoming information about infections, and to minimise the risk of transfer. Staff had relevant procedures for notifying ambulance crews about known or potential infections or hygiene issues at the scene of an incident. When it was appropriate, the triage system the emergency medical advisors used (to gather vital information about the incident or the patient) led staff to ask about possible infections or hygiene issues. This was particularly the case if a patient was being conveyed from one hospital to another, and might have a healthcare-acquired infection such as Clostridium difficile or other condition/infection. This information was passed through the call record to the emergency medical dispatch team. It was then made available to the ambulance personnel attending the scene or transferring the patient. Calls we listened to with advisors and dispatchers demonstrated how the system prompted enquiries about possible infections or risks, and these were passed on as required.
- There was a team of experienced clinical advisors available to give advice to emergency medical advisors or emergency medical dispatchers about possible risks from infections or environments. If staff were given information about a scene or a medical condition and wanted more information, they were able to ask for advice and guidance from the clinical advisors. The clinical advisors were also able to call the patient or person with them to get further information about possible risks. There was guidance on the trust intranet about how to proceed when certain infections or risks were known or suspected. This more specialist clinical guidance would be relayed to the ambulance crew attending the incident or patient.
- There was a lack of clarity with the use of hand gels in the EOCs. There was guidance on the wall in one of the corridors in the Bristol EOC, for example, directing staff to use hand gel before proceeding to enter an area. However, staff were not entering a clinical area, so hand gel was not essential, and we saw no staff using it. One member of staff said they were not entirely sure why it was there, and another said it was there for those who might want to use it. There was nothing mentioned in the trust's infection control policy about the use of hand gels in such non-clinical settings. Some staff were also carrying portable hand gel, which did meet the trust's uniform policy, but some staff again said they did not really know why and there were comments along the lines of "it's just for show."
- Staff in the EOCs followed trust policy in relation to hand-washing and uniform rules. Frontline staff in the EOCs were required to wear uniforms, and these were short sleeved. Trust policy required all staff in uniform not to wear wristwatches, bracelets, rings with stones, and have long nails, nail varnish or extensions. All EOC frontline staff we met followed trust policy and were 'bare below the elbow' in their uniforms with the objective of improving hand-washing results. Other staff in the EOCs, such as technical (IT) staff were not required to wear uniform or follow uniform dress-code rules.

Environment and equipment

- There were good working environments for staff, and the now overcrowded EOC in Bristol was relocating in November 2016 to larger premises. There was a safe system of working in the Exeter EOC, which would be replicated and further improved upon in the new Bristol offices later this year. The mostly open-plan area in Exeter had a quiet area for training, but otherwise banks of desks for staff teams in different roles (emergency medical advisors – taking calls, and emergency medical dispatchers – arranging transport). At the end of the set of desks (which were for around 10 staff at most) were the clinical advisors. These were nurses or paramedics, or could be a doctor, and Bristol's EOC had a midwife (part of a pilot being tested within Gloucestershire). They were able to give urgent or considered clinical

advice to the advisors, dispatchers, or others in the EOCs. The service was looking to extend the midwife pilot to 24-hour provision, and into a wider area, should the evidence support this. The Bristol EOC had recognised it had outgrown the physical space for the emergency team, and clinical staff were not co-located with the advisors or dispatchers. There was limited desk space and staff were close together, which made noise an issue. There was, nonetheless, office space and training areas on other floors within the Bristol building. This included quiet rooms and staff rest areas. The Exeter EOC also had some limitations with a lack of meeting rooms for one-to-one meetings. This had been raised on the risk register with a date to be resolved of November 2016.

- There were tested systems and procedures to follow if there were equipment or software failures. There were dedicated IT teams to respond to technical problems, and the server equipment was located within the trust's buildings, so there was access at all times for the internal IT experts. The EOCs had procedures for business continuity in the event of a failure in triage and/or dispatch systems. The EOC had experienced a number of conversions to their stand-by paper-based process when some or all of the equipment failed, and we were told these went well. There were procedures for transferring any information given or taken into the electronic records once the problem had been resolved. Staff did say, however, there were no regular practices of the stand-by system. Some staff were frustrated with the IT systems, and expressed a lack of confidence in their speed and reliability. There were 13 incidents reported by the EOCs in the six-month period of October 2015 to March 2016 under the two categories amounting to "failure of IT systems".
- The EOCs complied with the 'Display Screen Equipment Regulations 1992' to provide a safe environment for the staff within the workplace. Training and information was provided to staff during induction and training. This was repeated again within the three-yearly mandatory training. Staff also had a yearly online workstation assessment. Where it had been assessed as appropriate by occupational health, staff in the EOCs had been provided with customised desks and chairs.
- There were facilities to provide continuity if one of the EOCs went out of action for a sustained period. The EOCs had 'mirrored' facilities for staff to be relocated to either Exeter or Bristol in the event the service at one of the locations could not continue to function. There were reserved areas with computer screens, desks and chairs to accommodate an emergency team from one of the other EOCs to be able to take calls and dispatch ambulances to patients. These were able to be used by either team and were regularly tested to make sure they were functioning at all times.
- There were some common systems in use, but some still to be rolled-out to provide a uniform platform for the EOCs. At the time of our inspection, there were still some legacy systems in use following mergers of ambulance trusts, most recently in 2013, to form this larger trust. Some systems had now been replaced and introduced across the EOCs, including the computer-aided dispatch system. The new computer-aided dispatch system was introduced in Exeter in November 2015 and in Bristol in February 2016. With the same computer-aided dispatch system operational, the two EOCs now had a single regional view of patient incidents and ambulance resources. Other systems, including the telephony system and the triage software remained different between the South/East and North locations. The triage software used in the South (Exeter), called NHS Pathways, would be introduced in the North (Bristol) location at some point in the first half of 2017 when the team had relocated to their new offices and settled down. A common telephony system was to be introduced in Exeter in quarter two of 2016 and linked with the new Bristol office in quarter three or four, depending on the results of the pilot link.

Medicines

- The patient triage system used by the EOCs provided staff with advice to give to patients or carers about medicines that could be taken by the patient awaiting an ambulance. The system was regularly updated as part of the licence by the provider of the software, so the advice provided was based upon current guidance. The guidance on medicines was predominantly for recommending simple analgesia, or to advise patients to continue to take any prescribed medicines. When we were sitting with the emergency medical advisors, we heard them advising patients, for example, about taking paracetamol, as indicated by the triage system.
- The patient triage system directed advisors to prepare patients for a possible visit to hospital. Patients, or a person with the patient, were advised to gather any

medicines taken regularly. This was in case the ambulance crew took the patient onwards to hospital for assessment and/or treatment, and so the patient had their regular medicines with them.

- There was approved clinical guidance on medicines for staff to reference. The EOC clinical staff used the Joint Royal College Ambulance Liaison Committee (JRCALC) and British National Formulary (BNF) for medicines guidance. These were available electronically to ensure they were the most up-to-date versions. Copies could also be accessed by mobile smart phones and other devices if there were failures in the computer systems.

Records

- There was good security of patient records and confidential information. Patient details were held electronically and only staff with authorised access to the computer systems were able to access these records. Each member of staff had their own login name and password, so it was possible to see which member of staff had created or amended a record, and at what time and date. The only problem we saw with this system was when there was an unexpected problem with staff logging off the system. This was a temporary problem resulting in the computer system not coming back on line when staff logged off. To overcome this, temporarily, staff did not log off when they left their desk for the day or a short time. The incoming staff member used the previous staff login to enable them to use the computer system. As a result, the records at the time did not accurately record who had made them during this period.
- Patient's details were gathered and recorded where possible. The triage system prompted emergency medical advisors to get sufficient details from patients or those calling for them to enable ambulance crews to locate the patient, and know their name and basic details. There were times when this was not possible (due to the nature of the call, such as the patient being unconscious and a stranger to the caller). However, most calls included the patient's name, age, date of birth, telephone number and address. Brief notes were also kept if required of the person making the emergency call. This included any healthcare professional, such as a nurse ringing to urgently transfer a deteriorating patient to another specialist hospital, or a patient at the end of their life being taken home.
- There was a record made of all calls for audit and review. Part of the role of an ambulance EOC is to audit the way an emergency medical advisor or clinical advisor handles the call. This is to ensure they are following the right guidance and giving the right advice to the patient or caller. The calls coming into the trust from the 999 call-handling services were therefore recorded for audit, and to be used in training future staff in the roles.
- The service kept additional notes about some patients to help get them the right care. The EOCs made use of and updated what was termed as 'special notes'. These notes were held electronically, and contained information specific to the caller, or, more precisely, the address from where they were calling. These special notes assisted the emergency medical advisors and dispatchers in how to manage certain patients, situations, or known risks. Special notes might include, for example, key codes to gain access to a property (given with permission), known risks to ambulance personnel or others at the property, or information about a patient with a complex mental health problem or illness. We listened to a call where there were special notes for a patient who was a frequent caller to the service. The information from this latest call was passed to one of the clinical teams who called the patient with advice. This avoided what would have been an ambulance crew attending for a situation not needing that level of response. One of the two main deficiencies with this system was special notes not being available to personnel in the event of a system failure and the staff reverting, temporarily, to a paper-based system. This was largely unavoidable. The other problem was how the system worked only on an address, and not a name or other information. The system did not have any facility for updating, other than by manual input of new information. Therefore, if a patient moved house, or was calling from a mobile phone or other number, the special notes were not flagged to the EOC staff. At the time of our inspection, this was a national problem with no obvious resolution.
- There were places within patient records to record information to assist ambulance personnel with access, decision-making, and safety for all concerned. These were not the special notes referred to above, but information specific to the call or incident. This included, for example, patients who had made decisions about resuscitation, or who were on

end-of-life pathways. There were places in patient records to note information about patients with mobility problems, mental-health illnesses or conditions; how to access the property; and specifics about locations, some which were open spaces or public places. We listened to calls where patients were not at their home address. The patient record enabled the emergency medical advisor taking the call to note in some more detail where the patient was, particularly if this was in a large public open space, for example. This assisted the emergency medical dispatcher to give more specific details to the attending ambulance crew. We also heard advisors being told about patients who did not want to be resuscitated; obese patients who needed appropriate equipment; and patients in areas anticipated as hard to reach or move around in for ambulance personnel.

Assessing and responding to patient risk

- The EOCs used recognised approved triage systems to enable emergency medical dispatchers to prioritise calls in terms of risk and need. At the time of our inspection, the Exeter and St Leonards EOCs were using one system, and the Bristol team using another. This was due to legacy systems used by different NHS ambulance trusts prior to the 2013 merger to the current organisation. The Bristol system would be upgraded in early 2017 so all EOCs were using the same triage system.
- The trust was currently trialling new methodology for NHS England within a programme designed to improve ambulance response times to critically ill patients. This trial of the ambulance response programme clinical coding system was being carried out for NHS England by South Western Ambulance service with the Yorkshire Ambulance service. The 12-week trial was underway since 19 April 2016 and initial evidence relating to triage and response was positive. The objective for the trial was to move away from time-based targets, which could be met (albeit unintentionally) inappropriately with staff not qualified to provide the right help. The target time could equally be not met, despite the right ambulance personnel arriving, albeit not within the time required, and an excellent outcome for the patient. The new system was designed to send the best possible response to the scene, and not the fastest possible response (time-target driven), as was the current national objective. The major change was to rationalise and clarify the call-type definitions to one red response (critical life-threatening event) and three definitions each within the amber and green responses. Both triage systems in use had been adapted to use the same methodology as the ambulance response programme to determine the priority for a patient. It was too early to evaluate how the new system was improving patient outcomes, but there were largely positive comments from the staff using the system to take and prioritise calls. The staff seemed comfortable with the results the triage system was delivering, and many of them commented on the 'common sense' approach to getting the right response rather than necessarily the quickest. There were some inevitable anomalies and issues to be ironed out, but these were recognised and being dealt with as soon as or where practically possible.
- The triage systems used by the emergency medical advisors and clinicians had various risk assessment pathways, including for patients with a suspected cardiac arrest, stroke, breathing problems, or for pregnant women. The first questions asked of a patient or the caller by the advisor was whether the patient was breathing, and then if the patient was awake. The answer to these questions, and others that followed, took the advisor down a certain route to obtain more information or give urgent medical advice or guidance. If information suggested a patient was suffering a cardiac arrest, the advisor was able to provide resuscitation (CPR) guidance over the telephone until the ambulance personnel arrived. There was appropriate advice for other life-threatening conditions. Patients were otherwise given general advice including not getting too cold or too hot and, if the guidance required it, not to have anything to eat or drink.
- The clinical assessment team (a nurse, doctor, midwife or paramedic) used their clinical judgement to change the priority of calls if necessary. The clinical team were able to review decisions made by the advisors and the triage system. This was done by either reviewing the information within the patient's notes as recorded by the advisor, or calling the patient or person caring for them and getting more information or an update. The decision could raise or lower the priority assigned by the triage system depending on what information was seen or heard by the clinician. The emergency medical advisors were also able to ask advice from the clinicians if they were concerned the triage system had not produced the right priority.

- The service responded to situations where triage was clearly not delivering the right result. There had been changes to standard operating procedures when incidents or staff requests for changes had been recognised. One of these was a recent change to the standard operating procedure in relation to emergencies for pregnant women. If a healthcare professional contacted the EOC to arrange an urgent transfer of a pregnant women to an acute hospital (from a community hospital or birthing centre for example) the call would usually generate an amber (medium priority) response. However, if the healthcare professional stated there was a threat to the life of the mother or baby, the call would now be triaged as requiring an emergency red (high priority) response. We had a concern from a local general hospital about precisely this situation. Although staff we discussed this with did not know whether the trust response had been specifically to this incident, the change to the standard operating procedure had been made after the situation at the general hospital, so the next response should recognise this change.
- Staff were not permitted to accept a caller's request to 'stand down' an ambulance without getting clinical advice. However, we did observe one of the dispatch team stand-down an ambulance crew without first getting a review from a clinician. On another occasion, we did see an emergency medical advisor ensure a clinician had input into a record where a caller had self-conveyed himself or herself to hospital and the clinician approved the transport being stood down.
- The EOCs made 'welfare' calls to patients or carers waiting for an ambulance in a non-life-threatening situation. This was part of a pilot programme to see if having a person dedicated to this role made a difference to patients. This was following a theme of complaints about people having no information when waiting for an ambulance. Where it was evaluated as necessary, the clinical team or a specially trained colleague made these calls during busy periods, to check on patients' welfare. The welfare call provided a means of reassessment of the patient to make sure they were safe and to reassure them they had not been forgotten. If the patient or caller reported signs of deterioration, the call would be sent for triage again to determine if an ambulance response required upgrading. The clinical team were also available to support the patient by providing clinical advice over the telephone. At the time of our inspection, the EOC had not yet evaluated the effectiveness of the new role. However, the control manager told us the role had already been seen as a positive addition to the EOC. Call handlers were released from welfare calls when capacity was limited due to the increase in call volumes. There was anecdotal evidence from people who received the calls of them not feeling abandoned while they were waiting.
- The emergency medical dispatchers were aware of the skills and experience of their colleagues in the operational staff and the right personnel to send to an incident. This included mobilising specialised response teams such as the HART team (hazardous area response team), and the HEMS team (helicopter emergency medical service). The Emergency medical dispatchers were also able to request a community first responder to attend an emergency in their immediate vicinity, or ensure a crew of paramedics were not used to help a person who had fallen, was uninjured, but not able to get back on their feet.
- There was a risk from the use of special notes in records that were no longer current, potentially delaying ambulance personnel responding to a patient. The system of using special notes (see records above) was linked to a patient's address. There was, therefore, a risk from special notes recording significant issues at an address and this leading to ambulance personnel needing support from the police before entering a property, for example. There was currently no mechanism to update the special notes if a patient who was a known risk, for example, had moved from an address. If this address was a known serious risk, the new occupier might get delayed care if the ambulance crew were waiting for assistance. At the time of our inspection, this was a national problem with no obvious resolution.

Staffing

- There was an appropriate mix of skills within the staff in the EOCs to provide a safe service. The centres had emergency medical advisors who took calls from members of the public, healthcare professionals, the 111 service, and other emergency services. These staff were supported by supervisors who provided assistance with complex situations, mentoring, guidance and problem solving. Emergency medical dispatchers organised the dispatch of ambulance personnel to the scenes of accidents or emergencies. There were control

officers, duty managers and control managers supporting the dispatch team. Alongside were the clinical staff: paramedics, nurses, doctors, and a midwife on a pilot scheme for part of the trust's area. The clinicians were supported by clinical leads and managers. There was a team of administration and support staff surrounding the frontline staff. This included auditors, quality and safety staff, rota, and other administrators. The EOC team also included training staff and auditors monitoring the quality and safety of calls to the service. The EOCs were also staffed by the resilience teams, including the special operations desk, helicopter control team, hazardous area response team, and other specialist staff.

- The staffing levels were below the establishment (planned) levels, but the trust was responding to the increase in call volumes and work pressures by recruiting new staff. There had been active advertising and recruiting, and we met staff in Exeter who were completing their training to join the team of emergency medical advisors. Those we met (eight in total) were almost through their eight-week training course. They had been supervised and examined taking live calls, and were almost ready to commence their substantive role. In response to rising call volumes, overall, the trust planned to recruit to new posts. This included 10 new clinicians for each EOC, and 20 additional emergency medical advisors for Exeter and 10 for Bristol by the end of the current financial year 2016/17. Four new staff had been approved for the quality team due to recognition of their increasing workload. A number of the vacancies for the Bristol audit team had now been recruited to, and the team expected to be re-established by July 2016. The main aspects of staffing levels were:
  - There was a vacancy for 20 of 76 (27%) clinical staff in the EOCs, but this was due to these posts being recognised and established in May 2016. Recruitment was underway.
  - There was a vacancy for 40 of 154 (26%) emergency medical advisors: 25 in Exeter (30%) and 15 (22%) in Bristol. This was mostly to cover a recognised gap of 30 posts in planned staff levels, due to increasing call volumes. These additional 30 posts were recognised in May 2016 and were being advertised and recruitment was underway.
  - The overall vacancy rate when setting aside the 50 new posts being recruited to since May 2016 showed the trust was otherwise over budget with staff. There were additional staff against the budgeted levels in supervisory, administration and management posts.
- There was a relatively low turnover of staff, which had improved. Some of the numbers provided by the trust gave the impression these numbers were high. However, the figures supplied included staff not completing their training successfully. We asked the Bristol EOC to analyse the data about their leavers. When they looked back at the six months between December 2015 and May 2016, of the 21 staff leaving, nine had failed their training, two had relocated to another part of the UK, three had moved to other roles in the organisation, and three were dismissed for capability reasons. This left two who left for either higher wages offered elsewhere or two because they were not enjoying the job (related to the shift working).
- There were safe levels of staffing to provide the core service in the EOCs, but these levels did not provide sufficient relief cover. Relief cover was a level of staffing enabling the organisation to release staff for training, holidays, cover maternity leave, sickness cover, and unplanned absence. The organisation was running at around 20% above core service cover, when the trusts agreed level of relief was 29%. This was due to increased call volumes and recruitment issues. This was affecting staff training, pressure on rotas, staff working extra shifts, and constant change and evaluation of staffing, which took time and effort away from other roles.
- The organisation was taking action to address the difficulties with recruitment to some of the EOC roles. There was some local competition from other call centres, which had advantages for some potential recruits, with which the ambulance service could not compete. This included generally shorter shifts, and working daytime-hours only. The rates of pay were generally not dissimilar, but, due to different packages, some of the call centres looked better at first glance. To compensate for the dropout rate among new recruits, the EOCs had increased the length of their training for emergency medical advisors from 8 weeks to up to 12 weeks. There was pre-interview job experience for potential candidates to try to deter candidates who

might otherwise drop out during or shortly after training. The EOC was considering loyalty bonuses for staff within a trust-wide retention strategy to support the frontline workforce.

- The EOCs had a limited and reducing use of agency staff. Senior management in the EOC said the use of bank staff had been revisited and there was now a stronger and more engaged process to use internal staff to cover unfilled shifts. There was a review of bank staff in April 2016 and a recruitment programme commenced shortly afterwards. The payment to bank staff was to be reviewed in June 2016 and a revised structure introduced in the second quarter of 2016. The increased bank staff already recruited had led to a reduction in agency staff to almost zero.
- There was variable sickness rates for staff within the EOCs. Some percentages in some roles were high, but these were usually among small numbers of staff. There were periods of high volumes of sickness in some roles and centres, and then this would resolve within the following month. The EOC sickness rates between September 2015 and September 2016 showed, on average, short-term sickness was 5.1%, and long-term sickness was 2.5%. Total sickness is this period therefore averaged 7.6%, which was above the average of 5% for the staff in the NHS.
- There were arrangements to share staff resources in periods of high call volumes. There was a protocol in use for handing calls from one EOC to the other in certain circumstances. This required calls to transfer to the other EOC when it had not been answered by the EOC where it had arrived for 60 seconds. We saw this in practice during our unannounced visit when staff we were with at the Bristol (North) EOC took four of 10 calls within an hour for the South region, which had a period of high call volumes.
- The EOCs were improving the time staff were taking for their breaks and time off between shifts. The lack of breaks had been an issue for the EOCs in the recent past, due to high call volumes and staff vacancies. This had been recognised by senior staff, but had been a key factor in poor morale among frontline staff. The new ambulance response programme being trialled in the trust was championed for, among other things, delivering a better demand management system. Staff were therefore more able to get their breaks and take time out when it was needed. Staff we met confirmed this was beginning to make a difference. Some said they were able to set their break-times to suit them, where possible, at the start of their shift, and it fitted in with their team.

Anticipated resource and capacity risks

- The trust had a capacity plan for the EOC to manage rising call volumes, and adjust staffing accordingly, but this was not specifically able to deal with planning and managing different seasonal demands upon the service. The trust was part of the national resource escalation action plan (REAP) which meant it had overarching plans to respond to unplanned or unexpected increases in call volumes, but this was at it happened, rather than proactively to meet seasonal changes. Alongside REAP there were different software programmes referred to by staff for looking at internal staff planning as resources became stretched. However, the trust had not adjusted its workforce in the EOCs to manage rising call volumes it would be able to predict from previous experience or expectations based on future plans or historical data. This was particularly relevant for the responsiveness in the south of the area where the population could triple or more in the summer months with the influx of tourists to Dorset, Devon and Cornwall. There were also tourist pressures in the north area from Somerset, and some of the bigger cities in the patch, such as Bath and Bristol. Senior staff in the EOCs said they were in the process of modelling the demand for the region so the service could respond with different levels of staffing. However, at the time of our inspection, the staffing models were relatively uniform throughout the year. Rotas and shift patterns were designed to react to demand changes, but not with more predictable changes in seasonal demand. We were told the last time the trust reviewed the rotas was in 2012.
- The organisation had a major incident plan, which described how the ambulance service would work as part of a multi-agency approach to such an event. Each division of the organisation had an action plan detailing how it should respond. The EOCs (known as clinical hubs by the trust) had specific action cards, and the major incident plan detailed how they should respond. The plan outlined which of the EOCs would take the lead, or provide support, depending where the incident had occurred.

Response to major incidents

Emergency operations centre

- The trust was part of the national strategy for business continuity and responding to major incidents. All ambulance providers are category 1 responders under the Civil Contingencies Act 2004 and must therefore be a part of a national programme for management of ambulance trusts at times of excess call volumes and emergencies. To this end, the trust was part of the National Ambulance Resilience Unit (NARU) resource escalation action plan (REAP). The EOCs were part of the escalation plan response and their business continuity and major incident plans were based upon the national criteria. The nature of the EOC response would depend upon the level of the threat posed, which ranged from 'green: steady state' through amber and red to 'black: extreme pressure'. The EOC clinical teams also had access to National Ambulance Resilience Unit guidance for their part in responding to major emergencies.
- There was a process for notifying all parties of a major incident. The ambulance trust was responsible for alerting both internal and external stakeholders at the time of a standby or declared major incident. The responsibility for completing the notification cascade was with the EOCs. A new system for cascading notifications commenced on 1 April 2016 and the EOCs had tested the 'major incident notification process' which was to be repeated on a regular basis. The new system produced a mass communication automated voice telephone call, which was received by all the relevant parties at the same time (rather than through a chain of calls). The major incident call was then to be acknowledged by the recipient. The call was tested in the new live system on 6 April 2016 at 2:10pm. The cascade took just three minutes to complete. In that time, 54 organisations were contacted and 206 people within those organisations. The acknowledgement was received from 70% of those contacted. There were some significant organisations not acknowledging the major incident test call. Consequently, the process was repeated on 22 April 2016 at 12:32pm. Some of the significant organisations not acknowledging the first call did respond that time, although there were some notable failures, including one of the police constabularies in the area (who did acknowledge the first time), several clinical commissioning groups, and one of the 111 services (who did not acknowledge either). The report stated the exercise would be completed every two months and the results had been made available to stakeholders.
- The Bristol and Exeter EOCs had provision for rapidly establishing major incident rooms should these be required. These were set-up with radios, telephony and computer-aided dispatch systems, administration systems and information screens (known as SMART boards). The major incident plan set out who should staff these rooms as a minimum in the event of a major incident. The Bristol EOC incident room was last opened up for standby in the strike by NHS junior doctors. The major incident room in Exeter was, we were told, being used too frequently for other things, which prevented it being ready at all times for such an event. This had been raised on the trust's risk register.
- There were dedicated staff within the EOCs to respond with specialist knowledge where this was needed. Within the EOCs were specialised teams called the 'special operations desk' and HART team (hazardous area response team), both located in the Bristol centre, and another special operations desk and the helicopter emergency medical services (HEMS) desk in Exeter. These teams would be utilised in the same way in the event of a major incident as part of the EOC team. The roles and responsibilities of these teams are discussed further in our report on resilience.
- There were protocols for extreme or high-risk situations. There were policies, procedures and guidance for staff in the event they were called by a person making extreme threats, such as terrorism, or potential outbreaks or evidence of infectious disease such as Ebola or swine -flu. These instructions were in folders on the emergency medical advisors' supervisors' desks, or were available on the internet for those staff who had access. There was guidance and frequently asked questions for dealing with potentially infectious or contagious diseases, including action cards, clinical advice, and links to the Department of Health website. There were specific protocols with local airports in the event of a plane crash; with train operators in the event of a rail incident such as a derailment or crash; and action cards for dealing with marauding terrorists, active shooters, and bomb threats. Staff said they had been trained to remain calm in these situations, and follow the protocol for alerting all the right people. This could include internal staff, such as commanders and managers, and external parties including the police, the hospitals, and relevant other emergency partners and services.

Emergency operations centre

Is emergency operations centre effective?

Requires improvement

We rated effectiveness overall as requires improvement because:

- Staff were not being assessed for their competency and performance and the service was significantly below the trust's target for completing these appraisals each year. Some senior staff had not had appraisals for a number of years, but the organisation was not aware of this, and not addressing it. This issue had been on the trust's risk register for over nine years.
- Due to other training priorities, there had been a reduction in the number of calls audited for their quality and safety. The EOCs had not been able, therefore, to determine if the handling of incoming calls was effective at all times. However, we recognised this was being addressed, and improving.
- The service was struggling with rising call volumes and this had resulted in more calls being abandoned. This was being addressed with approved increases in staffing levels.

However:

- There were evidence-based systems to provide assessment and advice for patients. The EOC teams were using national guidelines and following best practice protocols to assess people's needs and provide the right service.
- Staff had the skills and knowledge to deliver effective advice and guidance. There were internal and external development opportunities and training available for staff.
- There was multidisciplinary work between teams in the EOC and with other local stakeholders.
- There was good access to information with special notes being used to provide effective outcomes for people where there were known risks or other issues.
- The service was performing within its target for 'hear and treat' calls, although was above (not as good as) the England average.

Evidence-based care and treatment

- The emergency operation centres (EOCs) used accredited triage and clinical management systems to prioritise patient care and ambulance responses. The Bristol EOC used the advanced medical priority dispatch system (AMPDS) while the Exeter EOC used NHS Pathways. Although both systems were accredited, the trust wanted one single system across the EOCs in future. A rollout to the Bristol EOC of the NHS Pathways system was therefore part of the operational plan for 2016/2017.
- Emergency medical advisors who took emergency calls into the EOCs had access to clinical support and advice from the clinical assessment team. The clinicians could see the information recorded by the advisors and provided support face-to-face with the advisor or over the telephone during a live call. In Exeter, clinicians could also listen into calls as they were happening and start to work on strategies to support the patient. New systems meant this facility would be available to the Bristol EOC clinicians when the team moved to their new office premises in November 2016. During our inspection, we observed good communication, teamwork, and interaction between the emergency medical advisors and the clinical assessment team.
- The EOCs were using approved clinical guidance. The clinical assessment team used electronic software based on the National Institute for Health and Care Excellence Guidelines (NICE) and Joint Royal Colleges Ambulance Liaison Service Committee (JRCALC) guidelines to assess patients. The Bristol EOC currently used 'stand-alone' systems requiring the input of patient information before further guidance could be obtained from the second system. Exeter EOC used an integrated system more user-friendly for staff. The systems would be aligned later in the year once the Bristol EOC had relocated and the new systems were operational. There were regular system updates at both EOCs to provide the latest and updated guidance.
- There had been an interruption in accreditation with an international audit programme. The Bristol EOC had held accreditation from a recognised international organisation for its high-quality work on call-taking performance. The Bristol EOC had lost this accreditation in 2016 due to a lack of call- performance audits being carried out. This was because of audit staff being

diverted to deliver essential training programmes and the EOCs making the hard choice to divert resources. The Bristol EOC was working towards becoming re-accredited in 2017.

Assessment and planning of care

- The EOC triage systems provided prompts and scripts enabling emergency medical advisors to assess the needs of a patient. Calls were coded for priority dispatch using new clinical codes as determined by the ambulance response programme recently introduced into the triage systems used by the EOCs.
- There was clinical assessment available at all times to support the advisors and dispatchers. The clinical assessment teams included trained nurses, paramedics and GPs, and a pilot testing a midwife working within the Bristol EOC. The clinical teams were based at both EOCs, and carried out detailed assessments of patients' needs as required. The assessment would support the triage system and provide checks and balances for the type of support and response the patient required.
- The clinical team prioritised the most unwell patients. The team dealt with urgent callers first which included providing clinical advice and support until the ambulance arrived at the scene. The triage system alerted the clinical teams through the priority rating as to what patients were the most urgent.
- The clinical teams assessed patients' pain and discomfort to help determine the severity of a problem. The clinicians had electronic scripted pain assessment tools for providing objective measures for pain scores. Questions about pain were asked differently depending upon what the patient was describing. This helped to provide an accurate assessment for the dispatch team, ambulance personnel, and the most appropriate response for the patient.
- There was a variable ability to identify and manage patients with mental health problems at the Bristol EOC. Experienced emergency medical advisors here felt they could identify patients with mental health problems, but learnt their skills around assessment and communication through experience rather than specific training. Mental health training was combined with suicide-call management during the induction-training programme and mandatory update training. In contrast, staff at Exeter EOC had received mental health training four months ago as part of an exercise to recognise gaps in knowledge and skills. Training around mental health was offered twice a year to support staff with assessing mental health callers. The training team provided staff with information and suggestions about how to manage a call with a mental health patient to ensure the best possible outcome. New emergency medical advisors we met at Exeter EOC said training consisted of role-play using examples of real calls from patients in a mental health crisis to prepare the call handlers for a real situation. We did note, however, the triage systems used by the EOCs did not prompt the advisors to ask any specific questions about mental health, although this was handled in better detail by the clinicians if they were involved.
- There was action taken to protect patients and others, which would involve the support of police officers. Section 136 of the Mental Health Act 1983 allowed a police officer to remove a person they believed was mentally unwell, and "in immediate need of care or control" from a public place, to a place of safety. EOC staff were aware of the Section 136 protocol and knew the procedure to implement for a patient experiencing a mental health crisis. Staff had access to local standard operating procedures providing guidance and support in the event of a Section 136 request to the police.
- The EOCs were piloting a programme to address the rise in the lower priority or 'green' calls. The 'green pilot' was launched in January 2016 in conjunction with a local clinical commissioning group to try to find a way to tackle the 8% increase in green calls to the EOCs. These calls were from members of the public with low-priority problems, or healthcare professionals wanting to arrange patient transport. Trained staff assessed and prioritised the green calls and spoke directly with healthcare professionals or patients to agree the most appropriate response. The aim of the pilot was to increase the proportion of green calls being safely managed by non-frontline ambulances, making better use of limited resources.
- The service made sure appropriate models for the deployment of ambulance were used and, where possible, to get the right vehicle to the right situation. Emergency medical dispatch teams used the ambulance response programme clinical coding framework to determine the most appropriate resource to send to a patient or scene. The system coded conditions under a single red (life-threatening emergency) code, three different amber codes, and three green codes. The coding was dependent upon

patient need and the treatment and support required. The Emergency medical dispatchers deployed various resources to the scene. This included community first responders(volunteers, trained to attend emergency calls received by the ambulance service and provide care until an ambulance arrived). There were rapid response vehicles (qualified paramedics working alone driving a smaller vehicle – usually an estate car) to get to a scene quickly, and usually located often in busy areas rather than at ambulance bases. The Emergency medical dispatchers would make decisions about where these rapid response vehicles were based by using their judgement and experience of times, places and other new information (such as road closures or likely traffic problems.) The emergency medical dispatchers also managed the double-crewed ambulances, and the skills of the staff on board, and other vehicles such as helicopters and motorbikes. This was to optimise the use of time and resources to manage rising call volumes. Appropriate deployment of vehicles required pre-planning in order to meet response times. Dispatch staff used their initiative to identify jobs appropriate for different vehicles and deploy the most appropriate resource to ensure the best patient outcome.

Response times

- The trust was, by its own admission, struggling to deal with the recent and often unrelenting increase in call volumes. This was leading to a rise in callers who hung-up before the call was answered. Data for the six months prior to our inspection showed an increase in abandoned calls from 0.7% in November 2015 to 3.5% in March 2016. This had reduced in April 2016 to 1.6%.
- Call volume in March 2016 was 21% higher than the previous year (call abandonment in March 2015 was 0.6%, and 3.5% in March 2016) and call volume in April 2016 was 7% higher than the previous year (call abandonment in April 2015 was 0.7%, and 1.6% in April 2016). There were no simple explanations for this rise. Trust staff told us anecdotal evidence from patients included misguided expectations that patients would be seen more quickly in A&E if they called and arrived in an ambulance. There was advice given to people without GPs, including official advice given to new arrivals to the country that they should call an ambulance if they needed medical help – and this did not specify this was for an emergency.
- The trust had improved and was performing reasonably well against its agreed threshold in terms of people not needing to call back again within 24 hours after they received only telephone advice (with no ambulance attending). It was improving also against the England average, which it had been above (worse than) for the two years prior to this inspection. Although there was a local threshold to measure this indicator, patients were not discouraged from calling the service again if their condition deteriorated. The trust had seen a decrease between 2014/15 and 2015/16 in people calling 999 more than once in 24 hours. In 2014/15 the trust fell below (did better than) the 11% local threshold of all 'hear and treat' callers phoning back in 10 months of the year. In 2015/16 it was just below the threshold for six months of the year and the other six months were slightly above. The average was 12.75%. By April 2016 (the latest available information) the trust had improved to 10.5% of all callers receiving just telephone advice calling the service back. This was against an England average for all NHS ambulance trusts of 6.8%.
- The trust performed similarly to other English NHS ambulance trusts in the time taken to answer emergency calls. Over the period July 2014 to March 2016, most calls were answered within two or three seconds. This had increased slightly at the end of this period and had been four seconds in March 2016, but back down to three seconds in April 2016. This slight deterioration was on the back of increased call volumes, and affected most other ambulance trusts in England in 2016. The data for April 2016 showed 95% of calls to the trust EOCs were answered within 31 seconds and 99% of calls were answered within 85 seconds. This was similar to the 10 other NHS ambulance trusts, some being much better (one trust answered 95% of calls in 4 seconds in April 2016) and others not so good (another trust answered 99% of calls in 154 seconds in April 2016).

Patient outcomes

- The EOC clinical teams provided an effective 'hear and treat' service for patients. The service was recognised as one of the highest performing in England for this service enabling clinicians to assess and triage patients over the telephone and close the call without sending an ambulance. There was a local standard agreed with clinical commissioning groups for the service, for the

trust to close 7.5% of calls with just telephone advice. The service had been well above (better than) this target in the 2015/16 year, averaging 12.7% of calls being closed with hear and treat advice. In April 2016 (the most recent data available), the EOCs reported they had managed 13% of calls with telephone advice. The England average was 8.9% and the trust had the second-best performance of all NHS ambulance trusts in April 2016. The success of this programme had enabled ambulance personnel to attend more appropriate calls, and save costs for the organisation.

- The service was falling below targets to get patients to hospital after a possible stroke. The national target for patients who tested positive for symptoms of a stroke was to arrive at a hyper-acute stroke centre within 60 minutes of the initial call. An average of 46.4% of the trust's patients were arriving at a stroke centre within 60 minutes of their initial call. This was below the trust's target of 57%. However, 97% of stroke patients had received an appropriate care pathway. This was in line with the England average and the trust's target of 97%.

Competent staff

- Not all staff had an annual appraisal, and data showed this was well below the trust's target. 'Career conversation' was the term used by the trust to refer to a staff member's yearly appraisal. EOC appraisal data showed not all staff had been given an annual review of their competence and professional development. Compliance at both Bristol and Exeter EOCs was poor and not meeting the trust target of 85%. Some senior staff in the EOCs had not had appraisals for a number of years. The was not tracked and senior management were not aware of the gaps between appraisals, only the percentage being carried out. The issue of poor performance in appraisal had been on the trust's risk register without a solution being reached since 2007. There were no action plans delivering improvement to this area of the trust's responsibility to staff. In May 2016, appraisals completed in the previous 12 months were:
  - 29% of clinical supervisors at Bristol EOC and 52% at Exeter EOC.
  - 20% of control officers at both Bristol and Exeter.
  - 17% of dispatchers and supervisors at Bristol and 25% at Exeter.
  - 11% of emergency medical advisors at Bristol and 50% at Exeter.
  - 24% of administration staff and managers at Bristol and 41% at Exeter.
- There were audit processes to monitor and assess how staff were handling calls into the service, but at the time of our inspection these had fallen well below target – although were improving. In Bristol, the EOC was required to complete 440 audits each month (approximately 1.7% of the total call volume). The Exeter EOC was required to complete 450. Between January and May 2016 an average of 118 calls were audited a month (with only 27 being audited in March 2016) at the Bristol EOC. At the Exeter EOC, an average of 386 calls were audited a month. The situation in Bristol was attributed to a diversion of staff resources to provide training, staff leaving, and recruitment problems. We were told by staff working in the Bristol audit team how the introduction of the new computer-aided dispatch system and the ambulance response programme training had recently taken priority over audit work. This was to ensure all staff were trained and competent to use the new systems. During this time, the training team had been two members of staff short, and had asked the audit team staff to support staff with training programmes for the new systems. This had affected the audit team's ability to carry out monthly audits. Since March 2016, focus had returned, and the Bristol EOC had managed to increase the number of audits completed monthly and this was continuing to rise.
- Any poor performance identified through the call audit process was addressed to ensure quality and safety for every call taken. Staff received feedback following a call audit. The audit team, in conjunction with the member of staff, would develop an action plan from feedback to improve performance. This was required if the target of 90% compliance for the emergency medical advisor was not achieved within each aspect of the call audit. The audit team said it was a challenge to get one-to-one time to feedback to underperforming staff, due to increased call volumes in the EOCs and staff not always being able to leave their desks. The audit team maintained an electronic record of all individual audits for each member of staff for use in the appraisal process or any disciplinary procedures.
- One-to-one sessions between staff and their team leaders provided support for staff, although they were not happening regularly in Bristol. These sessions created a safe and confidential environment for staff to discuss any worries or concerns. They were carried out

either monthly or bi-monthly in Exeter. Here, regular meetings enabled discussions around performance, audit, learning and objectives. Team leaders had developed a framework for the one-to-one sessions to ensure consistency. However, the majority of staff we spoke with at the Bristol EOC told us they did not receive one-to-one meetings with any regularity. Staff told us they could, nevertheless, approach their duty manager if they had any concerns or needed to discuss anything while on shift.

- There was direction and leadership in training and development. A dedicated training and development manager was responsible for directing recruitment training, training for existing members of staff, and training programmes for new systems. The training department had been responsible for providing training for the new computer aided dispatch system and the ambulance response programme. A mentioned above, the training team at the Bristol EOC had required the support of the audit team to carry out training for the new computer-aided dispatch and ambulance response programme. The team did not have enough staff on the training team for this specific one-off exercise. They also could not meet the requirement to have completed all training prior to the introduction of the new systems.
- There were specific programmes designed to train new staff. New emergency medical advisors attended an induction and training programme to provide staff with knowledge and skills to carry out their new role. The training schedule was different between the Bristol and Exeter EOCs. Bristol provided four weeks of classroom-based learning, including training around use of the triage system. Trainees then received three weeks of mentoring supported by an experienced and qualified mentor through an externally accredited company. Emergency medical advisors had to complete and pass 10 call audits of live incoming calls, before being signed off from the mentoring stage. We saw examples of daily feedback forms used by the mentor and trainee. There were action plans set out following call mentoring in order to improve performance if needed. There was a competence check on each aspect of the role. The Exeter EOC delivered up to a 12-week training programme for new emergency medical advisors, which consisted of classroom learning and supervised practice. A 10-day course was included in this 12-week programme to train new starters on the triage system used in Exeter. This enabled staff who were successful on the course to obtain their licence to take calls without further testing. New advisors had to be compliant with five live call audits before passing the training course.
- There were some situations for which the EOC had provided simplified guidance to staff. This enabled them to rapidly find guidance from what could otherwise be long documents and policies. Staff at the Exeter EOC had good access to simplified versions of care pathways and protocols to refer to for support when dealing with different calls. A member of the training team had put together a simplified electronic script containing important bullet points around management of different situations. This included conflict resolution and callers contemplating suicide. Each member of staff had access to these documents at their workstation. The Bristol staff could see these documents through a shared network, but not all staff had computers on their desk to get quick access. Staff were also encouraged during their training to put together their own manual of these prompts, which encouraged pro-active learning. Staff we spoke with found this electronic resource a very useful tool for support in the role. The objective was to provide all staff with access when the Bristol team relocated to their new premises and all staff had intranet access on their desks.
- Due to not all staff having access to emails or the intranet, not all staff were being informed about changes to policies, guidance or procedures in the most efficient way. Emails were sent to staff to provide information about changes to policies and procedures. Staff at the Exeter EOC had access to their emails at their workstation. However, some staff at the Bristol EOC did not have access to computers at their workstations, and were checking emails during breaks or outside of working hours. This had been recognised to an extent and the Bristol EOC had a memo file staff referred to at the start of a shift, which included updates and news. Staff also reported how managers would inform them of any updates or changes to policies and procedures verbally during a shift. This situation would improve when staff in the Bristol EOC relocated to their new premises.
- There were opportunities for staff to develop within the EOCs. For example, emergency medical advisors could and had progressed to the role of emergency medical dispatchers. A two-week internal face-to-face training session was provided for advisors looking to move up to

vacant positions, followed by support and mentoring to become established within the role. We saw copies of the dispatchers skills passport completed prior to new staff being assessed as competent within the role. The majority of the staff we met in more senior roles had progressed through the organisation's promotion programme.

- Apprenticeship courses provided staff with an opportunity to develop and gain further qualifications. Staff at the Bristol EOC, for example, had been offered apprenticeship courses in management, team leading, and customer service. The training and development manager reported a lot of interest in the courses, with 19 members of staff currently within the development programme.
- Certain EOC staff had access to additional, self-directed continuing dispatch education to develop, knowledge, skills and awareness around different topics. The training had been developed by the auditing team and consisted of relevant information, followed by a set of questions to test knowledge on learning. Topics such as epilepsy, stroke, and sepsis management were covered. Staff could send completed continuing dispatch education training back to the audit department to be assessed. If they were graded as competent, staff received a certificate counting towards their re-certification (maintaining the licence required to take calls) every two years. The audit team kept a record of all staff and completed the programme. The record identified a surge in compliance when re-certification was due, and differences between staff engaging and not engaging with the training. Staff told us it was difficult to find the time to undertake the training during working hours due to increased demand and call volumes.
- New strategies to improve staff retention on the emergency medical advisor training course had been developed by the call performance manager and the audit team. The interview process had changed to include the applicant sitting with an advisor for one hour prior to interview. This was to help provide a realistic understanding of the role and the types of calls dealt with daily. An open evening had also been set up to provide potential applicants with a realistic insight into the role of the advisor. Members of the emergency medical advisor team provided a presentation, along with the audit team and other staff members, to talk about expectations of the role. There had been two open evenings so far with a third scheduled for summer 2016.
- The systems used at the EOCs supported staff to competently assess children. The triage system guided staff through a series of questions and prompts designed to provide an effective assessment of a child. Staff could also speak to the clinicians for further advice if required. However, staff told us there was no specific training module around communicating with child callers. We were told that communicating with children was covered under a section on communication within the induction training. If staff were communicating with a small child during a call, they would ensure they had the patient's address, and then provided an emergency, priority response to that address.

Coordination with other providers

- There was work with other providers to effectively utilise resources. Both EOCs took calls from healthcare professionals and GPs requesting ambulance transfers for patients. A pilot project ('green pilot') was underway in Exeter to look at ensuring the response requested by the GP or healthcare professional was appropriate. A report produced for the pilot in April 2016 identified a need for some guidance for healthcare professionals and GPs to improve the initial request and subsequent response of the ambulance, particularly around chest pain and sepsis. There was evidence of a number of calls needing to be a higher priority, and others downgraded. The work around this was ongoing to identify trends where further guidance may be of value, and to determine how it would be delivered
- The EOCs worked effectively across boundaries with other ambulance services. This was to support patients safely and deliver an effective service regardless of boundaries in times of increased call volumes. The EOCs daily with other ambulances services and reported strong communication and working relationships with neighbouring services.
- Clinicians had access to information about patients' resuscitation decisions, special notes and advanced care plans. This was to support emergency medical advisors, clinicians and dispatchers to find the most appropriate action and response to deal with the call.

The electronic systems used in the EOCs gave relevant information associated with the patient from other healthcare providers or emergency services, and these flashed up as a warning for the advisor and clinician.

- There were direct telephone lines for the police and fire services. We listened to calls between advisors and the police sharing information to support patient and staff safety and wellbeing. Calls received from other emergency services demonstrated effective and coordinated working between the services and good communication. We observed the actions of an advisor involving the police to support the safety of the patient and ambulance crew when attending an incident at a mental health establishment.
- The ambulance service worked alongside the police and fire services on incidents requiring a multi-agency approach. This provided a forum for good communication and knowledge sharing, and to discuss the most effective way to manage a specific situation. Each of the EOCs were trained in the Joint Emergency Services Interoperability Programme(JESIP). Control officers, duty managers and emergency medical advisor team leaders had completed the JESIP training (100% compliance) and were enabled to use the joint decision making tool in a multi-agency situation.
- The EOCs worked closely with the coroner's offices. The manager of the quality team, who worked within the EOC, liaised with the coroners and had been developing links and a network across the region. A local coroner had spent a day with the Bristol EOC to experience staff working in the frontline of the control centre. Another coroner had acknowledged to the trust the high standard of EOC reports into investigations following requests by their office.

Multidisciplinary working

- The triage systems used by EOCs enabled all staff to provide a multidisciplinary approach to working. Each member of staff from the different teams had access to the information provided within the triaged system by the other teams. The system enabled information to flow from the emergency medical advisor through to the dispatch team to provide the appropriate response.
- There was good multidisciplinary working between the clinical team and the advisors. The triage system allowed the clinical team in Exeter to support advisors by listening into calls and providing support and advice. At the time of inspection this was not possible with the different triage system at the Bristol EOC, but this would change when the new triage system was implemented in Bristol. Otherwise, all clinicians could see the information provided to callers. The clinicians would support advisors by providing support during or after the call, or by having the call transferred, as appropriate. Advisors would talk with clinicians and be given advice either talking with them on the internal phone (in Exeter only at present) or face-to-face.
- Dispatch teams had handovers to enable a transition between shifts, but this was not factored into their work programme. Handovers included relevant information about the previous shift, performance, and current issues. The dispatch team told us they arrived between 10 and 20 minutes early for their shift to ensure there was time to have a handover with the previous team. The service relied on the goodwill of staff rather than factoring in time to allow a handover.
- There was good multidisciplinary working amongst the clinicians in the clinical teams. The clinical team were a mixture of skills including nurses, paramedics and GPs. There was a variety of knowledge and skills amongst the clinical team to support patients and for peer support. However, in the Bristol EOC, the clinical team sat within their own discrete area. The clinicians felt that for better multidisciplinary working they needed to be more visible and integrated with the other staff. The move to the new Bristol EOC later this year would resolve that, and put clinicians among the EOC teams as they were currently in the Exeter EOC.
- There were pilots to look at implementing other multidisciplinary working. The Bristol EOC were trialling the effectiveness of a midwife as part of the multidisciplinary team. The role provided more specialist knowledge and experience with pregnant women contacting the service. The midwife role provided 12 hours daytime cover seven days a week for the Bristol EOC and was specifically for women in the Gloucestershire area. The midwife supported call handlers or clinicians providing advice and telephone support for pregnant women. The clinical team lead was hoping to use the midwife to support other clinicians with continuing professional development. The pilot was due to finish in July 2016 and the trust believed it would be assessed as successful. It was hoped that the midwife role could be extended and possibly trialled in the Exeter EOC as well.

- There was multidisciplinary work to support the management of frequent callers to the EOCs. The trust had been working with other agencies, such as the police, safeguarding, the local authority and GPs to develop management plans or take action to reduce frequent callers. The aim of any plan was to provide frequent callers with individually tailored support to meet their needs. The multidisciplinary approach hoped to provide a more long-term sustainable solution for the individual and the trust or others.

Access to information

- The electronic triage systems used by the EOCs enabled all staff within the team to have access to information and records. All staff could view caller information in real time (or indeed later) and were able to see documentation or 'special notes' about the caller added to the system during the call. This level of access made it easy for all teams to provide support and advice when needed.
- Staff had electronic access to different records and extra information for patients through the systems they worked with. The business and system features team were able to update the system regularly with new information, which was accessible to all staff when required. New information included GPs informing the service about potential patients' end of life care and decisions, resuscitation decisions, advanced directives, and treatment escalation plans. Staff were able to access this information to support decision-making that may affect and improve the outcome for the patient in accordance with their wishes. Special notes had a review date that the system would flag when a review was required. However, there was no formal process to follow up on possibly expired notes.
- The clinical team had access to clinical guidance to support assessment and provision of advice and support to patients. Immediate access was provided for information from the British National Formulary (BNF) (information on selection and clinical use of medicines) and 'Toxbase' (information about the management of patients exposed to toxins). This supported treatment advice and guidance for patients and their medicines s.
- Staff had paper-based information at their desks to enable service continuation in case of system failure or shutdown. 'Card decks' were located at each workstation providing information to enable callers to continue to be assessed when electronic systems failed. There was access to information about local alternative care and treatment providers. The clinical teams in the EOCs had access to information about different treatment centres available within an individual patient's locality. This enabled clinicians to provide accurate information when signposting patients to receive care and treatment at more appropriate locations. Clinicians had back-up paper copies of locations where care and treatment could be accessed in case of system failures.
- The clinical team made information provided to the patient accessible for other healthcare professionals. Information documented by the clinical team was highlighted to the emergency medical dispatch team. Attending ambulance crews could then pass relevant information onwards to emergency departments.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was some but limited application for the Mental Capacity Act within the EOCs. The EOC staff were not in a position to assess a patient's mental capacity to make decisions from an emergency telephone call. The staff would, however, make any relevant information about a person's capacity available to ambulance personnel if this had been provided about the patient from their carer or the person making the call. The staff would, nevertheless, alert the dispatch team and in turn, the ambulance personnel of any concerns they might picked up directly about a patient's mental capacity. The ambulance personnel would then be expected to act in the best interests of any patient who was not able to make decisions.
- The trust provided training around the Mental Capacity Act 2005. This training was part of the three-yearly mandatory training programme. It was delivered as a paper exercise for staff to read then complete a set of questions and answers.

Is emergency operations centre caring?

Outstanding ☆

We rated caring, overall, as outstanding because:

- All staff in the EOCs we met and sat alongside consistently demonstrated compassion, kindness and respect towards callers and patients. We listened to over

120 calls, and this was demonstrated unfailingly by all staff at all times. All patients, relatives, healthcare professionals, and other callers were treated as individuals and given support and empathy in often the most difficult circumstances.

- Staff recognised when patients required further information and support and this was provided at all times. This was something particularly recognised when staff were speaking with a child or young person. Staff also thanked callers, who were otherwise strangers to the patient, for their actions to get help.
- Staff made sure people had understood the information given back to them by the advisor, and that provided to staff by the caller to make sure people were given the right response. Staff asked questions in a calm approach but with empathy and clarity. Staff recognised it was hard for people calling the service to interact over a telephone line, but staff got the best information and gave the best responses they could when they were otherwise not able to see the patient.
- Distressed and overwhelmed callers were well supported by staff. Staff used their initiative and skills to keep the caller calm, and provide emotional support in often highly stressful situations. This was witnessed in a particularly challenging situation for the advisors and the clinical team when dealing with a patient threatening to harm themselves and others.
- There were systems to support patients to manage their own health and to signpost them to other services where there was access to more appropriate care and treatment.

Compassionate care

- All staff demonstrated their commitment for caring for patients consistently during each of the 120 calls we listened to. The staff demonstrated compassion, kindness, respect and professionalism throughout each call despite the sometimes challenging nature of these. We listened to a number of calls where staff were abused, shouted at, and threatened. The staff remained calm, respectful, and showed their professionalism throughout. There was, at times, outstanding professionalism among the emergency medical advisors in the Bristol and Exeter teams. The staff remained calm under pressure, and handled the callers with courtesy and patience. We listened to staff handle a caller to the service who was threatening to harm themselves and others. The advisor quickly identified a member of the clinical team who could take over the call and provide support. This was done with professionalism to keep the patient safe, strength to persuade the patient to calm down, and an empathy with the patient's difficult and challenging circumstances. The clinical advisor also provided support and prompts to the patient's partner to help them with their efforts to make the situation safer.
- All staff in the emergency operations centres showed outstanding compassion and understanding to people in difficult and stressful situations. Staff made a genuine connection with patients and others who were scared or anxious and developed an, albeit temporary bond, with the person trying to help them. Staff would, appropriately, say "take care" and "all the best" to people, and this was often repeated back to staff by people who had appreciated their friendliness and warmth.
- All staff treated callers with compassion and empathy. We listened to a call from a member of the public about concerns for a friend following some bad news. Despite having to use scripted prompts from the triage system to assess the patient, the emergency medical advisor treated the situation and caller with compassion and kindness. They worked hard to identify the correct support for the person, despite the situation not requiring a response from the ambulance service.
- All staff dealt kindly with people who were distressed. For example, staff remained calm and showed kindness when talking to a tearful young adult during a call. This calm approach enabled the caller to relax and engage more effectively with the assessment. This helped the advisor to gain a thorough assessment to identify the caller's needs.
- There was guidance for staff on handling abusive callers. There was no specific training for staff to deal with rude or abusive callers, but there was support for staff if they were to encounter a call of this nature. A script was provided for advisors and clinicians that could be used if a caller was abusive. Staff demonstrated how they would calmly work through the script and follow the instructions provided. There was then the option for the call to be passed to a supervisor.

Understanding and involvement of patients and those close to them

- Staff engaged callers to help them understand and be able to follow some of the simple instructions to help them. We heard emergency medical advisors explain information clearly to callers and again, at the end of the call, summarise information for the patient. We also heard occasions where the advisor would ask the caller to repeat the instruction to ensure they had understood.
- Emergency medical advisors checked their understanding of the information they received from callers to ensure they had heard the information correctly. This helped produce an accurate assessment leading to the correct and most appropriate response, often in difficult circumstances where the line was not clear, or the caller was anxious. Staff communicated clearly and simply with callers. We heard staff providing precise instructions to the caller to get the right assessment of the incident. Call handlers provided instructions to people with the patient to support them and the patient until the ambulance arrived, and told them what the patient could and could not do to ensure safety.

Emotional support

- All staff provided emotional support by taking control of the call and providing reassurance to distressed callers. We listened to a call from a distressed parent whose child required an emergency ambulance response. The advisor took a confident but calm approach with the caller, providing them with assurance that the situation was being managed effectively. This enabled the advisor to fully assess the patient using the prompts provided, while continuing to provide reassurance and support to the parent throughout.
- Emergency medical advisors provided continuous emotional support to caller in certain circumstances when an emergency ambulance response was on its way. Where necessary, and unless other priorities took over, advisors remained on the line until the ambulance crew arrived at the scene. This provided reassurance to callers that they were not alone during a possibly distressing time.
- There was emotional support in many different situations. For example, the EOCs received calls from older people who were overwhelmed with the emergency, and required emotional support and guidance throughout the call. We heard support provided to an older person who was not coping well with the situation. They were struggling to engage with the assessment to provide information about their spouse's condition. The advisor immediately recognised the problem and used their initiative to take the time to reassure the caller and explain, clearly, what needed to be done. This helped calm the caller in order for them to provide the right information to the advisor. This action by the advisor led to a more thorough assessment and appropriate emergency response for the patient.
- The EOCs received calls from 'lifeline' companies (companies supporting calls from alarms worn by older or vulnerable people living alone in their own home). The lifeline companies called the ambulance service if they had judged the patient who had contacted them needed an ambulance. On receiving a call from the lifeline company, the emergency medical advisor usually called the patient directly to tell them an ambulance had been arranged. If possible, given the priorities, the advisor went on to provide emotional support and reassurance until the ambulance crew arrived. If the advisor was unable to speak to the patient, they would leave a clear message on the patient's answerphone informing them help was on the way.
- The clinical assessment team demonstrated an understanding of the patient's condition and its impact their emotional wellbeing. The clinical team took time to listen to the patient's fears and anxieties about their situation or condition. The team provided valuable advice, reassurance and support to patients throughout the call.

Supporting people to manage their own health

- The clinical assessment team supported patients to manage their own health when an ambulance response was triaged as not required. The clinical team had a directory of alternative health and wellbeing services for signposting to some patients. It provided locations within the patient's locality where they could go to access more appropriate care and treatment. Clinicians used this system to signpost patients to manage their own health more effectively in the community rather than attending hospital.
- The clinical assessment teams provided patients with direct advice to manage problems independently, without requiring an ambulance response or hospital admission. Clinicians were able talk to patients directly over the telephone and provide advice for patients, some of which could be tried while they were on the

telephone. We listened to a clinician provide advice to a patient who had a learning disability. The patient was a frequent caller who had concerns about a regular but natural condition. The clinician gave them support and advice about how to manage the situation and the caller was content with the advice.

- The EOCs worked with external agencies to develop support plans for frequent callers. The clinical team would support the frequent caller by providing reassurance and encouragement to the caller, while following a plan to support the individual to take control and manage their health problems.

Is emergency operations centre responsive to people's needs?
(for example, to feedback?)

Good

We rated responsiveness overall as good because:

- Services were planned and delivered to meet the needs of local people.
- The service was operating a responsive 'hear and treat' service to ensure the best use of limited resources.
- There were procedures and protocols for supporting people in vulnerable circumstances.
- Resources were used where they were most needed. The trust had been commended for its service to reduce and respond to frequent callers.
- The service had a variety of responses it could call upon. This included the services of trained personnel and extended to community and emergency first responders.
- There was learning and improvements made when people complained about the service they received.
- Complaints were handled with sensitivity and time was taken to provide a considered response.

However:

- The triage system being used in the Bristol EOC did not prompt staff to ask whether a person was vulnerable, such as living with dementia or a learning disability.
- Not all complaints were being responded to in the time required. However, this was being addressed with the recruitment of additional staff to this service.

Service planning and delivery to meet the needs of local people

- There were a number of different ways for the EOCs to respond to patients in their local community. This included using the ambulance core personnel, such as paramedics, technicians or care assistants. The service also used first responders. These were volunteers from the public, other services, or other professionals. First responders were trained by the ambulance service or their own organisation to respond to emergency calls. Community first responders were volunteers who often lived in rural areas and were able to provide basic first aid, including CPR, in life-threatening emergencies (but were not sent to high-risk situations such as road traffic collisions, or excess drug and alcohol incidents). The organisation also used establishment-based responders, which were similar to community responders, but trained individuals based in public locations such as railway stations, shopping or leisure centres. There were St John Ambulance community first responders and RNLI co-responders able to serve within the trust's region. The service could also contact fire co-responders. These were retained fire fighters who had basic life-support training and carried an emergency medical kit. They were dispatched through fire control and usually attended in fire-service vehicles. There were also ambulance personnel who acted as staff responders. These were staff who volunteered to attend emergencies in their local community on their day off.
- The facilities and resources for staff to work in were good in Exeter and adequate in Bristol for staff to carry out their roles and responsibilities. In Exeter, there was good desk space to accommodate up to four computer screens, including a PC for access to the intranet and other systems. There was a good degree of space between staff taking and making calls, and this meant staff were not disturbed by excessive noise in what was a busy centre. The supervisors and managers were also located centrally within the office so they could monitor and support their teams. For Bristol, this would be much improved when the staff moved to their new EOC premises in November 2016. At the time of our visit, the service had outgrown the office space in the Bristol Centre. Staff worked relatively close together and it was clear at times that the noise levels could be problematic. However, when we were listening to calls

in the Bristol office, the staff we observed had no problem with hearing callers clearly – unless there was a problem with noise or phone reception on the caller's side. Not all staff in Bristol had access to a PC on their desk, as there was only room for three screens. Supervisors and managers were also located centrally and in among their teams.

- There was good organisation of relevant staff to manage specific areas of the region. The trust had 96 ambulance stations, rapid response vehicles located in busy areas awaiting dispatch, access to six air ambulances (the helicopter and pilot provided by charitable organisations) and other vehicles to mobilise. Emergency medical dispatch teams in both centres were organised within a geographical area so staff had a clear picture of how the emergency response teams were managing. Emergency medical dispatchers also gained more specialist knowledge of a specific area, including temporary or longer-term problems. They were therefore able to update crews with essential information on route to an incident. Dispatches in Dorset were managed by the team in St Leonards, with calls taken and information passed through electronically from the other two EOCs.
- The EOCs operated a 'hear and treat' service. The clinical team assessed patients who required medical help, but this could be provided over the telephone. This avoided the need to send an ambulance and maintain that resource for more appropriate incidents.

Meeting people's individual needs

- There were interpretation services for callers who had limited or no spoken English. The majority of the translation services were provided in situations when there was time to organise them. Staff said the services were often not available at very short notice, but it was unusual for them to take a call for an emergency ambulance and not be able to get a basic understanding from the caller of what was needed. The clinical teams or welfare teams that called the patient for further information or updates were more likely to use the services of the translators. Those staff we spoke with who had used them said it had worked well.
- The service did not have any specific ways for the public to call for an ambulance other than through the telephone. People who used text messages to communicate (such as people who had impaired hearing) often had their own equipment to use this function themselves. The EOC call handlers (emergency medical advisors would then get a call from an operator who was able to relay information to and from the caller via the text system.
- Emergency medical advisors and clinicians had been trained to speak in a certain way to be able to communicate effectively. The EOCs were often quite noisy environments from lots of activity, but staff kept non-call related conversations relatively quiet. Staff did not shout or raise their voice with callers who could not hear well or were not listening. Staff spoke more slowly and firmly, and deepened their voice as if they were projecting to the back of a room. If a person said they had a hearing aid they were not wearing, staff would ask them to use it if possible if they were struggling to hear.
- The trust had a nationally recognised service for people identified as frequent callers. This service was set up to find and offer alternative ways to help people, who called the service frequently, mostly with non-emergency reasons. There was a dedicated small team (including a clinician) for identifying and managing frequent callers, with the vast majority of the calls recognised as inappropriate. The trust had recognised the use of resources diverted to people calling the service unnecessarily. As with other NHS ambulance trusts nationally, the trust had taken steps to respond to support people calling too often, and reduce the impact on resources. The trust was using the national description of a frequent callers, who were people aged over 18 years, living at a private residence (as opposed to a care setting) and who made five or more emergency calls a month, or 12 or more in three months.
- Staff were able to respond to people with a mental health problem or illness. The patient, or the person calling on their behalf, was taken through a set of triage questions designed to understand what was at the route of the current incident. Some of the problems presented were recognised as often a symptom of another problem that needed specific support. We were listening to one particularly difficult call from a patient with serious alcohol abuse who was threatening to harm themselves and others. This was managed in a calm and appropriate manner by the emergency medical advisor who gathered as much information as possible before handing the patient and their partner (who was intermittently on the call) to one of the clinical team for additional support. We listened to the advice

from the clinician, who, although had no specific professional mental-health qualifications, was able to make progress with the patient. They kept the situation under control while an ambulance was dispatched to the scene. The clinician made sure the patient had made contact with the mental health crisis team and any other professionals they were connected with. They then gave the patient's partner specific instructions about how to keep the patient as calm as possible, and to practice specific breathing exercises which the patient was familiar with as a calming method.

- The EOCs worked hard to resolve any silent calls received. One of the supervisors of the advisors in the Bristol EOC talked about how they would deal with a call when no one spoke, or the caller hung up without talking. They said they risk was the person on the other end of the phone had collapsed or was in a dangerous situation. The EOC was able to usually get the caller's mobile phone number from the operator or check with the phone provider for the address registered with the mobile phone. EOC staff were able to also check records to see if there was an address listed with the mobile phone from past calls. If the call were from a landline, the registered address would usually be provided. As soon as an address was found, an ambulance was dispatched to the scene.
- Only the Exeter EOC triage system (which was an approved system supplied by a third party and not easy to adapt by the EOCs) directed the advisors to ask whether a patient had a learning disability or was living with dementia. The triage system used at the Bristol EOC did not include this prompt for advisors. There was a freeform text area to add this information if it was offered, but it would otherwise not be questioned. However, advisors and dispatchers told us that most of the callers to the service tended to offer this information without being asked. A lack of this information meant the ambulance crew would not have information which would enable them to support patients in line with their individual needs. This would be resolved when the Bristol EOC moved to using the same system as Exeter in early 2017.
- There were protocols for staff to support a patient who was attempting or contemplating suicide. An ambulance was dispatched to anyone in these circumstances regardless of the priority of their symptoms. An advisor or a clinician remained on the call with the patient until help arrived with them. The clinical advice team liaised directly with the mental health crisis team also at this time.

Access and flow

- The service monitored the status of emergency calls in order to respond to a growing number of people waiting for their call to be answered. There were screens in the EOCs showing how many calls were waiting to be answered. This alerted supervisors and managers to rising call volumes. When calls waiting began to increase, the duty managers would look at getting additional staff to take calls (such as supervisors, staff undertaking training, or in meetings).
- As with all ambulance services in England, there were no methods or technology available at the time of our visit to screen people calling 999 for an ambulance. All calls were put through to an emergency medical advisor who were the first personnel (after the third-party call centre who answered the 999 calls initially) to speak with the caller. Therefore, the advisor did not know if the caller was for an emergency or life-threatening situation, or otherwise. Each call was therefore taken as it arrived and initially triaged in the same way. Emergency medical advisors we met said they were trained to get through all calls as safely and efficiently as possible. When we were listening to callers, we heard the advisors explain to patients or carers who did not need an emergency ambulance (such as non-injury fallers or frequent callers) that help was on its way, or a clinician would call them back, and end the call as soon as they could. This was not done without ensuring the person was safe, and had understood what would happen next. However, the efficiency allowed the service to respond to an increase in calls overall which could occur at any time.
- The EOCs were working to direct resources to where they were needed. The trust had a programme to manage frequent callers. In the last 18 months, the trust was managing and analysing statistics for around 900 people in Devon, Cornwall, Dorset and Somerset who had been identified as frequent callers. Data for 2015/16 showed that the work undertaken had a positive impact on the service and had reduced the numbers of, and resources used for supporting frequent callers. The south division (where the frequent caller programme had been running) had seen a significant increase of

between 40% and 94% in the 'hear and treat' service provided to frequent callers. The use of the 'see and treat' service (ambulance personnel attending the scene but not conveying the patient to hospital) had increased between 64% and 90%. The 'see and convey' service was much the same – suggesting where an emergency was identified, it was responded to appropriately. The other improvement was with 'on-scene' times. In 2015/16, this had reduced the time at the scene with frequent callers from 135 hours to 76 hours (New Devon area) and from 97 hours to 38 hours (South Devon and Torbay area).

- The organisation was part of the national resource escalation action plan or REAP. This plan operated at all times, but certain changes were designed to be made within operations when described circumstances occurred locally or nationally and tested resources. There were four REAP levels – of which level one was 'business as usual', through to level four which could be, for example, declaration of a major incident, much heightened activity in A&E, or a public event causing, or with the potential for, major disruption. Each level had various actions for ambulance trusts to take to endeavour to improve their responsiveness or support other services in their vicinity or beyond. This included "requesting mutual aid" which was where services took action to support one another across boundaries. The EOC could consider deploying private agency staff, and volunteer staff trained to take calls or dispatch ambulances. Doctors could be requested to assist with clinical triage in the EOCs, or emergency medical advisors could close all calls to everything but life-threatening emergencies.
- There was a standard operating procedure to divert calls to the out-of-hours service in times of extreme demand. The procedure, for those patients triaged as needing a face-to-face assessment within one hour, was for a clinical supervisor to make a decision to seek support from the out-of-hours service. The procedure required a trust clinician to handover any patient to another clinician only, and not to an operator within the out-of-hours service. If the patient had been assessed as vulnerable, the nature of this vulnerability must be made known to the receiving clinician.
- The trust had standard operating procedures with A&Es in the acute hospitals in the region to release ambulance crews back into service in busy periods. Crews arriving at A&Es in the region had a standard handover period of 15 minutes. They were, however, often waiting for longer periods to hand patients to A&E staff, particularly in periods of high call volumes for A&E services. When certain triggers in the standard operating procedures occurred, the staff had a number of options to employ to return their crews to the road. This mostly involved senior staff informing the A&E, or senior staff in the hospital, that they were invoking the standard operating procedures and the hospital given notices that ambulances would be withdrawn, usually within a further 30 minutes. Dispatch staff said they felt the service had a variable degree of success with this policy, and it did not always work as planned in practice.

Learning from complaints and concerns

- There were various ways for people to complain about the service they had received. This included contacting the organisation by letter, email or directly through the trust website. People were also able to telephone the service and speak with the patient experience team who had a direct number. The trust website pages relating to complaints or contact in general could be translated using an automated search engine translator into various languages including French, Polish, Italian and others.
- The patient experience team were responsible for taking complaints and were based in the Exeter headquarters. All complaints and comments either came directly or were routed to the patient experience team. The patient experience team then liaised with the complainant, looked up all relevant documentation, and managed contact with the EOCs. The information was then sent to the relevant quality team to investigate.
- Complaints were handled with sensitivity and responded to after an appropriate level of investigation. Complaints were properly investigated and a considered response provided. People who complained were either written to or telephoned, specifically where they had expressed how they wanted to be responded to. For appropriately significant complaints, there were face-to-face meetings where the complaints' manager and a senior manager of the trust, including EOC managers, had met with the patient and/or the family.
- There had been changes and improvements to practice following complaints. This had included issues with communication across ambulance trust boundaries. There was a direct telephone line established with one

neighbouring trust to improve communication because of a complaint. There had been actions taken with some staff where there had been complaints about their poor attitude. This included attendance at a customer care course. We reviewed one complaint in detail. This had a number of themes. Each had been addressed by a high standard of investigation and response. The areas the investigation had looked at were relayed to the complainant. The response explained how and why this had been done and what had come from the review. This had included upholding the majority of the complaint. The language of the triage system had been reviewed as a reflection of how this had made the complainant feel. The member of staff involved with the complainant at the time had been made aware of the complaint and a different approach had been discussed with them. One of the complaints team highlighted how the managers had both been active in looking for areas in the complaints where staff were complimented for some areas of their work and making sure these were passed on too.

- All complaints and responses relating to operations were seen and signed off by the chief executive.
- There had been an increase in the number of complaints received by the division in which the EOCs sat (A&E service line). In the year 2014/15, there were 864 complaints and this rose to 1,101 in 2015/16. The trust did not provided us with information on how many of these complaints within this specific service line were upheld. However, for the overall organisation, 750 from 1,519 were considered to be well founded. The trust's definition of well-founded was: if any, or all, of the complainants concerns were upheld.
- The trust's annual report into patient safety and experience 2015/16 stated that, of the complainants who responded further to a trust survey (178 respondents), 90% felt the trust had taken their complaint seriously. The respondents were asked whether they felt the trust apologised when it had recognised a mistake, and 93% said yes.
- The trust was not responding to most complainants within the periods agreed. Staff we met who worked in the complaints team said this was due to the volume of complaints, and the high standard by which each was investigated. We met with the complaints manager in both Bristol and Exeter. The Bristol manager felt overwhelmed with the number of complaints due to the increase in volumes coming into the service. The Exeter manager was able to respond to complaints in due time. There seemed to be an entirely different experience for the complaints manager in terms of volume across the two centres. However, both managers refused to compromise on the quality of their response.
- In 2015/16 the trust responded to just 35% of complaints within the internal 35-working-day deadline. However, only 3% of complaint files were reopened following the trust response, suggesting the vast majority of complainants were satisfied with the response. The trust recognised its poor performance in responding to complaints and three new posts were being recruited to for this department at the time of our inspection.
- The trust received 2,225 compliments in 2015/16. This was an increase of 7% over the previous year. Of these, 2,004 were made about staff in the division in which the EOCs sat (the A&E service line). This was an increase of 12% over 2014/15. Compliments for the A&E service line staff represented 1.9% of calls, which was higher than the 1% of calls resulting in a complaint.

Is emergency operations centre well-led?

Good

We rated well-led overall as good because:

- There was a clear vision and credible strategy for the service.
- The governance framework had clear responsibilities and most risks were understood and managed. There was a comprehensive and detailed risk register, which was well managed.
- The leadership reflected the values of the service and were open, approachable and supportive.
- There was a strong wellbeing and support service for staff.
- A number of the issues of integration and support within the Bristol EOC should be resolved with the relocation later in 2016 to their new building.
- There was good engagement with staff and the public.
- The service was innovative and looking for ways to improve and sustain its service. This included

participation in the programme to overhaul the way ambulances respond to patients, and move away from a time target to deliver the right response, first time. There was good governance around this pilot scheme.

However:

- There was a lack of quality review at local level.
- The leadership was not aware of when the levels of professional support given to staff were failing.
- There was a variable degree of and formality in one-to-one support for staff.
- There were some risks on the risk register that had remained there too long without resolution. This included the poor performance in staff appraisals which had been added in 2007 and staff turnover added in 2013.
- There were missed opportunities for better integration with the staff working in the different EOCs.

Vision and strategy for this service

- The trust had a mission statement, a vision, and a set of values for staff and patients. These were underpinned by a set of four strategic goals for service, and an operational plan to take it through 2016/17, and beyond. The mission statement was patient focused, and centred on saving lives. The values were around respect and dignity, commitment to quality of care, and 'everyone counts'.
- The operational plan included high-level objectives, and matters affecting the EOCs. One of the high-level objectives was the implementation of the external transformation project: the ambulance response programme clinical coding trial. The operational plan described how measured success of the ambulance response programme trial would lead to a proposal to change the way the ambulance fleet was structured. The success of the ambulance response programme, which was driven by the right response to an incident, rather than the quickest, would involve changing the ambulance fleet. The ambulance response programme model required more double-crewed ambulances in order to provide the most appropriate response, and fewer single-crewed rapid-response vehicles (cars).
- The EOCs were included in other areas of the vision and strategy for the service. This included the move to a single telephony system in quarter two of 2016/17; the 'green call pilot' (a trial in Devon to look at a different way of handling 'green' (urgent but low priority) calls) which was underway; and relocation in November 2016 of the North EOC in Bristol to larger premises. All these projects were part of the work programme designed to supplement the projects in the operational plan.

Governance, risk management and quality measurement

- Major programmes were underpinned by quality and risk measurement. The trust's participation in the ambulance response programme, for example, was supported by a governance structure. This included the sponsors of the programme (Secretary of State for Health; NHS England; and NHS Improvement) and various sub-groups in which the trust, as one of the two organisations chosen to pilot this new approach, was represented.
- The trust had a straightforward governance structure. The EOCs were represented through both the clinical effectiveness group and quality governance committee. The quality governance committee was accountable to the trust board of directors, but also referred relevant issues of concern to the directors' group.
- There was a comprehensive and well-managed risk register, although some risks had not been adequately addressed. There were clearly defined measures of risks with controls and actions identified. There were some risks, however, identified a number of years ago, remaining on the register without adequate progress. The problems with providing staff with reviews of their performance (appraisals), for example, had been on the risk register since 2007 and the problem continued to be a significant issue for the service. Problems with high staff turnover had been added in 2013.
- There were different meetings within the EOC providing information on quality and safety of the service, although the quality of the service was not as well represented as other administrative and strategic matters. The EOCs had performance meetings at regional level. These were formal meetings with senior staff and led by the head of operations for the local EOC. Discussion items included staffing issues such as sickness, maternity leave, recruitment and agency staff use. The teams also looked at performance, training, project updates and budgetary matters. We saw the minutes and agendas for four of these meetings for the north hub, which took place every two weeks. There were duty manager meetings held quarterly and issues from this meeting and the local EOC meetings were fed

back to the director of operations through his managers. The meetings had some good content, but they had not acknowledged or addressed the poor training and appraisal results. They did not look at depth at complaints or incidents at local levels in order to make direct changes at frontline level.

- Audits of calls taken by EOC staff were of a high quality, although due to pressure to deliver training had been well-below required targets in recent months. Calls were audited to check if the emergency medical advisor or the clinician had followed the right clinical pathway and triaged the patient correctly. When this quality and safety measure was being effectively operated, it showed a high quality response by the EOCs. If there were areas of concern, these were addressed through one-to-one meetings with the audit team or line manager as appropriate. Staff said this was part of their role and did not see this as adversarial, but as a chance to learn and to know each member of the team was working together.
- The senior management within the EOC and the operations directorate had regular and formal contact with one another on matters of safety and quality monitoring. The head of operations had a weekly one-to-one meeting with the head of the clinical hubs (the trust name for the EOCs). There was a weekly operations conference call with all the heads of department, which included the EOCs. These calls had an agenda, although minutes were not produced. An action log was created for the weekly conference call, which was monitored and updated. The A&E service line meeting (for the whole operations team) met monthly. An agenda and minutes were produced. These minutes were made available to the trust board.
- The EOCs provided staff with quick guides to policies and procedures. As with many large organisations, there were a high number of policies, protocols and standard operating procedures. A member of staff had developed a set of simplified guidelines for staff to reference at a quick glance. Policies and procedures had been revised to a set of bullet points on one page where possible. This was available to all staff, and particularly EOC staff. The problem, as written about elsewhere, was some staff in the Bristol EOC not yet having access to personal computers and therefore the trust intranet on their desks. Supervisors and managers had access, however, and were working alongside staff giving advice and guidance. The situation in Bristol would improve with the move to the new EOC in November 2016.
- The organisation had established a group to look at standardising policies and procedures for the EOC. The merger of organisations and different working practices within the EOC led to a number of non-standardised procedures. This issue had been escalated to the risk register with the merger of the two organisations in 2013. The head of the clinical hubs (the EOCs) had recognised this had not been moved forward since 2013. It had been addressed with establishment of a working group to bring policies and procedures into a standardised format. It was to continue to develop these as new systems became standardised and practices more common across locations. The deadline for completion on the risk register was December 2016, but this would be dependent upon the conclusion of current programmes, particularly the ambulance response programme.

Leadership of service

- There was dedicated and experienced leadership within the EOCs. The senior staff had almost all been part of the ambulance service for many years. Many had worked in numerous posts throughout the organisation, often progressing to senior roles. The senior management therefore understood the roles of their own staff and teams.
- Senior staff were visible and made themselves known to staff. All the staff we met in the EOCs knew who their line managers were, and those of their colleagues where they could also go for support. Staff also knew whom their manager reported to and felt they had the opportunity to meet with more senior management if they needed to. All staff knew the head of the EOCs, and had met and seen both these managers regularly. The senior manager in the Bristol EOC (deputy head of operations: clinical hubs) was located in an office within the main call centre and had a good oversight of how the centre was operating. The senior manager in the Exeter EOC (head of operations: clinical hubs) was located downstairs from the main call centre with the management team. There were advantages and disadvantages to these different arrangements and staff who experienced both styles of working had numerous different views.

Emergency operations centre

- We received positive comments from almost all staff about the support, guidance and attitude of their own line managers. Some of the team leaders we met said they felt well supported day-to-day, but they were concerned the trust was not listening to their more overarching concerns. One of the concerns described was relating to the staffing rotas and the impact these were having on staff morale. Staff also mentioned changes to meal-break routines. Another related to the number of changes to procedures or systems at the same time. Some staff felt this was not communicated well, and staff views or input had not always been sought in advance.
- There was recognised support for staff wellbeing and welfare. Almost all the staff we met said they believed the organisation cared strongly about staff wellbeing and welfare and had produced a number of schemes or offers for staff around these areas. However, staff said there were some areas where the organisation did not appear to have considered the impact upon them. A number of staff told us they did not feel the organisation imposed change without thought, but was enthusiastic and keen to innovate and improve. Staff said, however, some of this felt like it contradicted the organisation's otherwise clear views on staff wellbeing and welfare.
- Staff told us they did not fear retribution from raising concerns. They said they were confident in the organisation's processes to protect them and policies to that effect. Staff said they would usually want to raise issues with their own line manager and had confidence this would be the best route to follow. Staff also said they would take the matter higher within the organisation if they felt this was appropriate or important. Staff said they would not hesitate to blow the whistle if they thought the service was not safe or a member of staff was not performing and putting people at risk.

Culture within the service

- There was a varied response to our questions about staff morale. Many staff told us they loved their job and their teams. The major problems affecting morale had been with rising call volumes met with limited resources, and pressure of work. Staff said the trial of the new ambulance response programme had started to improve things that were important to them, such as getting their breaks in what were long shifts, and being able to finish on time. However, there was ongoing work by the trust to support the staff. The trust was providing 'staying well' sessions in the EOCs and staff were supported through sickness monitoring. For teams that had been identified particularly at risk, for example, the advisors, the trust had approved and implemented an increase in staffing levels.
- Staff told us they were aware of new staff being recruited and coming into frontline operations once they had finished their training. There were, nevertheless, some dedicated and committed staff working long and excessive hours in order to deliver a high-quality performance. Some of these staff had good day-to-day support from their line managers, but the more formal system of performance review (the appraisal or career conversation) had not happened with some for a number of years. The organisation did not appear to be aware of this and was not acting to protect some staff from exhaustion when they were trying to deliver an excellent performance.
- Staff knew how important each of their roles were within the EOC system, although sometimes felt the pressure to get everything right at all times was not realistic with excessive demand pressures. The EOCs recognised they had good teams of hard-working, committed and caring staff. Both the organisation and the staff knew the importance of making the right decisions, often under a lot of pressure, and coupled with increasing call volumes and changes to systems. Some of the staff told us they did not feel confident in the IT systems; the training for new systems; and managing with new staff in a climate of growing call volumes. However, a number of staff told us they felt the senior management were well aware of the pressures, but had limited resources or competing priorities to manage.
- Staff had been recognised for delivering improvements and making changes. One of the senior executives had written to the quality team to compliment them on the improvements made to the investigations and reports around serious incidents. This had encouraged the staff in this team to maintain this high standard and continue to find ways to improve.
- There was a varied response to questions about day-to-day organised support, but the vast majority of staff said they felt valued by the organisation. There

were some staff who had regular one-to-one conversations with their line manager and others who had these infrequently. This aspect of support was poorly understood by the organisation.

- There was no senior oversight or monitoring of performance reviews to make sure they were happening as required. We met staff who had not had an appraisal for three and a half years and four years in two of the extreme cases. These staff were EOC middle management, who appeared, at least in the Bristol EOC to have fallen into a pattern of good day-to-day support, but a serious shortfall of formal support.
- Most of the staff we met said they would recommend the organisation as a place to work. Some had promoted working for the trust to their friends and family and some had gone on to have careers in the EOCs, or train as paramedics or technicians. We asked staff to describe their colleagues. Staff said they felt their colleagues were "hard-working", "patient", "courteous" and "passionate". One of the clinical team said they "feel privileged to work in the EOC" and "made a difference to someone every day".
- We observed that staff dealt patiently and courteously with people who called at all times and added real value to the EOCs. A few of the calls we listened to involved highly agitated, confused, angry or simply rude people. There were people who did not have patience with the system the staff had to follow. This included a doctor's receptionist who was abrupt with staff who were following the guidance correctly, and a nurse who was impatient and abrupt with one of the emergency medical advisors. Staff said this was not always easy, but they tried to put themselves in the place of the person on the phone. They said they tried to just do their job as professionally as possible and not take things personally.
- Staff in the EOCs said they were made aware when a person they had been dealing with had complimented them. They told us this meant a lot to them. When we listened to calls into the EOCs, we heard a number of anxious and/or unwell people take the time to thank the staff particularly for their patience, professional and calm approach.
- We observed, and were told by staff, that due to the pressure for space and the layout of the office, there was less integration of the clinical team in the Bristol EOC than the Exeter EOC. The Exeter clinicians were sat with the emergency medical teams providing close-proximity support. The Bristol clinical team were in a slightly separate area of the clinical floor, and less integrated. The new Bristol EOC would transform this area of concern, as the new layout would replicate how clinicians were based in Exeter. The introduction of the pilot ambulance response programme had also located clinicians physically with the dispatch team, and not just the advisor team. The clinical lead for the EOCs saw this as a positive and well–received change that was developing well.
- There were procedures and opportunities for staff to receive support. Staff were actively encouraged to take time out after a particularly difficult call, or when the job became more overwhelming than usual. There were quiet areas for staff to use and staff trained in trauma risk management (known as TriM). TriM is a recognised peer-delivered psychological support mechanism. It is used by frontline organisations such as the ambulance service, but also the police and army, for example, to endeavour to prevent post-traumatic stress disorder following a disturbing event. There were staff in the EOCs trained in TriM who would be available or released from their duties to support staff who had taken a difficult call or managed a serious incident.
- There was a lack of connection between the Bristol and Exeter EOCs (or clinical hubs as they were called by the trust). During our inspection, we were asked questions about the other EOC, which showed staff on the frontline had little knowledge about their colleagues working in the other area. One area where this was demonstrated was with staff in one of the EOCs who were taking calls for the other region. They were, understandably, not familiar with the area, local landmarks, local descriptions of places or geography. However, the trust had provided some opportunities for joint working. There was, for example, a combined local consultative committee, a combined standard operating procedure task and finish group, a review of training materials to ensure consistency, and regular joint management meetings. A manual had also been produced to support trust-wide common call handling to ensure local knowledge was shared. The frontline staff we spoke with did not, however, recognise how they had benefitted from these collaborations or how many were applicable to frontline members of staff.
- The service had many opportunities for peer review, peer support, and cooperative working, but although these existed at senior manager level, they were not

always available to the clinical, dispatch or advisor teams. There appeared to be no healthy competition between sites when this might be appropriate to improve or celebrate performance.

- There were parking facilities for staff who worked in the evenings and nights. Staff in the EOCs were located in what were otherwise quiet commercial locations with no passing traffic. Staff said they could always park directly outside of the buildings in the evenings. The buildings were well lit, but they were mostly not visible and parking was obscured by trees and bushes. When we visited the EOCs at night there was no offer to see staff safely to their cars. There was CCTV for the building but this was not actively monitored.
- There was support to the community of volunteers who supported the trust. Community first responders were volunteers who often lived in rural areas and were able to provide basic first aid, including CPR, in life-threatening emergencies (but were not sent to high-risk situations such as road traffic collisions, or excess drug and alcohol incidents). A community first responder wrote to us to after eight years in the role. They had regularly attended cardiac arrest calls and said "every single time I get a follow-up call to ensure I am OK and to see if there is anything I want to talk about regarding the call. The staff are patient, caring and a total credit to the ambulance service."

Public and staff engagement

- The service had a good response to the NHS Friends and Family Test. The A&E service line had 223 responses in 2015/16 and an average of 90% of people who responded said they would recommend the service.
- The trust asked staff if they would recommend the EOCs as a place to work. In the first quarter of 2015/16, 1,349 staff responded. This was 31% of the trust's overall staff (so this did not relate specifically to EOC staff). As a place to work, 46% of staff said they would recommend the trust, and 33% said they would not. By quarter four of 2015/16, the results had deteriorated, although only half the number of staff responded. There were 40% of staff who would recommend the trust as a place to work. We asked staff about the results and most said they believed the deterioration in views had been directly linked to the rising call volumes, no evidence of improvement to stretched resources, the abuse some had from people calling the service, and pressures of work. We spoke with many staff (around 60) and most of these said, however, they would recommend the EOCs as a place to work.
- The trust asked staff if they would recommend the trust if they needed care or treatment. Of the 1,349 who responded to the survey, 85% said they would recommend the trust to their friends and family if they needed care or treatment. By quarter four of 2015/16, the results had deteriorated, although only half the number of staff responded. There were 76% who would recommend the care and treatment. We spoke with many staff and most of these said, however, they would recommend the care and treatment.
- There was engagement from the trust with local and national events. There were recruitment road shows, which had been attended by staff in many different roles, including EOC staff. The trust had its annual general meeting in Exeter, which EOC staff attended. There were visits to schools and stands at large events such as the annual Bath and West Show.
- There was regular engagement with staff, although there was poor access for staff in the Bristol office for electronic communication. There was a weekly bulletin from the chief executive for all staff. This contained organisation news and updates, staff news, upcoming charity events and events looking for volunteers, and data on performance. Staff were sent other updates, including clinical and corporate guidance and updates usually by email. There were a high number of staff in the Bristol EOC who, due to issues with space, did not have access to a trust computer to access their emails or training. This was a significant issue for these staff, who had to find time and space to access a computer elsewhere in the room or building. This led to a risk of staff not having sufficient or effective engagement with the organisation. The trust had recognised this problem and staff were relocating to a significantly larger and vastly improved office building in November 2016. At this stage, all EOC staff would then have access to a computer on their desk.
- The audit teams proactively engaged with emergency medical advisors to improve staff engagement with the auditing process to improve call quality. An anonymous staff survey was sent out by the Exeter audit team to gather feedback from the staff about the audit process. The survey had a 70% response rate. This helped the team to look for actions and learning from the response

of a high number of staff. Following this survey there were improvements to the audit feedback process, which as a result was provided at the advisor's desk so the member of staff did not feel so exposed to others by going into a one-to-one meeting. The audit team also held morning drop-in sessions in the control room for staff to discuss concerns. Staff received recognition from the team for 100% compliance with audits, and a gold star for gaining 100% for call audits over a three-month period. Staff in the audit team felt these changes had improved relationships and engagement with the team.

- There were publications for members of the public. The trust produced a newsletter called "twentyfourseven" published for members of the public with news, long-service awards for staff, notable events taken place or coming up in the trust's area, and success stories. These newsletters were available on the trust's website. The high-quality publication provided the public with good information about the service and its achievements. There was no specific news in the latest edition about the EOCs, but some of the figures about the volume of calls handled and the numbers of patients able to be helped without the need to send an ambulance.
- The trust placed a high value on staff wellbeing and welfare. There were external independent confidential counselling services available to staff in all areas including the EOCs. These were available for problems both directly connected with the member of staff's job, but also other areas that might not be connected, but they felt were affecting them and their work. The Staying Well service was launched on 1 December 2015 to support the staff and their physical and mental health. The system could be accessed by phone or email and was confidential. The service covered but was not limited to staff with problems associated with stress, anxiety, financial concerns, drug or alcohol problems, physical injuries and domestic violence. The trust offered access to further services such as occupational health, physiotherapy, or specialist counselling.
- The trust had recognised staff resilience could be at risk as a result of speaking with abusive or angry people – which was something we experienced with staff when listening in with the emergency medical advisors taking calls. The trust's new peer support network was a response to support staff and the trust was looking at developing an emotional resilience course for accreditation and delivery in 2016/17.

Innovation, improvement and sustainability

- The trust had a number of improvement and sustainability projects underway or planned. The relocation of the Bristol EOC would bring improved working conditions for staff, and provide opportunities for future expansion or links with other key stakeholders.
- The continuation of and investment in integration and modernisation was providing efficiencies and savings. The service-wide computer-aided dispatch system had been rolled-out in February 2016. This had enabled the service to dispatch ambulances located anywhere in the region from any of the EOCs. The next phase was to integrate the telephony system to ensure the EOCs were able to communicate through voice and computers with all the vehicles in the operational area. The next phase of integration was the move to a single triage system, as the north and south EOCs were using different systems (although both were recognised and approved). The implementation of the new system in the Bristol (north) EOC was anticipated for early 2017. This would be subject to the assessment and evaluation of the ambulance response programme, which was a six-month programme underway since April 2016.
- The trust had been commended for its work both with frequent callers and collaborative work in this area with other stakeholders. The trust was part of the national network on frequent callers, which met quarterly.
- The EOCs worked with local prisons in order to change working practices to improve the emergency response to patients. Following a report into the death in custody of a prisoner in the trust area, there had been a recommendation for NHS England and Healthcare providers to work with the trust on 999 calls to prisons. The NHS Health and Justice Commissioner for the south region had worked with the trust in the South West to implement the Secondary Emergency Notification of Dispatch (SEND) protocol. A nominated member of prison staff carried a small laminated card containing a list of questions which EOC staff would require the answer to in order to inform the attending ambulance crew. NHS England had commended the Bristol EOC head of operations and team for their involvement in staff training and implementation of the new process to improve safety for the patients concerned.
- The EOCs were looking at options to increase the use of non-frontline emergency ambulance resources. The 'green call activity' project was a local pilot in the NEW

Devon clinical commissioning group area, which started in the Exeter EOC in January 2016 and was to be extended to Cornwall, South Devon and Torbay in July 2016. The pilot would be analysed to establish if the trust was able use a different approach to these urgent, but lowest priority calls. The date for the end of the pilot was 31 March 2017 with an interim review in September 2016.

- There were further plans to develop further the 'green' pilot with specialist paramedics. The trust was looking at options to use a specialist paramedic vehicle in each operational area, which was supported by a specialist paramedic working at the EOC. The EOC paramedic would identify appropriate green calls for the specialist paramedic to respond to. The aim would be to make better use of resources with the specialist paramedic on the road providing a response to calls requiring specialist input, but did not otherwise require an emergency ambulance response or hospital admission.
- The trust were looking to use community first responders for patients who had sustained a non-injury fall. The trust had liaised with the community first responders' team to discuss a pilot project. It aimed to develop a specific training package to ensure the team had the knowledge and skills to perform the role safely.
- Exeter EOC had planned to trial the addition of a mental health nurse to the team. The objective was to directly support callers with mental health problems and to provide support for staff with mental health related calls. The role would be aim to provide the most appropriate actions and response. This would support the caller and provide a more independent approach to management of the problem, rather than sending an inappropriate ambulance response. The clinical team leader was keen to use the knowledge and skills of a mental health nurse. The objective was to provide learning opportunities for existing staff around assessment and communication with mental health patients to support continued professional development.

Resilience planning

Safe	Outstanding ☆
Effective	Good ●
Caring	Good ●
Responsive	Good ●
Well-led	Outstanding ☆
Overall	Outstanding ☆

Information about the service

South Western Ambulance Service NHS Foundation Trust (SWAST) provided NHS ambulance services across the South West of England covering the counties of Gloucestershire, Wiltshire, North East Somerset, Somerset, Devon, Dorset, Cornwall and the Isles of Scilly. SWAST provided a service to a local population of 5.3 million and a yearly visitor population of 17.5 million.

The SWAST resilience team was based across two sites – Exeter and Bristol.

SWAST resilience provided services, planning and business continuity functions to deliver its statutory obligations as category 1 responders under the Civil Contingencies Act (2004) working collaboratively with multi-agency services. The resilience department held responsibility for:

- Major incident planning
- Business continuity
- Emergency preparedness, resilience and response (EPRR)
- Air ambulances (six) and critical care paramedics
- Two Hazardous area response teams (HART).
- Event planning
- Special operations and air operations dispatch desks

The SWAST EPRR team planned for and responded to a wide range of incidents and emergencies. These included major transport accidents, planning the safety for large public events, patients suffering injury at height or in water and terrorist incidents.

We conducted a planned inspection at both HART bases, two air ambulance bases and the control rooms for special and air operations. We spoke with over 40 staff including services managers, HART paramedics, air ambulance teams, resilience and capacity teams and the events team. We inspected 10 vehicles (including rapid response cars, officer's cars and specialist HART vehicles). We also looked at two aircraft providing the air ambulance service in Bristol and Exeter. We also attended a number of emergency calls with the HART paramedics. We were not able to speak to any patients during our inspection due to the type of emergencies we observed, however, we were able to speak to relatives and friends of the patients.

Resilience planning

Summary of findings

Overall we rated resilience planning within SWAST as outstanding because:

- People were protected by a comprehensive safety system that focused on openness, and transparency, with learning when things went wrong. There were robust systems in place to keep equipment and vehicles clean, well maintained and fit for purpose.
- There was a proactive approach to the management of risk.
- The numbers of staff, the training they received and the policies they followed was compliant with national recommendations from the National Ambulance Resilience Unit (NARU).
- The EPRR teams worked well and had good co-ordination with a range of other agencies including NHS Providers, other emergency services, local authorities, commercial operators, voluntary organisations and the different departments within SWAST.
- Specialist computer applications had been developed for managing staff training records (i-auditor) and for use in major incidents (Commander).
- The special operations team were supported by six air ambulances provided by five charities providing cover for the whole of the geographical area covered by SWAST.
- Staff treated patients with respect, patience and sensitivity. The paramedics were calm and professional in their approach but remained friendly to quickly build a rapport with the patient.
- Staff took time to listen to patients and their families and consistently explained what they were doing and continually offered reassurance.
- Leaders were both supportive and visible, inspiring and motivating staff across all EPRR teams. Staff welfare was of great importance and various services such as traumatic risk monitoring and the 'staying well service' were available to staff should they need it.
- There was a proactive approach to change and innovation. A dedicated events team had taken responsibility for planning, resourcing and managing SWAST attendance at public events.
- A computer application 'SWAST Commander' had been developed for iPad and Android platforms which was used by operational commanders during major incidents.

Resilience planning

Is resilience planning services safe?

Outstanding ☆

We rated safe as outstanding because:

- People were protected by a comprehensive safety system that focused on openness, and transparency, with learning when things went wrong. Systems were in place to support staff in reporting incidents and feedback was consistently given.
- Staff were appropriately trained and premises and vehicles cleaned, maintained and serviced appropriately
- There was a proactive approach to the management of risk. Risk assessments were in place for the environment and equipment. Staff were able to assess risks to patients and themselves and respond appropriately.
- Comprehensive briefings were produced by the business continuity team in response to incidents that took place across the SWAST area.

Incidents

- Systems were in place to support staff in reporting incidents and feedback was consistently given within the team. All the staff we spoke with during this inspection were aware of how and when to report incidents. They were aware of their responsibilities to report incidents and would have no hesitation in doing so. Staff gave us examples of where they had reported incidents and the feedback they had received. As an example, one member of staff reported an incident regarding a regular caller and not being aware of the particular issues with the patient. As a result, an electronic flag was added which would provide staff with this information should the patient call again.
- There was some inconsistency in staff within EPRR getting to know about lessons learnt from serious incidents that took place in other SWAST departments. Some staff told us they were aware of incidents in other parts of the organisation and other staff told us they were not. A bi-monthly newsletter was available to share learning across moderate and serious incidents, complaints, claims and inquests. The newsletter shared the incident summary and findings together with compliments that had come in from patients.
- We saw evidence that staff within EPRR reported incidents regularly. These included incidents where a response to an emergency was delayed because of traffic through to damage caused to vehicles.
- From 1 October 2015 to 31 March 2016, the teams reported 26 incidents out of the 1,482 reported trust wide. None of the incidents were recorded as serious incidents. The majority of incidents related to transporting patients (seven vehicle related), treatment (four related to treatment provided at scene), abusive patients (four) and accidents (four staff accident related)
- A 'lessons identified tracker' was used for major incidents to make sure lessons were learnt. This showed the exercise or incident and the issues faced. Each entry was dated and risk assessed and updates were included when necessary together with actions taken. As an example, during a major incident in May 2016, it was identified that control room staff needed easier access to their action cards. Hand held action cards were developed and issued to each individual member of control room staff. We saw three different sets of action cards for a call handler, duty manager and a dispatcher. All the action cards were easy to read and comprehensive.
- Safety alerts and clinical notices were circulated to staff and discussed at the handovers that took place twice a day. Staff we spoke with were aware of this system and were able to give us examples of recent safety notices that had been discussed.

Duty of candour

- All the staff we spoke with were aware of the Duty of Candour and their responsibilities to be open with patients when things did not go as planned. From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to incidents or harm categorised as 'notifiable safety incidents'.

Mandatory training

- Mandatory training included fire, manual handling and information governance. The training records showed us that 92% of staff had completed their fire and manual handling training and 95% of staff had completed their information governance training. Plans were in place to make sure all staff had completed their mandatory training within the required timescales.

Resilience planning

- All the members of the Hazardous Area Response Team (HART) had received advanced driver training, plus driving with blue lights and in convoy.
- HART paramedics had to achieve a certain level of physical fitness each year. A gym was available to staff to exercise during quiet moments during their shifts. This encouraged staff to maintain their levels of fitness required to meet the expectations of their job.
- The HART service met with National Ambulance Resilience Unit (NARU) national training standards in accordance with the NHS Service Specification for HART 2015/2016. This meant that the staff were trained to deal with the wide variety of incidents they could be called upon to attend. As an example to provide care to patients in confined spaces such as collapsed buildings.
- The HART service provided mandatory training to SORT (Special Operations Response Team) staff. These were front line paramedics and emergency care practitioners who were specially trained to deal with decontaminating patients involved in chemical, biological, radiological and nuclear incidents.
- The HART and resilience teams have also trained staff to deal with MFTA (medical response for firearm incidents). This had led to 150 additional SWAST staff being competent to attend such an incident.

Safeguarding

- There were systems and processes in place to identify people at risk from abuse. Staff knew who the trust safeguarding lead was.
- All staff within EPRR had received safeguarding training for both adults and children. The staff we spoke with understood their responsibilities around safeguarding and how and when to report their concerns. One member of staff was able to give an example of a safeguarding incident. Once the emergency had been dealt with, the police were notified and the trust safeguarding lead contacted.

Cleanliness, infection control and hygiene

- There were robust systems in place to prevent and protect people from healthcare associated infections. Staff received yearly updates in infection control as part of their mandatory training. Staff within the HART teams had also received additional specialist training relating to precautions that needed to be taken with biological incidents to contain infections. The resilience and HART service bases were purpose built and in a good state of repair, which made it easier to keep clean. Toilets, crew rest rooms, sluice rooms, changing rooms and offices were visibly clean and free from clutter. The exception to this was the air ambulance station in Bristol. This was because of the age of the building; the aircraft and crew were being relocated to a new base once physically built.
- The domestic staff made sure these areas were cleaned in line with the cleaning schedules.
- The garage areas were spacious and in a good state of repair and well maintained.
- Systems were in place to deal with sharps i.e. needles and syringes. Each vehicle had a specialist container for sharps to be safely disposed of. We saw evidence that once these had been used, they were sealed and placed into the central sharps bin at their base station. We saw that this bin was kept locked and processes were in place where the bins were removed for safe disposal.
- Systems were in place at each of the HART bases to dispose of waste and dirty laundry including domestic and clinical waste. This reduced the risk of cross infection.
- The vehicles were also clean and tidy. We saw evidence that showed vehicles were cleaned daily and deep cleaned once a week.
- The sluice room was clean and had the necessary equipment to clean the vehicles and equipment and reduce the risk of cross infection between patients.
- Staff had access to personal protective equipment such as gloves and eye protectors and we observed staff using them appropriately. Each paramedic carried hand sanitizer gel and this was also available on each vehicle. We observed staff using this before and after treating patients.

Environment and equipment

- Both facilities in Bristol and Exeter met the NARU/ NHS Shared Specification for HART 2015/2016 Resource). All equipment met national requirements set out by NARU and was maintained in accordance with manufacturer's recommendations and best practice.
- The bases were in a good state of repair, spacious and provided a suitable working environment to meet the needs of the service and staff.

Resilience planning

- Equipment was stored in several designated areas including vehicles, storerooms and secure cages. There was a range of equipment within the bases ranging from standard equipment bags through to specialised vehicles and breathing apparatus.
- Systems were in place to record equipment that was faulty. Any item of equipment found not to be working was logged on a 'defect form'. This included details of the fault and when it was reported. The piece of equipment was then inspected and appropriate action taken and the form updated and signed accordingly. This confirmed whether the piece of equipment had been deemed safe to use, for repair and not for use or for disposal. As an example during a routine check it was noted that there was no groin strap on one lifejacket. This was reported on the defect form on 1 March 2016. The form was updated within a few days confirming that a new strap had been added and the lifejacket was safe to use. In another example, a specialist mounting on a vehicle had been damaged; this was removed from the vehicle and sent for repair.
- At the start of every shift, each paramedic would check their vehicle and their own personal protective equipment. This was signed off on daily check sheets and we saw evidence that this was consistently completed at the start of each shift. Every week each vehicle underwent a 'de-kit'. This meant that all the equipment was taken off the vehicle and thoroughly checked and the vehicle deep cleaned. Each vehicle would receive this 'de-kit' on a different day which ensured vehicles were available for use. Documents showed us that this was consistently carried out at both the Exeter and Bristol HART bases. Each month specialist equipment would be checked such as winch kits, medicine bags and the medical stores. There were robust systems in place which identified the next out of date consumable or medicines.
- Before our inspection, the HART teams had received a Health and Safety inspection. This recommended that visual checks of ladders were carried out as a matter of routine. We saw evidence that this had been implemented and staff were aware of the additional checks they needed to carry out.
- Appropriate processes were in place to make sure vehicles were roadworthy and fit for purpose.
- During our inspection, we checked 10 vehicles. We found that they were all stocked with the necessary equipment and it was all within date. Daily, weekly and monthly checks had all taken place and we were shown documentation to confirm this.
- Some of the specialist vehicles had specific equipment. Layout pictures were included in these vehicles to support consistency in the way the vehicles were packed. This meant that when used in emergencies, all the crew knew exactly where each piece of equipment was located on each vehicle.
- The bases and vehicles within HART met the specifications set by NARU.
- Each base underwent a health and safety inspection as a minimum every year. We saw evidence of these inspections for three of the air ambulance bases and one of the HART bases. These inspections covered the physical environment, record keeping and equipment. The inspections were comprehensive and identified compliance with each standard or areas for improvement and actions that needed to be taken. Action plans were produced with each inspection and followed through by the relevant staff. The inspections dealt with the individual needs of each base. For example one of the standards looked at the availability of salt for de-icing in the winter. The inspections for the air ambulance bases recognised that salt was corrosive to the aircraft, and therefore specialist de-icing chemicals were used.

Medicines

- Robust systems were in place for managing medicines with the HART teams. There was a booking in and out process for prescription only medicines and controlled medicines. Medicines were stored securely, filmed by security cameras and access restricted to authorised staff.
- There was a log that detailed stocks in and out. Audits of this log were carried out. We checked these audits against the medicine stock levels and found them all to be correct. The documentation showed that these audits took place regularly and consistently.
- We found one set of specialist medicines carried within the HART teams were out of date and expired in June 2014. This had been identified as a national problem because the Department of Health had been unable to secure replacement. Special authorisation was obtained to continue to use this specialist medicine

until the replacements were obtained. The trust had issued a clinical notice to staff to inform them of this development and to confirm the medicines were safe to use.

- Some staff in the critical care teams and air ambulance had received additional training to give Ketamine (a specialist medicine used for increased pain control) when necessary. This training was being rolled out to the HART teams. We saw that the patient group directions were in place. These documents specified what training and experience staff needed to have, when they could give the medicine and under what circumstances.
- We observed medicines being given during an incident. These were double checked by two members of staff and doses recorded in the patient record.
- Medical gasses were stored securely and appropriately and the area was vented to prevent any possible build-up of gasses. A log was used to record when stock was taken in or out.

Records

- When the HART paramedics attended an emergency at the request of another paramedic crew, it was the responsibility of the initial attending crew to complete the patient report form. However, in the event of a more serious emergency where multiple staff were attending, a member of staff under the supervision of the incident commander or HART team leader would document the care and treatment provided. We looked at the records for the emergencies we observed and found the records were accurate, complete and contemporaneous.
- In the event of a major incident or mass casualty event, a specialist computer application had been developed that could be used to document and record the events and decisions taking place. This application had been used by incident commanders during major incidents. This allowed positive and negative feedback had been given by the commanders to further develop the application.

Assessing and responding to patient risk

- HART operatives, (Helicopter Emergency Medical Services (HEMS) operatives and the critical care teams attached to the air ambulances were all qualified paramedics with additional skills and equipment to deal with deteriorating patients and medical emergencies in difficult situations. This allowed changes in the patient's condition to be rapidly assessed and dealt with in accordance with national policies and best practice guidelines.
- We attended three emergency call outs with the HART team to observe how they approached each emergency. We observed staff risk assessing the situation to make sure it was as safe as possible for both the patient and the paramedic. As an example in moving a patient from their bedroom, they assessed the patient's condition, the space available and the numbers of staff that would be needed to lift the patient safely. Assessments were carried out as to which piece of specialist equipment would be most suitable for that particular situation. The plan was explained to all the staff present so they knew exactly what would happen and when to lift.
- In another example, the HART team attended to a patient who had fallen from height onto the roof of their conservatory. The first crew to arrive assessed the incident and what resources were required. Once other staff had arrived, the most senior paramedic took the role of incident commander, allocated another member of the team to act as safety officer. Their role was to support the team attending to the patient and alert them to potential hazards. Additional specialist advice was obtained from the fire service. Staff were equipped with personal protective equipment. This included hard hat, gloves, eye protection and specialist equipment such as breathing apparatus.
- Standard Operating Procedures following national guidelines were in place for specific patient risk activities such as working near water or at height.
- When assessing and responding to patient risk with other agencies, the resilience teams followed the Joint Emergency Services Interoperability Programme (JESIP). This programme developed principles of joint working between different agencies involved in responding to emergency situations. It provided a common communication framework (METHANE) to make sure all emergency services were effectively responding to risk.
- Risk assessments were in place for the special operations teams for a variety of situations such as working in close proximity to fire and deployment in adverse weather conditions. Risk assessments were also in place for specific equipment such as specialist stretchers and the exercise equipment used by staff.

Staffing

Resilience planning

- The trust was supported by doctors working on honorary contracts across the geographical area covered by SWAST. As an example, there were 21 doctors covering the north of the SWAST region. These doctors were trained to provide medical support at the scene of an accident, major incident or public event. These doctors worked closely with the paramedic crews and in particular the critical care and HART teams. Some of the doctors were attached to the air ambulance operations.
- There were six air ambulance helicopters across the SWAST area. These aircraft were provided by five charities who either owned the aircraft and employed their own pilots, or the aircraft and pilot were provided on leased arrangements by a separate company. These aircraft were staffed by 44 paramedics who had been specially trained to work in air operations.
- Each HART team consisted of 42 full time paramedics. This meant that a team of six were available to respond to emergencies 24 hours a day, seven days a week. This was in line with the national recommendations from NARU.
- There had only been two months from April 2015 to March 2016 when the sickness rate for the resilience teams had risen above 5%. The HART team's sickness in Bristol rose to 8.3% in October 2015 but had since reduced to below 2%. The HART team sickness in Exeter had risen to 5.6% in January 2016 but had since reduced to below 4%.This is below both the trust and national average of 5%.
- The events team had a staff of three to plan each event. Bank staff were used to provide the paramedic cover which reduced the impact on normal day to day resource planning within the Trust.

Anticipated resource and capacity risks

- The EPRR policy detailed the statutory duties of the ambulance service under the Civil Contingencies Act (2004) and reflected the NHS England EPRR Framework (2015).
- Local risk assessments were completed in accordance with national guidance from NARU to meet service specification standards.
- Command and control procedures were current to deal with anticipated resource and capacity risks. Command and control meant having appropriately trained and experienced staff able to take command of an incident, make decisions and allocate resources appropriately.
- Business continuity (the capability of the organisation to continue to provide a service to patients during a disruptive incident. As an example, power failures, flooding etc.) was part of the emergency preparedness team. The business continuity team had produced a business continuity plan for 35 departmental planning areas including the clinical hubs, special operations unit, trust headquarters and the emergency and urgent care service. Once the plan had been produced, it was disseminated throughout the individual department and approved for use. It was then validated through exercises to make sure the plans did what they were supposed to. This confirmed whether the plan was accurate and appropriate to that department. We saw evidence that confirmed 22 of the 35 plans had completed the validation of their plans. A timetable was also in place to validate the reminder of the plans.
- Each of the business continuity plans were reviewed yearly and we saw evidence that this had been done consistently.
- Seven exercises had taken place since May 2014 that had tested the business continuity process for SWAST. These included fuel planning, all weather planning, logistics and facilities. In addition some plans were also tested through major incidents that had taken place in the region.
- Following exercises, evaluation reports were produced. We saw copies of these reports and found them to be comprehensive. As an example, one report gave a brief overview of the exercise including the aims and objectives. The report looked at how the exercise had progressed, that the objectives had been achieved and any changes that needed to be made to the continuity plan. We saw that the action plan had tasks allocated to specific SWAST staff, were rated red, amber or green depending on the risk. We saw actions that had been completed and updates on those actions that were outstanding.
- When incidents took place in the local community, business continuity incident briefings were issued by the resilience team. These briefings included the situation that had occurred, the background, the assessment and any recommendations. The briefings also included the impact on the trust services. As an example, during our inspection there was a burst water main in Tewkesbury. The briefing for this incident was comprehensive and included the actions taken by other agencies involved. The briefing confirmed that this

resulted in no impact for the majority of trust services, but had a low impact on operations because of the Tewkesbury ambulance station. Staff were given relevant links and teleconference details for operational officers to dial into for further information. The briefing was emailed to all staff to keep them informed of the incident and gave operational officers and team leaders information in case they needed to assess their resources and capacity to attend future emergency calls.

- The HART bases were equipped with a briefing room which was used for handover between shifts. It could also be used as a command area during a major incident with the ability to receive live feeds from the HART teams at the scene. The handovers followed a set agenda and included clinical / medicine updates, any equipment issues, changes in any site specific information, shift activity, operational updates, general communications and an exceptions register. We viewed the presentation from the handover and judged it to be an area of outstanding practice, because staff were well informed about issues locally and across the SWAST region that they might need to be aware of.

Is resilience planning services effective?

Good

We rated effective as good because:

- Business continuity plans were developed in line with International Standardisation Organisation (ISO) standards.
- Standard operating procedures were in place and in line with national guidance from NARU.
- HART, critical care and the air operations teams worked more closely together as 'special operations' to enhance the care patients received.
- Staff in the EPRR teams were competent and well trained.
- The EPRR teams worked well and had good co-ordination with a range of other agencies including NHS Providers, other emergency services, local authorities, commercial operators, voluntary organisations and the different departments within SWAST.
- An electronic database had been developed to hold and manage comprehensive training records for staff.
- The special operations team were supported by six air ambulances provided by five charities providing cover for the whole of the geographical area covered by SWAST.

Evidence-based care and treatment

- We saw evidence that the business continuity plans were developed in line with ISO guidance. ISO (International Standardisation Organisation) works to share knowledge and develop voluntary, consensus-based and market relevant international standards that support innovation. ISO provide guidance and a framework for business continuity and health service resilience. A strategy was in place to complete ISO accreditation within three years.
- The trust's emergency preparedness, resilience and response (EPRR) strategy complied with the Civil Contingencies Act 2004, and the core EPRR framework and standards from NHS England.
- A number of paramedics within the HART and Air Operations teams were specialist in particular core competences such as USAR (Urban Search and Rescue) and provided care and treatment updates to colleagues.
- HART operatives followed training to inform evidence based care. Every seven weeks each HART team completed evidence based training covering clinical practice, skills and procedures.

Assessment and planning of care

- Staff told us that the assessment and planning of care was not limited on grounds of age or disability. Staff delivered care in the best interests of each individual patient depending on their physical and emotional needs at the time. This was reflected by the training staff received and what staff told us.
- Standard Operating Procedures (SOPs) were in place and in line with NARU guidelines. These were used in conjunction with risk assessments to support HART safe systems of work.
- HART and Critical Care paramedics were able to administer intravenous fluids to patients in need of fluid replenishment, this included the administration of blood in some circumstances. This meant patients did not have to wait until they arrived at a hospital to be prescribed urgent fluids.

- We observed how staff constantly assessed a patient's pain level, and administered appropriate medicines to help relieve the pain. HART and Critical Care paramedics were able to prescribe intravenous paracetamol through to stronger pain killers such as morphine and ketamine. Specialist pain relief gases such as nitrous oxide and oxygen gas mixture were also used.

Response time

- The location of the HART bases meant they had easy access to the major road networks in the region. This allowed the teams to attend the majority of strategic sites of interest as defined by the Home Office Model Response Strategy within 45 minutes. The exception to this was Cornwall and the Isles of Scilly because of the distance from the Exeter base. It was explained however, that both Cornwall and the Isles of Scilly were well served by the air ambulance teams and support from other agencies such as the Coast Guard, Royal Air Force search and rescue and the Royal National Lifeboat Institute
- The rapid response vehicles within HART were used to attend certain 999 calls within the SWAST area to assist with the demand on the service. Arrangements were in place that should the HART team be called out to a general emergency, they could be released within 15 minutes should an emergency take place that required their specialist skills. This was in line with national recommendations from NARU.

Patient outcomes

- It was estimated that 95.5% of patients cared for by SWAST were managed safely and effectively by paramedics and emergency care technicians. However, the remainder 4.5% require the enhanced skills of specialist staff such as critical care paramedics and doctors trained in pre-hospital care. SWAST had aligned the critical care function together with the air ambulance and HART teams under special operations. As an example, the Bristol air ambulance team included critical care paramedics and specially trained doctors to provide that enhanced response for patients. At another air ambulance base, the paramedics were completing training to become critical care paramedics.
- The critical care teams and air ambulances were able to respond to the most critically ill and injured patients and transport them quickly to specialist centres. As an example, a patient with serious burns in Exeter could be transported to the specialist adult burns unit in less than 20 minutes by air ambulance instead of several hours in a road ambulance.
- The critical care teams attached to the air ambulances were using the same endotracheal tubes (ET) used in hospital rather than cheaper alternatives. This meant that when the patient arrived at an intensive care unit the ET tube did not need to be changed which presented less risk to the patient.
- HART made it possible to provide paramedic care to people involved in hazardous incidents that would otherwise have been beyond the reach of healthcare staff. It had been recognised nationally by the Government that this increased patient's chances of survival and their outcomes.

Competent staff

- All HART and air operations operatives and team leaders were qualified and registered paramedics. In addition the paramedics attached to the air ambulances had either received specialist training to become critical care paramedics or were in the process of training. Specialist doctors were also part of the air operations team.
- All the staff within EPRR were trained in accordance with local and national requirements. We saw evidence to support this. As an example the paramedics working with air operations had all received specialist training to work on aircraft. This complied with training specified by the civil aviation authority.
- We saw evidence that a resilience officer had met with the leads for all 35 departments across SWAST to complete an analysis of their business continuity plans. This increased the awareness of business continuity across the trust.
- We saw evidence that HART teams received training against the 144 national competencies set out by NARU. The training was scheduled for the year to make sure all staff received the necessary training in a timely way. If staff were absent on a particular training day they were booked onto the next available training.
- Each team of six paramedics were rostered so that one team would be on a dedicated training week for one week out of seven. This meant that during that week they were not operational but spent the entire week training. As an example, during our inspection, one team had just finished their weeks training concentrating on water rescue. At the end of the training

a report was produced for the training managers. This meant the training could be logged for each member of staff and any concerns or risks identified and raised at appraisal or nationally with NARU.

- An electronic training database (i-auditor) had been developed by staff within the resilience team. This held comprehensive training records for staff. These records showed the courses people had attended, what the course involved and the training provider. It showed those staff that had missed any individual piece of training, the reasons why and plans to rebook the training. The records also showed what core skills had been learnt plus a debriefing and reflection from staff on each piece of training.
- Staff and managers could access the electronic training database from any computer to either enter their course details or to monitor compliance. Information could be displayed for an individual member of staff or for a complete team. As an example, one area of training was for steep ground working (working on the side of steep slopes, hills, cliffs etc.). Staff added photographs to illustrate the training. Details were captured of the core skills learnt such as health and safety, risk assessments, specialist personal protection for their feet, head and hands, command and control, harness training and the use of specialist equipment to move patients safely from steep slopes.
- The staff we spoke with were very complimentary about the training provided, but recognised they were a specialist team and as such were given time within their work schedule for all the necessary training.
- A well-stocked library was available at both the Exeter and Bristol HART bases. This was available to staff to update their knowledge or as a quiet area to study for exams.
- There were opportunities for career progression from the HART team. As an example several HART paramedics had progressed to the critical care teams to work with the air ambulances.

Co-ordination with other providers

- The National Ambulance Resilience Unit (NARU) had a national mutual aid memorandum of understanding for the ambulance services (May 2015) across the NHS. This was an agreed structured set of arrangements to provide mutual aid between ambulance services in the event of major incidents. The special operations unit within SWAST were part of the mutual aid scheme and were clear on what resources they could offer and what resources were available should they need additional support. Staff were also aware of response times for those resources so that in the event of a major incident, they knew how long it would take for additional help to arrive. This informed their resource planning and management during a major incident.
- SWAST was represented at a number of national working groups and committees. As an example, the business continuity team contributed to the national business continuity working group every three months. This has led to the sharing of best practice amongst ambulance services.
- Operational officers had received JESIP training (Joint Emergency Services Interoperability Programme). This programme was established in 2012 following a number of recommendations from major incidents. The training helped commanders from the ambulance service, fire service and police arriving at the scene of a major incident to make contact with commanders of other emergency services. This increased information sharing, improved communication and a joint understanding of the incident.
- We were shown evidence that the trust reviewed concerns within other NHS provider organisations to identify how these affected the ambulance service. As an example, a briefing had been produced for senior staff about the problems one particular hospital was experiencing. This showed that there had been an increase in partnership working between the ambulance trust, the hospital concerned, local commissioners and other NHS providers. This increased partnership had improved the communication and understanding of the problems and gave a clear focus for the ambulance trust on what actions needed to be taken.
- The trust and special operations team worked closely with the five separate air ambulance charities that provided the six aircraft. Regular meetings were held to agree equipment that was needed, staff skills and hours of operation.

Multidisciplinary working

- The EPRR teams had worked closely with all 35 departments across the trust in developing their business continuity plans.
- Good multidisciplinary and multiagency working was reflected in various documents seen as part of the

inspection, such as minutes from meetings. We also observed this in practice when attending emergency calls with the HART team who worked in partnership with the fire service to safely treat and move a patient who had fallen from a height onto their conservatory roof.

- We were also told about a risk the HART team were concerned about in accessing a particular site in the SWAST area. A multidisciplinary and multiagency working group had been established with all relevant organisations to discuss and resolve the risk. This group included the other emergency services (such as the fire brigade and police), local authorities, ministry of defence, specialist commercial operators all the different departments across SWAST.
- The air operations teams had been brought together with HART under the overall banner of special operations. This had resulted in joint training, sharing of standard operating procedures and joint exercising. Staff on both teams had told us that this had helped to build a greater understanding of each other's skills and expertise.

Access to information

- Email and a specialist alert system was used to communicate important information to staff, in particular major incident information. We saw this in evidence during our inspection when Tewkesbury suffered disruption to their water supply. Staff were informed of the incident and a briefing was sent out to key staff which included information they needed to be aware of.
- The staff we spoke with within the teams that made up EPRR felt they had sufficient access to internal organisational information, role specific information and clinical evidence to support their roles. This information was contained in the trust's intranet site, the trusts Aspire staff portal and the commander application.
- Trust wide bulletins were cascaded within the team and regular emails were received with various updates.

Consent and Mental Capacity Act (include Deprivation of Liberty Safeguards if appropriate)

- The trust had specific policies relating to Mental Capacity and joint working arrangements between healthcare organisations.
- Information was available to staff to assist them when assessing mental capacity. The information highlighted important questions to ask and actions to take.
- Staff told us that they had received training in mental health issues and mental capacity. Some paramedics had additional knowledge of mental health issues and could be used as a resource when needed.
- Where patients with mental health issues were to be carried by the air ambulance helicopter, the pilot would take advice from the paramedic and/or doctor before the patient was allowed into the aircraft. An assessment was done to make sure the patient did not pose a risk to the crew and aircraft once airborne. Under the Civil Aviation Authority regulations, the pilot is ultimately responsible for the aircraft and those flying and makes the decision as to who can fly. If a patient was deemed unsuitable to fly in an aircraft, they would be transported by road ambulance.
- We observed staff explaining to patients what was happening and seeking their consent where necessary. As an example the patient was asked permission to move them and to get their door keys to lock their house.

Is resilience planning services caring?

Good

We rated caring as good because:

- Staff treated patients with respect, patience and sensitivity. The paramedics were calm and professional in their approach but remained friendly to quickly build a rapport with the patient.
- Staff consistently explained what they were doing to the patient and their family, and continually offered reassurance.
- Staff took time to listen to the patient and what their concerns were and looked after their medical and emotional needs.
- Staff recognised the importance of involving patients and their family when obtaining information to help assess and plan their care.

Compassionate care

Resilience planning

- We observed the HART team providing clinical care when we accompanied them on their call outs. The paramedics were calm and professional whilst communicating constantly with the patient and reassuring them.
- We observed patients being treated with respect, patience and sensitivity by the paramedics. They maintained patient's privacy and dignity. As an example, the paramedic suggested to one patient that they use blankets to maintain their dignity whilst transferring them from their bed to the ambulance.
- We heard the paramedics speaking to patients in a kind and supportive manner whilst treating them.
- One relative of a patient told us that they were grateful for the professionalism and skills of the paramedics when treating their loved one.
- We observed staff looking after patients possessions. For example, staff made an assessment on how to safely move several patients from their house to the ambulance. This assessment included moving personal possessions to make sure they were not damaged whilst moving the patient. They explained what they were doing to the patient or relatives and sought their permission.
- HART paramedics prioritised pain relief to a patient before moving them onto a specialist stretcher. This made the process less traumatic for the patient.

Understanding and involvement of patients and those close to them

- We observed staff involving relatives and friends where appropriate in the care of the patient. Staff explained what they were doing and what the plan was.
- Staff understood the needs of the patients and what was important to them. As an example, one patient needed moving from their bedroom to the ambulance. The patient was concerned about their pet, however, the staff made sure the pet was safe and had food and water until a relative could visit the house.
- HART paramedics were able to gain a rapid understanding of the patient needs when responding to emergency situations. This was evidenced through their training and during our observation when attending emergency calls with HART.

Emotional support

- We observed the paramedics reassuring the patients whilst they were providing care and treatment. We observed the staff also providing reassurance to the patient's relative.
- The staff recognised the importance of involving the patient, their family and carers when obtaining information and planning care.

Is resilience planning services responsive to people's needs?
(for example, to feedback?)

Good

We rated responsive as good because:

- The resilience facilities were purpose built and located to cover the majority of the SWAST operational area.
- SWAST was supported by five air ambulance charities with six aircraft providing good air ambulance coverage.
- The events team took the lead for assessing, planning and resourcing public events to minimise the effect on the trust's normal business.
- A complaints process was in place and staff were aware of when changes had been implemented as a result.

However:

- The HART teams were able to respond quickly to emergencies within their area, except within Cornwall due to the distance from Exeter.

Service planning and delivery to meet the needs of local people

- The resilience facilities were purpose built and located strategically for the best geographical coverage, ease of access to those areas of greatest population and highest risk.
- The events team took the lead in assessing, planning and resourcing for public events that had the potential to affect the 'normal' running of the service.
- The SWAST resilience and HART response was available 24 hours a day, seven days a week to meet the needs of the local population.
- Day to day resource planning followed a structured approach using the NARU and Association of Ambulance Chief Executive national decision model known as REAP (Resource Escalation Action Plan). The

Resilience planning

trust adopted REAP to inform escalation procedures due to surge and disruptive challenges to protect staff, patients and the organisations. As an example, when acute hospitals were struggling to admit patients leading to ambulances waiting at accident and emergency departments.

- Bespoke plans and risk assessments were in place for certain public areas such as shopping centres and COMAH sites (Control of Major Accident Hazards) to protect local people from specific location risks. This involved planning with suppliers of utilities such as water and electric, local authorities and voluntary organisations. This made sure the service was compliant with the NHS HART Service Specification 2015/2016.
- The EPRR teams were responsible for training and planning SORT and HART capability to meet the service need for specific major events such as a terrorist related incident.
- The trust operations used the HART rapid response vehicles for emergency calls on the understanding that they could be released if a specialist incident took place that required the skills of the HART team.
- During May 2016, the HART teams responded to 160 incidents across the SWAST area (86 from the Bristol team and 74 from the Exeter team). These incidents ranged from road traffic accidents with single casualties through to major incidents with multiple casualties.
- The special operations teams were developed in conjunction with national organisations such as NARU and air ambulance working groups plus local commissioners and NHS England.

Meeting people's individual needs

- Staff had received training to deal with patients who had particular individual needs such as those with dementia, or children and young people.
- Staff had access to language support via a telephone interpreting line for those patients who did not speak English.
- When children were carried on the air ambulance, the crew would make sure space was available for a parent to travel with their child in the aircraft.

Access and flow

- The trust is supported by five air ambulance charities providing six helicopters to provide a response across the geographical area provided by SWAST.
- HART team leaders and managers monitored the team's movements, workload and use by general operations throughout the shift.
- We asked whether data was kept to show HART and air operations response and release times. We were told that when the teams were established, it was not necessary to collect that specific data. However, we were also told that now HART and the air operations team come under the special operations team with its own dispatch desk this data will be routinely collected and monitored.

Learning from complaints and concerns

- Staff were aware of the complaints process and how to direct patients should they have any concerns about the care and treatment they received.
- We saw examples of where the teams had learnt from complaints. As an example, during one winter and a weekend of particularly high demand on the service, a 'no-send' policy was temporarily introduced for minor calls. This meant that for those calls, no ambulance response would be sent. Following a review of this decision, it was recognised across the trust that it was the wrong decision and it was agreed that all decisions are clinically led i.e. based on the patient's condition, need and the resources available.

Is resilience planning services well-led?

Outstanding ☆

We rated well led as outstanding because:

- There was a clear vision in place for the EPRR teams, especially special operations and where they wanted to take the service over the coming five years which was ambitious.
- Robust governance and assurance systems were in place across the EPRR teams to share information across the teams and the trust board. Best practice was also shared across a wide variety of national groups and committees.
- A peer review in May 2016 across SWAST showed they had a robust business continuity management system in place.

Resilience planning

- Leaders were both supportive and visible, inspiring and motivating staff across all EPRR teams. Staff welfare was of great importance and various services such as traumatic risk monitoring and the 'staying well service' were available to staff should they need it.
- There was a proactive approach to change and innovation. A dedicated events team had taken responsibility for planning, resourcing and managing SWAST attendance at public events.
- A computer application 'SWAST Commander' had been developed for iPad and Android platforms. This was used by operational commanders during major incidents.

Vision and strategy for this service

- The overall trust values were respect and dignity, commitment to quality of care, compassion, improving lives, working together for patients and everyone counts. Posters with the trust mission and values were on display at both Exeter and Bristol bases.
- Within EPRR, the special operations team had used the trust objectives to define the objectives and vision for their service. These objectives included: staff engagement, performance, finance and reputation. The vision for the special operations department was 'to provide rapid delivery of enhanced and critical care, via land, air and water, to the general public and other emergency responders, in environments where medical services are unable or untrained to operate, in order to increase patient survival and enhance clinical outcomes.'
- There was a vision to provide enhanced skills by aligning critical care with the air ambulance services. It was the ambition of the trust to become the highest performing enhanced and critical care provider in the UK. During our inspection, we saw that critical care, air ambulances and HART had been brought together under one overall manager for special operations. Work was taking place to identity how the service could meet their ambition.
- The long term aspirations for the critical care teams within special operations were to base a critical care paramedic alongside the air ambulances where night time flying was provided. Alternatively rapid response vehicles would be used to provide a 24 hour cover for enhanced care.

Governance, risk management and quality measurement

- Managers were in place for each of the teams that were part of EPRR. They reported to the Head of EPRR who in turn reported to the Director of Operations. EPRR also reported externally to organisations such as the National Ambulance Resilience Unit (NARU).
- We looked at the resilience risk register. This showed that risks were assessed for severity and allocated to a manager who would be responsible for the actions. Risks were updated when actions had been completed and reviewed regularly. The risk register reflected local issues that related just to the teams that came under emergency preparedness such as the HART teams. They also included trust wide issues when it related to resilience and to significant concerns when attending specific locations as a result of a major incident. As an example, 124 paramedics and emergency care technicians needed to be trained to deal with specific major incidents. This had been achieved and exceeded. In another example, the failure of a specific piece of equipment used by the special operations team had led to monthly checks of the equipment and plans to replace them.
- All the senior managers we spoke with were aware of their risks and what was being done to mitigate the risks.
- The minutes of meetings showed that the risk register was discussed regularly. As an example, the emergency preparedness team meeting discussed the risk register and agreed which risks needed to be reviewed or removed. New risks were also discussed and added.
- We saw an example of how staff were updated following an operational officers meeting. A brief report was produced and made available to staff and included with the minutes of the meeting.
- The Head of EPRR and Special Operations completed an assurance review with NHS England and the commissioners to confirm compliance with the core standards of the Civil Contingencies Act 2004 and the NHS England EPRR Framework. Once this review and resulting action plan had been accepted, assurance was given to the trust board.
- Business continuity update reports were provided to the trust directors every six months. This report included how the systems were being embedded across the trust, results from local and national steering groups, business continuity incidents and plans for the next six months. Included with the report were updates from the objectives set out in the business continuity policy,

Resilience planning

September 2014 (reviewed in September 2015). Each objective was rated using the Red, Amber and Green colours. None of the objectives were rated red. This showed that the trust had robust systems in place to manage business continuity and the trust board received regular assurances to confirm this.

- We were provided with information on all the business continuity plans. This showed when each plan had been approved, when it was due for review and at what stage each plan was at (i.e. embedding, implementation or validation)
- A new report from special operations was in development at the time of our inspection. We saw that this report broke down the activity within special operations including the number of incidents attended to, times in the day the incidents occurred, types of incidents the teams were being called to and incidents and complaints. This provided more accurate and specific performance information for the HART and air operations teams.
- Operational officers met with team leaders each month and the teams in Exeter and Bristol met as one team every six months. Each base had its own governance meetings which took place monthly which fed into the monthly management meetings. The managers of Special Operations, resilience, business continuity and events all met with the head of EPRR every month and the head of EPRR met with the director of operations every month. Reports were produced and went to the quality groups and trust board. This meant the EPRR teams were communicating well with each other and had a good knowledge of the risks across the teams.
- We saw examples of where the teams were held to account externally as well as internally through various national groups such as NARU, Air Ambulance national working group and business continuity national working group.
- We observed the daily conference call that took place with a number of departments across SWAST including HART. It was chaired by an operational 'silver' officer and covered demand and resources, trust performance, resilience, first responders and trust infrastructure and staff welfare. A breakdown was provided on each area within the SWAST geographical area. This alerted staff to the resources available in each area and any potential areas for concern. Managers were then able to allocate resources more appropriately as necessary.
- In May 2016, the business continuity processes were reviewed by another ambulance service. The report for this review confirmed the Trust had a robust business continuity management system since the introduction of the dedicated resilience officer. The report stated that the trust demonstrated a high level of commitment, resources and had a good understanding of business continuity. Nine recommendations were made as a result of the peer review which were in the process of being actioned at the time of our inspection.

Leadership of service

- We spoke with various managers within the EPRR teams. Without exception they all told us how proud they were of their teams. They commented on the enthusiasm of staff, and the dedication in giving enhanced care to benefit patients.
- The staff we spoke with told us they had excellent team leaders, managers, director of operations and chief executive. They told us they were very supportive and visible. One member of staff told us 'I have trust in the management, they know what they are doing and I trust their judgement'. Staff told us that the director of operations and chief executive were very visible and approachable. They told us that they did not physically see them that often, but you could email or tweet the chief executive and he would always respond.

Culture within the service

- Managers we spoke with told us that operational resilience and capacity planning was broader than dealing with major incidents, but was about providing a safe service at all times.
- Staff told us that the organisation regarded staff welfare very seriously and provided various levels of support to staff in their daily work and those that have experienced family difficulties and/or traumatic events.
- Staff participated in a debrief (a discussion with a team leader about what had gone well or not so well, and gave staff a chance to express how they felt) after each emergency call out that resulted in staff dealing with traumatic events. Staff told us that this worked well, but that also they supported each other in their teams. Staff told us that where necessary TRiM (Traumatic risk management) was available. TRiM was recognised as a very effective tool for identifying, monitoring and managing post-traumatic stress. Staff were able to talk to a TRiM practitioner in complete confidence.

Resilience planning

- Staff had access to the 'Staying well service'. This service started in December 2015 and had received over 450 referrals by the time of our inspection. Staff could self-refer (via e-mail, phone or drop in) or give their consent for their manager or colleague to refer them. The aims of the service was to support staff and offer a gateway to other specialist support services such as occupational health and physiotherapy.

Public and staff engagement

- Staff told us they were encouraged to give their feedback and ideas for developing the service. Staff felt they were listened to and their views respected. As an example staff had requested changes to some equipment used which had subsequently been reviewed and authorised.
- Open days were held to raise the profile of the HART teams both internally within SWAST and with the general public and the local community.

Innovation, improvement and sustainability

- We were told that planning and covering public events was overwhelming for operational officers in the emergency and urgent care teams, especially large scale events such as the Glastonbury music festival or the International Air Tattoo. The introduction of the events team had centralised all the planning for events and taken that pressure away from operational staff. This had been seen as a very positive move from operational staff and managers because it allowed staff to concentrate on the day to day work.
- A member of resilience staff had worked with a computer software company to develop a 'SWAST Commander' application for the iPad and Android platforms. This application was used by operational commanders in the event of major incidents. Through this application staff were able to access all the policies, standard operation procedures, actions cards that they might need in a major incident. The application had mapping abilities so that cordons could be drawn around an incident, or simply to allow the commanders to see the area involved in the incident. The application had the facilities to record voice and video so staff could record key events as part of the incident management and record keeping. Staff were also able to see in real time how many beds each emergency department had available, which meant staff knew what the most appropriate hospitals to divert patients to were. This was seen as an area of outstanding innovation and JESIP were looking at integrating their information into the application and NARU were aware of the application and its possibilities. At the time of our inspection, the trust were considering whether to offer the application to other ambulance services.
- Several managers represented the trust and their department at national meetings and were involved in driving national agendas for resilience. As an example, one manager had recently been made chair of the NARU business continuity group.

Urgent and Emergency Care

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

Information about the service

Tiverton Urgent Care Centre is located at Tiverton and District hospital and has been run by South Western Ambulance Service Trust (SWAST) since July 2014. It provides a minor injury and illness service for the people of Tiverton and surrounding areas. The type of ailments that can be treated include cuts, grazes, joint injuries, broken bones, eye problems, minor head injuries and minor infections. During the day the service is nurse led and is managed by the lead advanced nurse practitioner. Treatment is also provided by paramedics who have undertaken further training.

The centre consists of four examination rooms, a clinical room for the application of plaster casts, a waiting area and a reception shared with other services in the hospital. The main X-ray department is adjacent to the urgent care centre. It is open 365 days a year from 8am until 10pm. In the year ending March 2016 it treated almost 16,000 people. 29% were children under the age of 17 years.

We visited on 8 June 2016 and carried out an unannounced inspection during the afternoon and evening of 17 June. During this inspection we observed care and treatment of patients, looked at 9 treatment records and reviewed performance information about the department. We spoke with four patients and approximately 10 members of staff including nurses, receptionists, managers and support staff.

Summary of findings

Overall, we rated the urgent care service as good because:

- Safety performance was monitored and reported to senior managers on a monthly basis. Openness and transparency about safety was encouraged.
- There were sufficient staff to treat and care for the patients who attended.
- Nurses and paramedics were well qualified and demonstrated the skills that were required to carry out their roles effectively and according to best practice. They worked collaboratively with multidisciplinary teams from community services and acute services at neighboring hospitals
- Staff used evidence based guidelines in order to ensure effective treatment was delivered.
- Feedback from patients and those close to them confirmed that staff were caring and kind.
- We observed staff taking trouble to maintain people's privacy, dignity and confidentiality. They demonstrated empathy towards people who were in pain or distressed and were skilled in providing reassurance and comfort.
- Services were planned to meet the needs of all patients, including those who were vulnerable or who had complex needs.
- 99.8% of patients were treated, discharged or transferred within four hours in the year ending March 2016. The average time to treatment was 49 minutes.

Urgent and Emergency Care

- There was a cohesive strategy for the urgent care centre and this was supported by the staff who worked there.
- Clinical leaders were respected by staff. They were knowledgeable about quality issues and priorities, understood what the challenges were and took action to address them. They promoted a strong sense of teamwork.
- Governance arrangements were well structured with risks and quality being regularly monitored and action taken if necessary.

However:

- The environment and use of facilities was not designed to ensure the safety of children.
- There was no competency framework for, or formal assessment of, staff in the initial clinical assessment of patients.
- Safeguarding arrangements for vulnerable adults were not sufficiently robust.

There was insufficient space in the waiting area for the number of people attending the centre.

Is Urgent and Emergency Care safe?

Requires improvement

We rated safety as requires improvement because:

- The environment and use of facilities was not designed to ensure the safety of children.
- Although initial clinical assessment was conducted by experienced health care assistants they did not use an assessment framework and there had been no competency assessment to confirm appropriate knowledge and skills.
- Safeguarding arrangements for vulnerable adults were not sufficiently robust.
- Computer errors in patient records could not be corrected. This sometimes led to an incorrect diagnosis or medicines dose remaining on patient records.
- There was insufficient space in the waiting area for the number of people attending the centre.
- Prescription pads were not sufficiently monitored in order to prevent misuse.

However:

- Openness and transparency about safety was encouraged. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Lessons were learned from incidents and communicated widely to support improvement.
- Safety performance was monitored and reported to senior managers on a monthly basis.
- Safeguarding of children was well understood and implemented.
- Medicines were stored and administered correctly.
- The urgent care centre was visibly clean, well equipped and well maintained.
- Risks to people who used the centre were assessed, monitored and managed on a day-to-day basis.
- There were sufficient staff to treat and care for the patients that attended. The centre formed part of the trust's response to major incidents. It would receive and treat people with minor injuries via the ambulance service.

Safety performance

- Safety performance including waiting times for assessment and treatment, unplanned re-attendances

and adverse incidents were monitored continuously and reported to the South Western Ambulance Service NHS Foundation Trust (SWAST) Director of Nursing on a monthly basis. Quarterly meetings were held with the clinical commissioning group to discuss safety performance.
- We reviewed safety data for the year ending March 2016 and found no serious issues.

Incident reporting, learning and improvement

- All staff that we spoke with were aware of their responsibilities in reporting incidents and we saw examples which had been submitted. Staff told us they would report incidents such as medicines errors, aggressive incidents or faulty equipment.
- Incidents and accidents were reported using a trust wide electronic system. All staff had access to this and knew which incidents required reporting.
- There were eighteen reported incidents in the year ending March 2016. None of them were assessed to be serious incidents. They had been logged appropriately, were clearly described and appropriate remedial action had been taken when necessary. For example, the type of antibiotics kept in the urgent care centre were being reviewed following the presentation of a patient with sepsis.
- Learning from incidents was discussed and recorded during the clinical governance section of service line meetings and at staff meetings.

Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation which was introduced in November 2014. This Regulation requires the trust to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm which falls into defined thresholds. This is known as the duty of candour. Any reportable or suspected patient safety incident falling within these categories must be investigated and reported to the patient, and any other 'relevant person', within 10 days.
- Staff that we spoke with understood the principles of openness and transparency that are encompassed by the duty of candour. There had been no incidents requiring the duty of candour in the last year.

Safeguarding

- Staff that we spoke with were familiar with processes for the identification and management of children at risk of abuse. They understood their responsibility to report concerns**.**
- Although the majority of staff had received the required level three training in child safeguarding, none had done so in the last three years. Two practitioners had never undertaken level three child safeguarding training.
- Children who were on the 'At risk' register were automatically flagged by the computer system. Clinical staff had access to local safeguarding teams at all times and would phone them to check the details of the safeguarding concerns.
- There was a risk assessment available if there was a possibility that a child was at risk. There was less knowledge about the safeguarding of vulnerable adults and some staff were unable to identify factors that would lead to an adult safeguarding alert. There was no risk assessment available to help them identify at risk adults.
- Although some basic safeguarding awareness training had taken place in 2014 the majority of staff had had no specific training for four or five years. One practitioner had never received specific safeguarding training.

Medicines

- Medicines were stored correctly in locked cupboards or fridges. Controlled medicines and fridge temperatures were regularly checked by staff working in the department and seen to be within required parameters.
- Unused medicines were disposed of in accordance with local policy.
- Allergies were clearly recorded and antibiotics were prescribed according to local protocols. These were up-to-date and readily available
- Two members of staff were trained as nurse prescribers so that they could supply and administer certain medicines. There were also Patient Group Directions (PGDs) in place. PGDs are agreements which allow some registered nurses to supply or administer certain medicines to a pre-defined group of patients without them having to see a doctor. We saw evidence that staff had been appropriately assessed and signed off as competent to use PGDs.
- The majority of prescriptions were computer generated but a stock of paper FP10 prescriptions were kept in

case of computer failure. These were stored and supplied securely but they were not checked on a regular basis. No record was kept of when they were used and by whom. This meant that there was a small risk of them being used fraudulently without staff being aware.

Environment and equipment

- The clinical environment was spacious, modern, light and well ventilated. However, patients and their families had to wait on either side of the corridor inside the entrance to the centre. This quickly became crowded and one patient told us that she found it uncomfortable. It was not possible for staff to view people in the waiting area at all times. This meant that there was a risk that a patient's condition could deteriorate without staff being aware of it.
- Although toys and entertainment was provided for children in the waiting area there was no separation between them and adult patients. This meant that they were not protected from the risks associated with an adult environment. At one point a small child crawled into the middle of the busy thoroughfare whilst its mother was comforting her crying baby.
- None of the examination rooms had been adapted to become child-friendly
- The door to the plaster room remained open during our inspection. A number of large bandage scissors, plaster cutters and safety pins were clearly visible on a shelf that was low enough to be reached by a small child.
- The examination rooms had window blinds controlled by long cords. We were concerned that children could wrap these around their necks. We spoke to a member of staff who told us that a risk assessment had been carried. In order to reduce the risk to children a warning notice had been attached to each cord and parents were told not to leave children unaccompanied in the examination rooms.
- The urgent care centre was well equipped and the equipment was checked daily to ensure that it was ready for use. We saw maintenance records showing a regular programme of maintenance and servicing.
- One examination room was designated for the sickest patients and contained an ECG machine, pulse oximeter and resuscitation equipment.
- There was a comprehensive range of resuscitation equipment for both children and adults. This was stored in tamper-evident resuscitation trolleys which were checked monthly, in line with trust policy.

Quality of records

- Patient records were fully computerised. Access to the system was controlled by individual passwords. This helped to ensure that the name of the practitioner and the time that they saw each patient was accurately recorded.
- Computer screens were arranged so that only healthcare professionals could see them. If a screen was inactive for more than a minute a screensaver appeared. This helped to ensure that unattended screens could not be viewed by unauthorised individuals.
- We reviewed nine random patient records from the previous day and found them to be clear, detailed and easy to read.
- We reviewed the records of a patient who had been treated during our inspection and found that the diagnosis appeared confused. In one section of the record it was stated to be a dislocation but in another it appeared as a closed fracture. We discussed this with the nurse manager. He explained that certain parts of the patient record were completed by clicking on a drop down menu. A fault with the system meant that, if the wrong item on the menu was accidently selected, it was not possible to correct it. This applied to final patient diagnosis and prescribed medicines. Staff ensured that the correct information was recorded in the free text section of the patient record, but it was not possible to delete the incorrect information.
- The fault had been reported to the manufacturer of the system and the nurse manager had been told that it appeared on the trust's risk register. He had not been told when the fault would be corrected.

Cleanliness, infection control and hygiene

- The centre appeared clean and tidy. Hand washing facilities were readily available and we observed staff clean their hands before and after patient contact. This helped to prevent the spread of infection and complied with NICE quality standard 61 statement 3. The "bare below the elbow" policy was adhered to.

- A recent infection control audit showed that the centre was rated as "Green" which meant that they had achieved between 90% and 100% compliance with infection control standards.

Mandatory training

- There were a wide range of topics included in mandatory training. For example, information governance, health and safety, infection control, consent and mental capacity assessment.
- Staff were trained to deal with life threatening emergencies. All clinical staff were trained to deliver intermediate life support (ILS) to both adults and children. Two staff had advanced life support (ALS and PALS) qualifications for adults and children and one was an ALS instructor.
- Some of the topics were covered by e-learning and others took place during mandatory training sessions which were tailored to the specific needs of the staff attending.
- At the time of our inspection 100% of staff had completed training in the last year. The trust's target was 95%.

Assessing and responding to patient risk

- Guidance from the Royal College of Nursing and the Royal College of Emergency Medicine (RCEM) (Triage Position Statement, April 2011) states that patients should be rapidly assessed on arrival in order identify or rule out life/limb threatening conditions and ensure patient safety. This is often referred to as triage. It should be a face-to-face encounter which should occur within 15 minutes of arrival or registration and assessment be carried out by a trained clinician. This ensures that patients are streamed or directed to the appropriate part of the department and the appropriate clinician. It also ensures that serious or life threatening conditions are identified or ruled out so that the appropriate care pathway is selected.
- Continuous monitoring showed that 99.8% of patients were triaged within 15 minutes in the year ending March 2016.
- During our inspection most patients were triaged by an experienced healthcare assistant, not a qualified clinician. There was no assessment framework to guide them. The nurse manager told us that healthcare assistants underwent four weeks supervised practice before being able to triage on their own. However, there was no structured competency framework for this training and no formal competency assessment. This meant that there was a risk of some healthcare assistants having incomplete knowledge and skills when triaging patients despite being experienced.
- We were told that immediate feedback was given to triage staff if there were any shortcomings in their assessments. In this way, any mistakes were corrected and learning enhanced.
- We reviewed the triage notes of eight patients from the previous day. They had been triaged by three different members of staff and the assessments appeared appropriate for the presenting complaint.
- Reception staff were aware of "red flag" presenting complaints such as chest pain, shortness of breath and severe bleeding. They told us that they would contact a nurse immediately, rather than delaying treatment by registering the patient on the computer system first. Basic registration details would be taken while the patient was being assessed and further details obtained was the patient's condition had stabilised.
- We observed the triage of two patients, with their consent. Clinical observations and a pain score were recorded and a priority category was allocated. This was highlighted on the computer screen so that practitioners knew who to see first.
- Early warning scores were not used to identify patients whose condition was at risk of deteriorating. Staff felt that they were not necessary because there were few delays in patients being treated.
- Seriously ill or injured patients were always escorted to the X-ray department by a member of urgent care centre staff.
- Records showed that all staff with patient contact were trained in basic life support and the use of the automatic defibrillator.
- Patients who were seriously ill or injured were transferred by ambulance to the emergency department at nearby hospitals according to local protocols.

Staffing levels and caseload

- A review of staff rotas for the month prior to our inspection showed that the urgent care centre had a minimum of one nurse practitioner or paramedic on

duty at all times. They were supported by a healthcare assistant or a second qualified member of staff. An additional qualified member of staff was added during predictably busy periods, such as Mondays.
- The GPs working in the centre were drawn from local practices.
- There were no current staff vacancies. Annual leave and sickness absence was covered by fully qualified "bank" staff employed by the trust. No agency staff had been used in recent months. Satisfactory staffing levels and skill mix meant that there had been no un-filled shifts in the previous month.
- Flexibility of staffing meant that the centre had not had to close on any occasions in the last year.
- Although 29% of patients were children less than 17 years there were no qualified children's nurses at the centre and no lead nurse for children. However, all practitioners had been trained to assess and treat children and to decide which services would best meet their needs.

Managing anticipated risks

- There were plans in place to deal with possible disruptions to services such as computer failure, power cuts and flood.
- The urgent care centre was part of the trust's response to major incidents. They formed part of the "Bronze 3" receiving units which meant the ambulance service would bring people with minor injuries to be treated.
- There were arrangements in place to call in extra staff from home if necessary.
- There were emergency call bells throughout the centre should staff need to summon assistance. They had been trained in conflict resolution and felt confident in diffusing aggressive situations. Should there be the risk of violence towards patients or staff the police would be called. Staff told us that this happened rarely but that local police responded very quickly when called.

Is Urgent and Emergency Care effective?

Good

We rated effectiveness as good because:

- Nurses and paramedics were well qualified and demonstrated the skills that were required to carry out their roles effectively and according to best practice. They worked collaboratively with multidisciplinary teams from community services and acute services at neighbouring hospitals
- Evidence based guidelines and protocols were easily available although not all of them were specifically designed for an urgent care centre.
- Pain relief was administered quickly and effectively.
- X-ray results were reviewed by a specialist radiology doctor within 24 hours. Any discrepancies were followed-up by senior staff.
- There was a low rate of unplanned re-attendances.
- Clinical audits took place and the information gained was used to improve care and treatment.
- The learning needs of staff were identified at six-weekly clinical supervision sessions and at annual appraisals.
- Staff had a sound knowledge of consent from children and adults.

Evidence based care and treatment

- There were treatment guidelines in place based on guidance from the National Institute for Health and Care Excellence (NICE) and Royal College of Emergency Medicine (RCEM). They included topics such as lower limb fractures, sepsis and removal of taser barbs.
- The majority of clinical guidance was written for the needs of ambulance crews and did not always give precise advice for staff in an urgent care centre in a community hospital setting. For example, the guidance for diarrhoea and vomiting stated that patients should be conveyed to hospital if they were unable to retain oral fluids or had been abroad recently and had a fever. Nursing staff told us that they would ask one of the GPs to see any patients to whom this applied.
- We noted that some guidance was not up-to-date. Resuscitation algorithms displayed next to resuscitation equipment had been published in 2010. The most recent version was published in 2015.
- Staff were familiar with the use of the guidelines and they were easily available on the computer system or in hard copy. New guidance was discussed at service line meetings and changes to local guidance made as necessary. For example, the treatment of scaphoid fractures had recently been reviewed.
- There had previously been regular audits of patient records to check that national guidance had been followed. However, due to personnel difficulties, these

had not taken place in recent months. We looked at the results of the last two audits that had taken place and found that evidence-based guidance had been followed in the majority of cases.
- We observed the nurse manager checking records while patients were still in the department and discussing them with relevant staff if national guidance appeared not to have been followed.
- Records that we reviewed showed that clinical assessment was methodical, appropriate and clearly documented.
- All x-rays were reviewed by a specialist radiology doctor within 24 hours. If there were any discrepancies in diagnosis the patient would be recalled and re-assessed.
- Records showed that, where appropriate, patients were referred back to their own GP once their urgent care needs had been met.
- There was a wide range of information leaflets available to help patients manage their injury or illness. We reviewed a random sample of these and found that they followed current national guidance.

Pain relief

- Patient records showed that a pain score was always calculated and recorded. Appropriate pain relief was given and the effects monitored.
- During our inspection we observed timely pain relief administered to adults and children. The results of the pain relief were monitored and additional treatment given if necessary.

Patient outcomes

- There was real-time peer review of the effectiveness of care and treatment. We observed a number of discussions between staff regarding diagnosis and treatment. If necessary, further advice could be sought from specialists at nearby hospitals. In addition, there was always a senior clinical decision maker available at SWAST control centre for staff to refer to for advice.
- The nurse manager undertook spot audits of common conditions such as ankle or wrist injuries.
- No national organisations had arranged audits specific to minor injuries or illnesses in the last year.
- The urgent care centre encouraged feedback from other healthcare professionals and they were reviewed at quarterly meetings with the clinical commissioning group. In the last year one or two healthcare professionals had provided feedback each quarter. No major deficiencies had been detected in patient outcomes.
- A low rate of unplanned re-attendances within seven days is often used as an indicator of good patient outcomes. The national average for urgent and emergency care is 7.5%. The rate at Tiverton is better than this, at 5.7 % for year ending March 2016.

Competent staff

- Staff who were new to the department took part in a structured orientation programme. Staff that we spoke with told us that they found it informative and effective.
- The orientation programme for nurse practitioners and emergency care practitioners lasted for a minimum of four weeks and practice during this time was always supervised.
- There were six-weekly individual clinical supervision sessions where staff could discuss any difficulties that they might have experienced.
- Specific learning needs for all staff were identified at a yearly appraisal meeting. Records showed that all staff had received an appraisal in the last year.
- Yearly clinical updates took place based on identified learning needs. The most recent update included topics such as palliative care, identifying seriously ill children, investigation and treatment of the acute abdomen.
- In-house teaching was run by senior staff and included topics such as lower limb fractures, treatment of burns and resuscitation scenarios. Updates on the application of plaster casts had recently taken place in the fracture clinic at the Royal Devon and Exeter hospital.
- There was no specific training or competency framework to ensure that healthcare assistant had sufficient skills to undertake initial patient assessment (triage).

Multi-disciplinary working and coordinated care pathways

- There were good working relationships with community services, and local acute trusts.
- If patients needed urgent hospital treatment they could be referred directly to specialist doctors such as orthopaedic surgeons, burns specialists,

rheumatologists, and dermatologists. A referral letter was always sent with the patient in order to confirm information discussed with the specialist at the time of the referral.
- Practitioners could discuss complicated injuries or X-rays with a senior doctor at nearby emergency departments.
- Direct referrals could be made to physiotherapists for conditions such as soft tissue injuries or ligament strains. There were therapy departments based at Tiverton hospital which enabled face-to-face discussions about individual patient needs.
- There were effective links with other services such as health visitors, sexual health clinics, district nurses, and social services.
- GPs from the adjacent practice would respond quickly if a patient was identified as having a serious or complex problem that could not be dealt with by staff in the urgent care centre

Referral, transfer, discharge and transition

- Letters were sent to GPs after each attendance. We reviewed eight letters and found clear and comprehensive descriptions of diagnosis, treatment, and advice was recorded in all.
- Practitioners told us that, if people were likely to have difficulty making follow-up appointments with their own GP (for example, those with communication difficulties or dementia), staff would make them for them before they left the centre.

Access to information

- Information needed to deliver effective care and treatment was well organised and accessible. Treatment protocols and clinical guidelines were computer based and we observed staff referring to them when necessary.
- The computer system was shared with NHS 111 service and out-of- hours GP service so that previous records could easily be accessed.
- Previous X-rays and their results were always available via computer.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- We observed that consent was obtained for any procedures undertaken by the staff. This included both written and verbal consent.
- Consent forms were available for people with parental responsibility to consent on behalf of children. The nursing staff that we spoke with had a good working knowledge of the guidance for gaining valid informed consent from a child. They were aware of the legal guidelines which meant children under the age of 16 were able to give their own consent if they demonstrated sufficient maturity and intelligence to do so. (Gillick competencies). Otherwise, consent would be sought from the child's parent or guardian. If a child attended without a person who was able to provide consent, staff would attempt to contact an appropriate adult.
- The staff we spoke with had sound knowledge about consent and mental capacity. Practitioners had not been trained to undertake mental capacity assessments but would call a GP if they felt one was required.
- Staff were able gain telephone advice from local psychiatric crisis teams but patients would have to be taken to the nearest emergency department in order to be assessed by a mental health professional.

Is Urgent and Emergency Care caring?

Good

We rated caring as good because:

- Feedback from patients and those close to them confirmed that staff were caring and kind.
- We observed staff taking trouble to maintain people's privacy, dignity and confidentiality. They demonstrated empathy towards people who were in pain or distressed and were skilled in providing reassurance and comfort.
- People were kept informed and given information about their condition and their care and treatment. Their social and cultural needs were taken into account and they were helped to maintain their independence whenever possible.
- Communication with children and young people was age appropriate and effective.

Compassionate care

- Confidentiality was maintained at the reception desks by means of signs asking people to stand back from the desk when someone was being registered.

- All examination and treatment rooms had doors to ensure privacy when patients were being examined. We saw that staff knocked and waited to be called before entering
- We observed staff introduce themselves and explain what was about to happen before examining patients.
- All staff wore name badges which clearly stated their name and role. This helped to ensure that patients were aware of the professionals involved in their care.
- We saw several examples of patients being treated with compassion, dignity and respect. Staff spoke in a respectful but friendly manner and made allowances when people were stressed or worried. We observed a nurse putting their arm around a patient's shoulders when they became upset about the difficulties that their injury was likely to cause them in the next few weeks.
- Practitioners took time to distract and comfort children during injections and wound cleaning. Parents were involved in the assessment and treatment of their children and clear explanations were given.
- We spoke with four patients. They all reported a positive experience. One said "They have done everything in a very kind way". Another told us "The service here is calm and friendly".
- We were shown written feedback from patients and their families. One wrote "I attended with my daughter who had had a fall. The doctor was lovely with my daughter and immediately put her at ease. He was very attentive, thorough and very reassuring"
- Results from the Friends and Family test for the year ending April 2016 were consistently good. They showed that between 96% and 100% of people would recommend the urgent care centre.

Understanding and involvement of patients and those close to them

- We spoke with four patients whose care and treatment we followed on the day of our inspection including a child and their parents. They all told us they were satisfied with the care they received and the staff who provided it. They had been involved in how and where their ongoing treatment took place.
- We observed staff interacting with patients and family members. Staff talked to them in a way that patients could understand and described what they were going to do.
- Staff also checked that people had understood what they'd been told and what needed to happen next.

Emotional support

- We observed reassurance being given to patients and nurses offering emotional support. Relatives were able to remain with patients throughout their time in the centre to ensure they were supported.
- Staff took account of people's social needs when deciding on treatment options.
- Communication with children was thoughtful and age appropriate.
- The wife of one patient told us "The nurse spent as much time looking after me as she did my husband. She was very reassuring and made me feel a lot better".
- Staff were aware of local counselling services and would refer patients when appropriate.

Is Urgent and Emergency Care responsive to people's needs?

(for example, to feedback?)

Good

We rated responsiveness as good because:

- Services were planned to meet the needs of all patients, including those who were vulnerable or who had complex needs.
- The units were easy to access and there was sufficient space for the number of people using them.
- X-ray services were not always available when patients needed them. The x-ray department closed at 5pm during the week and was only open for four hours a day at weekends. Although patients told us they did not mind returning the next day, there was a possibility of delayed treatment.
- 99.8% of patients were treated, discharged or transferred within four hours in the year ending March 2016. This was as good as, or slightly better than, most other urgent care centres.
- The average time to treatment was 49 minutes. Waiting times were constantly monitored in real-time by clinical staff.
- The needs of people with complex needs were well understood and addressed appropriately. People with dementia or learning disabilities received care and treatment that was sympathetic and knowledgeable.

- Improvements were made to the quality of care as a result of complaints and concerns

However:

- X-ray facilities were not always available. The X-ray department closed at 5pm during the week and was only open for four hours on a Saturday and Sunday.

Planning and delivering services which meet people's needs

- Following public consultation in 2014 the service at Tiverton had changed from a minor injury unit to an urgent care centre. Adults and children with minor illnesses as well as injuries could now be treated. GPs were available to treat any conditions that fell outside the scope of the advanced practitioners.
- As a result of the changes the centre better meets the needs of local people. Staff told us that attendances had increased from 100 a week in 2014 to 300 a week by May 2016.
- Although the changes had been well advertised, road signs and external hospital signs still described a minor injuries unit. This could be confusing for the public. The manager of the centre had recently spoken to a local councillor who had commenced the process to change the road signs.
- X-ray facilities were not always available. The X-ray department closed at 5pm during the week and was only open for four hours on a Saturday and Sunday. Most patients that we spoke with were happy to come back the next day to be X-rayed. However, patients with more serious injuries had to travel 15 or 20 miles to an emergency department for an X-ray.
- Patients told us that they appreciated the short waiting times in comparison to local accident and emergency departments.
- Neither the centre itself, nor the hospital as a whole, had a staff dining room or rest facilities. This meant that staff had to bring and prepare their own meals to work. Staff breaks were taken at the clinical base which sometimes disrupted clinical activities. For example, a telephone referral to an orthopaedic specialist was interrupted by a lively staff discussion that was taking place during a break period.

Equality and diversity

- There was a drop-off point close to the entrance of the urgent care centre to assist people with disabilities or mobility problems. There were ample disabled parking spaces close to the entrance. There were always empty spaces throughout our inspection.
- Equality and diversity training was delivered at induction and then on a yearly basis.
- Translators could be accessed via the telephone translation system provided by the hospital. In addition there were posters in many different languages informing people of community based translation services
- Senior staff were aware of the Accessible Information standard but did not know how the computer system would be adapted to comply with it.

Meeting the needs of people in vulnerable circumstances

- Staff that we spoke with demonstrated a good understanding of the requirements of patients with complex needs. There were close links with community services to provide support.
- The majority of staff had undertaken training in the specific needs of people with dementia and learning disabilities and the involvement of families was encouraged.
- We observed a patient living with dementia being given extra time during treatment to enable them to understand what was happening. Clear and simple explanations were given and calmly repeated in order to reassure the patient.
- We were told that care and treatment of people with learning disabilities would be provided in a quiet part of the centre so that their exposure to the unfamiliar and confusing environment of a hospital was kept to a minimum. Their particular needs would be discussed with them and their carers and treatment adapted if necessary

Access to the right care at the right time

- The trust consistently exceeded the national standard which requires that 95% of patients are discharged, admitted or transferred within four hours of arrival at urgent care and emergency departments. Annual performance for the year ending March 2016 was 99.8%.
- While waiting no more than four hours from arrival to departure is a key measure of urgent care performance, there are other important indicators, such as how long

patients wait for their treatment to begin. A short wait will reduce patient risk and discomfort. The national target is a wait of below 60 minutes. The centre consistently achieved this target. The average time to treatment in 2015/16 was 49 minutes.

- If X-ray results were unclear, they could be immediately reviewed electronically by a specialist radiology doctor at a nearby hospital. This reduced any delays in accurate diagnosis and appropriate treatment.
- The percentage of patients who leave without being seen is often used as an indicator of the responsiveness of a unit. The lower the percentage the better. An average of 0.2 % of patients left without being seen in 2015/16. This compared well to emergency departments where the average in England was 2.5%.

Learning from complaints and concerns

- There had been few complaints about the urgent care centre with only eight having been received in the year ending March 2016. These had been handled in line with the trust policy. If a patient or relative wanted to make an informal complaint they were directed to the person in charge of the department. If the concern was not able to be resolved locally, patients were referred to the Patient Experience team that would formally log their complaint and attempt to resolve their issue within a set period of time. Information about how to make a complaint was displayed on noticeboards in public areas and was included in patient information leaflets.
- Formal complaints were investigated by senior staff in the urgent care centre. Replies were sent to the complainant in an agreed timeframe. Where possible, action was taken to prevent similar complaints. For example, the procedure for informing patients of test results had been changed following a complaint about delays.
- We saw that learning from complaints was discussed at governance meetings and team meetings.

Is Urgent and Emergency Care well-led?

Good

We rated the service as good for well-led because:

- There was a cohesive strategy for the service and this was supported by the staff who worked there.
- Clinical leaders were respected by staff. They were knowledgeable about quality issues and priorities, understood what the challenges were and took action to address them. A number of SWAST directors had visited the centre in the last two years.
- There was a strong sense of teamwork between all staff. There were shared values of delivering high quality patient care.
- Governance arrangements were well structured with risks and quality being regularly monitored and action taken if necessary. The integrated service report provided consistency and ensured that performance and quality was understood by senior trust managers.
- Quarterly meetings took place with clinical commissioning group to ensure that the service was continuing to meet the needs of the local population.

Service vision and strategy

- The strategy for the urgent care centre formed part of the overall trust strategy for urgent care which includes GP out-of-hours services and NHS 111 telephone advice services. The centre was regarded as important for providing timely and effective treatment for the local population and in reducing the number of lengthy ambulance journeys to neighbouring emergency departments.
- Staff agreed with, and supported this strategy.

Governance, risk management and quality measurement

- The nurse manager carried out monthly reviews of adverse incidents, compliance with local and national standards and safeguarding training. Reviews of complaints and compliments and NICE guidance also took place monthly. Following the review an integrated service report was compiled and sent to the SWAST governance team and the planning and performance team.
- There was no risk register specific to the urgent care centre. Any serious risks would be included on the trust risk register. None existed at the time of writing. The nurse manager told us that any new risks were discussed with the line manager and escalated if necessary.
- Risk assessments had taken place and mitigating actions put in place. For example, staff had recognised the risk associated with an unstaffed reception desk for 30 minutes each morning. They ensured that clinical

staff could view the entrance during this time in order to recognise sick or injured people arriving at the hospital. We observed this working well when we first arrived at the centre.

Leadership of this service

- Managerial and clinical leadership of the urgent care centre was provided by the lead advanced nurse practitioner (nurse manager) who in turn reported to head of operations.
- The GPs who worked at the centre reported to the SWAST medical director.
- The nurse manager and medical director both worked clinically in the centre and had a full understanding of the caseload and issues experienced by staff.
- Staff told us that the leadership had the knowledge, skills and capability required to lead the service.
- Staff told us that they trusted the leadership team and knew that they would be listened to if they raised concerns. They told us that there was a 'no blame' culture that made it easier to admit mistakes and to learn from them.
- The SWAST chief executive had visited and three times in the last two years and other board members such as the director of nursing and the director of operations had also been to talk to staff.

Culture within this service

- Staff told us that they felt respected and valued by their colleagues and the leadership team within the urgent care centre. One nurse said "We look after each other here". They felt well supported by their manager who took the trouble to access training opportunities for them that had not been immediately available.
- The culture within the centre gave priority to the needs and experience of people who used the service. Several staff told us "The patient comes first".
- Two nurse practitioners told us that they were part of a strong team that looked after each other.
- As the only urgent care centre in SWAST there was a slight sense of isolation, although this had lessened in the last 18 months. Staff told us that they would value closer links with other similar services in order to gain peer support and focussed professional development.

Public engagement

- Quarterly meetings took place with clinical commissioning group to ensure that the service was continuing to meet the needs of the local population.
- The nurse manager kept copies of patient feedback and letters of comment or complaint. Both were included in monthly performance reports. He told us that there were many more compliments than complaints.

Staff engagement

- Staff that we spoke with said that they felt actively engaged in the running of the centre and that their views were taken into account when decisions were made about the service. For example, there had been staff involvement in upgrades to the clinical computer system and the organisation of the co-located fracture clinic.
- Staff concerns regarding a limited receptionist service had been addressed and the hours had been extended into the evening.
- A team brief document was sent to all members of staff every six to eight weeks. Items included quality and service updates, clinical supervision and new developments such as the introduction of student nurses to the centre. A communication book was used for more day-to-day information.
- Staff had been consulted about the frequency of staff meetings and it had been agreed that they would take place every six months.

Innovation, improvement and sustainability

- Senior staff had access to the ambulance service dispatch system so that they could monitor the details of ambulance calls. These were monitored to detect real-time activity in the local area. Staff would liaise with control to check whether local patients with an urgent, rather than emergency, problem could be diverted to the centre. This was often more convenient for the patient and helped to reduce the workload of neighbouring emergency departments.
- South Western ambulance trust was originally awarded the contract to run the urgent care centre for 20 months. Performance and quality improved in that time and the contract was renewed in March 2016.

Outstanding practice and areas for improvement

Outstanding practice

- The trust was influencing service improvements at a national level, for example the ambulance response programme.
- The Aspire programme, developed by the trust, was providing excellent opportunities for personal and career development to all staff.
- There was, at times, outstanding professionalism and grace under pressure among the emergency medical advisors in the Bristol and Exeter emergency operation centre (clinical hub) teams. We heard staff being criticised, shouted at, called abusive names and threatened. All of this was disruptive to staff and unsettling. The staff remained calm, and handled the callers with courtesy and patience.
- Staff in the emergency operations centres showed outstanding compassion and understanding to people in difficult and stressful situations. Staff made a genuine connection with patients and others who were scared or anxious and developed an, albeit temporary bond, with the person trying to help them. Staff would, appropriately, say "take care" and "all the best" to people, and this was often repeated back to staff by people who had appreciated their friendliness and warmth.
- Although the emergency operation centres' call-quality audit programme was not completed as often as required because of other priorities, and staff shortages, it had been previously commended and recognised for its quality. There was, nevertheless, an outstanding quality to the audits when they were being undertaken. This included the feedback, which was delivered with thoughtfulness, professionalism and the intention for staff to do well. There had been changes based on staff being asked how they found the process to make it more empathetic for those being examined.
- There was an outstanding and commended programme to manage frequent callers to the service. This was helping to release the organisation's limited resources to more appropriate situations. There was strong multidisciplinary working to support frequent callers with the service promoting the issue among the wider community and partner organisations.
- At the time of our inspection the service had just embarked on a trial, known as the Ambulance Response Programme. This 12-week pilot aimed to improve response times to critically ill patients, making sure the best response was sent to each incident first time and with the appropriate degree of urgency. The trust was one of two ambulance services nationally participating in this trial.
- The introduction of Right Care had resulted in 56.8% of patients, who called for an ambulance, being treated at the scene or referred to other services, rather than being conveyed to hospital emergency department.
- Operational staff took time to interact with patients and were supportive to them and to their relatives/ carers. Staff treated patients with compassion and dignity and respected their privacy at all times.
- The trust produced a newsletter called "twentyfourseven" published for members of the public with news, long-service awards for staff, notable events taken place or coming up in the trust's area, and success stories. These newsletters were available on the trust's website. The high-quality publication provided the public with good information about the service and its achievements. Staff had access to the 'Staying well service. Debriefing sessions, TRiM and welfare checks to ensure their wellbeing.
- The trust had a dedicated events team to manage the assessment, planning and resourcing for public events.

Areas for improvement

Action the hospital MUST take to improve

- Ensure mandatory training for all staff, including safeguarding for vulnerable people, is updated and maintained in accordance with the trust's target.

Outstanding practice and areas for improvement

- Ensure staff appraisals are completed each year to meet the trust's target. The organisation must also ensure it is aware of those staff who have not had an appraisal for many years, and offer support and recognition where warranted.
- Ensure risk registers are aligned with operational risks and that risk registered are reviewed regularly to monitor and mitigate risks
- Ensure work intensity and fatigue is monitored and actions put in place to mitigate risks to staff
- Ensure governance meetings at local levels contain a strong focus upon quality and safety. This will include performance reports on training, appraisals, patient outcomes, complaints and incidents relevant to the local level. Actions from addressing any shortcomings or changes must be recognised and completed. Leaders of the Patient Transport Services must ensure that staff are encouraged to report incidents and that feedback and learning from incidents is shared with the team. Incidents should be an integral part of the governance process and viewed as a positive opportunity for learning.
- Ensure patient transport service engage in a regular programme of audit including infection control, safety of vehicles. These audits should be recorded and an agreed action plan documented and progress monitored through the governance processes.
- Ensure accurate, contemporaneous and complete record of all treatment undertaken by Patient Transport Services staff and that across all services records are stored securely at all times to prevent unauthorised access.
- Ensure adequate guidelines and protocols are in place to guide patient transport staff in their clinical decisions regarding adjustment of oxygen therapy.
- Ensure a system is put into place which informs patient transport service crews of any important clinical information relating to the patients they convey, such as when a patient has diabetes.
- Ensure that healthcare assistants who undertake initial clinical assessment of patients are assessed as competent before working independently
- Ensure that all staff are familiar with their responsibilities in regard to the safeguarding of vulnerable adults and that robust reporting arrangements are in place.
- Ensure partly administered controlled medicines no longer required are disposed of in accordance with the service standard operating procedures and that medicines are stored securely in the back of ambulances and cars when the crew is not present.
- Review the management of clinical waste in ambulance stations to avoid risks to staff.
- Ensure infection control issues identified in this report are addressed.
- Ensure complaints are handled effectively. Information and guidance about how to complain must be available and accessible to everyone who uses the service in a language and format to meet the needs of the people using the service, for example those who were hearing or sight impaired.
- Take action to meet locally agreed thresholds in respect of Ambulance Clinical Quality Outcomes.

Action the hospital SHOULD take to improve

- Ensure all staff have the time and resources to directly report incidents, and all staff recognise and respond to their duty to report them in a timely way following trust policy.
- Make improvements to the delays in investigating and reporting on serious incidents within the period granted.
- Be clear as to how the feedback from serious incidents is disseminated to staff in future.
- Extend the infection control policy in the emergency operations centres so the procedures for staff around the use of hand gels were clear and consistent for all members of the teams.
- Consider implementing occasional test or practice runs for IT system failures in the emergency operations centres when most convenient and safe to do so.
- Continue with the work to provide commonality among the systems used within the emergency operations centres.
- Ensure all emergency operations centres staff are aware of the need to have clinical input into the decision to stand down an ambulance from a scene.
- Consider possible solutions for emergency operations centres staff from having outdated special notes linked to an address where the notes were no longer relevant.
- Undertaken a staff review within the emergency operations centres to review the percentage of relief cover modelled against the increasing call volumes.

Outstanding practice and areas for improvement

Ensure staff can be released for training, holidays, special leave, and sickness, for example, without this affecting the quality of the service and pressure on remaining staff.

- Remodel the staffing rotas to take account of the known or predictable changes in seasonal demand.
- Ensure the major incident room in Exeter is not being used for other things preventing it being established for its purpose at immediate notice.
- Re-focus upon the emergency operations centres call-quality audit programme to provide staff with good feedback, encourage improvement, and reward excellence.
- Provide some relevant and useful mental-health training to all emergency operations centres staff.
- Improve the response to stroke patients so at least 57% of patients reach a hyper acute stroke centre within 60 minutes of their call to the service.
- Look for methods for emergency operations centres staff to spread out their continuing despatch education throughout the year and not just prior to their recertification being due.
- Consider training or guidance for emergency operations centres staff for communicating with young children.
- Ensure there is a formal handover period factored into the working pattern of the emergency medical dispatchers in the emergency operations centres.
- Establish one-to-one sessions for staff and line managers to take place within the emergency operations centres on a regular basis. Ensure these are taking place and add value to the staff concerned and the organisation.
- Ensure all staff who do not have direct access to emails or the trust's intranet are kept up-to-date and well informed of new or updated information at all times.
- Review how a patient's mental health status is determined. Triage protocols do not proactively determine if the person is living with dementia or might have a learning disability.
- Develop and nurture valuable connections between staff in the emergency operations centres in Bristol and Exeter.
- Review security for all staff working in the emergency operations centres, when the surrounding area was largely unoccupied by other people, were able to leave the offices safely.
- Review the lighting for vehicles reversing onto the quay in St Agnes to ensure safety of staff and patients when reversing onto the quay to meet the boat.
- Review the audit of the services provided on the Isles of Scilly undertaken in June 2015, to ensure actions identified have been implemented.
- Review the provision, availability and contact ability of community first responders on the Isles of Scilly.
- Work to develop a more positive culture within patient transport services. This includes taking action to listen to all groups of staff in a forum that is perceived to be safe and confidential, and addressing the development needs of staff in leadership positions.
- Ensure exit interviews are conducted and take action to address concerns identified by staff within these exit interviews.
- Ensure regular staff meetings occur within patient transport services and these are recorded for the benefit of those staff unable to attend.
- Ensure the environment in the urgent care centre is safe for children.
- Ensure that there is sufficient space in the waiting area and that waiting patients can be viewed by staff at all times.
- Ensure that patient transport services monitor compliance with The National Institute for Health and Care Excellence (NICE) Quality Standard QS72 Renal Replacement Therapy services for Adults.
- Ensure the handheld electronic patient care record devices are fit for purpose in all areas.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12(1) Care and treatment must be provided in a safe way for service users. (a) ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely; Most patients within the minor injuries unit were triaged by an experienced healthcare assistant, not a qualified clinician. There was no assessment framework to guide them. The nurse manager told us that healthcare assistants underwent four weeks supervised practice before being able to triage on their own. However, there was no structured competency framework for this training and no formal competency assessment. (e) Ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way The statutory responsibility to ensure daily vehicle inspections take place could not be evidenced to give assurance of vehicle safety. (g) the proper and safe management of medicines; Patient Transport Services staff did not maintain a record of adjustment of oxygen therapy during transit and the administering of Entenox (medical nitrous oxide and oxygen mixture). Medicines were not stored securely. Examples included, at Torquay station, the door to the storeroom containing medicines was propped open and at Plymouth station, the door was tied open with a bandage. Vehicles were

Requirement notices

left unattended and unlocked. When some ambulances were outside emergency departments these were also left open and the cupboards where the medicines bags were stored were not locked.

We observed controlled medicines being administered by a staff member who had not checked it.

Excess medicines were incorrectly disposed of by either squirting on to the floor or down a sink.

(h) assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated;

Environmental cleaning did not always occur. Completion and recording of rotas for environmental cleaning of ambulance stations varied. At Barnstaple station, there were no signatures entered onto the rota to show areas had been cleaned. Here staff could not demonstrate completed cleaning schedules by the contract cleaner. At Exeter station, there was a cleaner for the station but the sluice, the supplies store for sterile consumables and the medical devices store rooms were not part of the cleaning schedule. As a result, these rooms were not routinely cleaned. In most of the stations we inspected, boxes of equipment were kept on the floor of storage areas making effective cleaning difficult. We saw debris and dirt on the floor around the boxes.

In Launceston station, cleaning chemicals, clean equipment and soiled storage boxes were stored together. The work surface area in this sluice was damaged and could not be effectively cleaned.

In Plymouth, the area around the medical devices store was contaminated with guano from nesting birds. Clean linen and stores had been delivered and placed in the area outside the medical devices room. Two linen bags had been opened, leaving clean linen exposed to the risk of guano dropping on them. Two bags had spilled from the crate and were on the floor of the garage.

In Dorchester station, consumable items, including masks, disposable bedpans and neck braces were stored in the sluice.

This section is primarily information for the provider

Requirement notices

Some clinical waste bins in the stations did not have lids meaning their contents could easily spill out if the bin was overturned. Some of the large clinical waste storage bins were not locked and were visibly dirty with used items in the bottom.

At Exeter station patient equipment was stored on trolleys which were visibly dirty with dust on the underside and around the base. These trolleys were stored alongside discarded equipment awaiting disposal such as office chairs.

The trust standard required vehicle 'deep cleans' to be completed every 8 weeks. Only 21.3% of patient transport service vehicles had consistently achieved this standard during April 2015 to March 2016. Spot checks undertaken were not routinely recorded.

Some internal patient transport service vehicle defects caused a risk to infection control. We observed several vehicles with ripped fabric on seats with exposed foam padding.

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 17(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. (2) Without limiting paragraph (1), such systems of processes must enable the registered person, in particular, to- (a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from carrying on of the regulated activity;

This section is primarily information for the provider

Requirement notices

There was insufficient attention and understanding of the quality of the emergency operations service being provided by staff at local frontline level. This included there not being an in-depth regular review of incidents, reporting, near-misses, quality of performance, complaints, training delivered and appraisals provided in local performance meetings.

Across emergency and urgent care and patient transport services risk registers were not aligned with operational risks, nor were they always reviewed regularly to monitor and mitigate risks.

Within the Patient Transport Services there was no system of audit to inform their understanding of the safety of the service.

There were inadequate systems in place to assure the safety of patients when medical gases such as oxygen were adjusted and Entenox (medical nitrous oxide and oxygen gas mixture) were administered

The Patient Transport Services staff did not reliably and consistently complete vehicle daily inspections. Leaders of the service had no system in place to monitor or audit completion of these checklists. These checklists were not reviewed effectively to provide assurance of the safety of the vehicles used to transport patients and staff.

(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing 18(2) Persons employed by the service provider in the provision of a regulated activity must – (a) receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Insufficient numbers of staff in the emergency operation centres were up-to-date with their mandatory training. Only around 50% of staff, from a trust target of 95% of staff, had updated their three-yearly training. Insufficient numbers of staff in the emergency operation centres had been provided with an annual review of their performance and competence to perform their duties. Some results were as low as 11% of frontline staff from a trust target of 85%.

Within the emergency operations centres incoming staff members used the previous staff login to enable them to use the computer system. As a result, the records at the time did not accurately record who had made them during this period.

Records of care were not maintained by patient transport staff, for example when oxygen flow was adjusted.

A hand held device on an unmanned ambulance at Bournemouth Station could be accessed by unauthorised personnel to view confidential patient information. At Torquay station we saw log books for recording the use of morphine placed on a desk in the main garage. This was accessible to all staff and visitors to the garage.

This section is primarily information for the provider

Requirement notices

Within patient transport services, not all leaders had the necessary leadership skills to lead effectively and promote supportive relationships.

The rate of annual performance appraisals within emergency and urgent care was variable ranging from 38.4% for specialist paramedics to 87.7% for paramedics. This was below the trust target of 90%. The quality of the appraisals was also variable.

Make ready operatives had not received any update or infection control training since induction.