West Midlands Ambulance Service NHS Foundation Trust

West Midlands Ambulance Service NHS Foundation Trust

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.

Ratings

Overall rating for this ambulance location	Outstanding ☆
Emergency and urgent care services	Good
Patient transport services (PTS)	Requires improvement
Emergency operations centre	Good
Resilience planning	Outstanding ☆

Summary of findings

Letter from the Chief Inspector of Hospitals

West Midlands Ambulance Service NHS Foundation Trust (WMASFT) is one of 10 ambulance trusts in England and provides services to the following six counties:

- Herefordshire
- Shropshire
- Staffordshire
- Warwickshire
- West Midlands
- Worcestershire

WMASFT serves a population of approximately 5.6 million, covers 5,000 square miles and provides services to 26 NHS trusts.

The services employs over 4,500 staff including Paramedics, Emergency Care Practitioners, Advanced Technicians, Ambulance Care Assistants and Nurse Practitioners) and is supported by approximately 1,000 volunteers, over 63 sites and responds to around 3,000 '999' calls each day. WMAS operate from 16 fleet preparation hubs across the region and a network of over 90 Community Ambulance Stations.

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 two emergency operation centres (EOC), based at: Millennium Point, Brierley Hill (Trust HQ) and Tollgate Drive, Stafford where clinical advice is provided and from where emergency vehicles are dispatched if required.

In addition, the trust provides a patient transport services, employing 400 staff, a Hazardous Area Response Team of 49 staff and provides clinical teams to three air ambulances. Air Ambulance services in the region were provided by the Midlands Air Ambulance Charity. Paramedics and doctors on the service are funded by the charity but are provided by WMAS. The Air ambulance service was not included as part of this inspection.

We carried out this inspection as part of the CQC's comprehensive inspection programme. We carried out our announced inspection between 27 June 2016 to 1 July 2016 and conducted unannounced inspections on 13 and 14 July 2016. We inspected the following core services unannounced:

Patient Transport Services

Hospital Ambulance Liaison Officer (HALO) at one NHS trust.

Emergency and Urgent Care

Overall, the trust was rated outstanding. We rated safe, responsive and well led good and we rated effective and caring as outstanding.

Our key findings were as follows:

Safe

- Incidents were reported in line with trust guidance and staff received feedback following untoward incidents.
- All staff did not fully understand the process or the terminology for duty of candour, but were fully aware of the need to be 'open and honest' regarding incidents.
- There were reliable systems, processes and practices in place across the majority of areas to keep patients and staff safe and safeguard from abuse and avoidable harm.

Summary of findings

- Emergency and Urgent Care services (EUC) and Resilience services surpassed the trusts mandatory training targets of 85%, however, PTS did not meet this target, for example PTS Stoke scored between 34 and 54%, as the staffing levels were not sufficient to provide relief for staff to attend training.
- Records were stored securely, with a clear audit trail.
- Staff were competent in their roles and provided with timely appraisals and learning opportunities. We saw consistently high standards of cleanliness and infection control prevention in the majority of the ambulance hubs, community stations, control rooms and vehicles.
- Across the majority of areas, the supply of equipment, storage and maintenance was good. In Worcester, we found there was confusion regarding whose responsibility it was to test the defibrillator therapy cable. We escalated this the same day and it was quickly resolved with the senior management team.
- The trust medicine management policy was in place and the majority of staff followed the policy on a daily basis.
- There was a strong culture of improving medicine safety with clear governance pathways to ensure that learning was acted upon throughout the trust.
- There was a good skill mix and level of staff to meet the needs of patients and keep people safe across all areas.
- All of the staff we spoke with told us they had either received training or were booked on to participate in response to major incident training and that was part of the mandatory training programme. Resilience staff attended 68 multi-agency exercises between February 2015 and June 2016. These included firearms sieges, flooding, simulated explosion and fire in a nightclub premises, readiness exercises for international sporting events, and communications exercises.

However, we also saw;

- We saw challenges around Prescription only Medicines (POM's). For example, at one of the Worcester hubs we visited, we counted 56 recording errors between the 13 April and 29 June 2016, which staff had not been reported as incidents.
- We inspected an HDU vehicle at PTS Stoke and saw not all CD’s were stored appropriately.
- In PTS, we saw staff did not always carry out equipment checks and sterile environments were not always maintained.
- Staff were not aware of incidents that had affected change so learning was not always shared, which potentially meant missed opportunities to improve patient care trust-wide.
- PTS staff did not consistently lock ambulances when parked at the hubs or outside homes when collecting patients.
- Within EUC Erdington hub we saw dirty equipment and sluice area, where under the sink and floors were soiled and visibly dirty.

Effective

- Between April 2015 and March 2016 the trust was the only ambulance trust to meet all national targets for response times for the most immediately life threatening calls and answering 999 calls.
- The trust was part of a national pilot designed to change the way that ambulances respond to patients and was actively working with external providers and services to improve patient outcomes.
- The trust was a part of an operational delivery network, it was developed to manage the care and treatment for patients with major trauma.
- The design and functions of the regional co-ordination centre (RCC) within the EOC provided excellent specialist support for the local community.

Summary of findings

- All staff were actively engaged in activities to monitor and improve quality and outcomes. The trust encouraged widespread opportunities to participate in benchmarking, peer review, accreditation and research.
- Within Resilience, credible external bodies such as a Joint Emergency Services Interoperability Programme (JESIP) and National Ambulance Resilience Unit (NARU) recognised high performance. The continuing development of staff skills, competence and knowledge was recognised by the trust as being integral to ensuring high quality care. Managers proactively supported their staff to acquire new skills and share best practice. Hazardous Area Response Team staff had protected training time. One week in seven was dedicated to training.
- Data provided by the trust showed that 96% of EUC staff had attended Mental Health Conditions training in 2015/16, which was significantly better than the trust target of 85%.

However, we also saw;

- All NHS ambulance services must respond to 75% of Category A/Red emergency calls. We found local performance data for emergency calls that were immediately life threatening showed variation across areas. Birmingham and Black Country achieved 83.5 and 81.8% respectively. However, Coventry and Warwickshire achieved 72.3%, West Mercia 69.8%, and Staffordshire 68.0%.
- Staff at PTS Stoke needed more mental health training to support patients with a mental health condition. The trust board took immediate and remedial action to address concerns raised.

Caring

- Staff across all areas staff consistently demonstrated kindness, compassion and respect towards patients, relatives and carers. All patients, relatives, and 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.
- Staff asked questions in a calm manner and demonstrated an empathetic approach to information gathering when communicating with patients, relatives and carers. This was observed during EUC and PTS with staff and patient interaction and in the EOC with call handlers during telephone conversations.
- Callers who were distressed and overwhelmed 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 made sure people had understood the information given back to them by telephone advisors.
- Staff took time to interact with patients and supported them and their relatives and carers. They treated patients with dignity and respected their privacy at all times.
- Feedback from people who use the service, those who are close to them and stakeholders were consistently positive about the way staff treated people.
- There was a strong, visible person centred culture. Staff and management were fully committed to working in partnership with people and find innovative ways to make it a reality for each person using the service.
- Communication with children and young people was age appropriate and effective.
- Staff were highly motivated and inspired to offer kind and compassionate care; they displayed determination and went the extra mile to achieve this. For example, one staff member arranged for a patients' cat to be cared for whilst the patient was in hospital, which alleviated the patient's anxiety and they agreed to leave their home and go to hospital.

Responsive

Summary of findings

- The trust planned and delivered services in a co-ordinated and efficient way that responded to the needs of the local population. For example, PTS had a good escalation and planning process for the next day's journey. The plans detailed monitoring of transport times, cancellations and aborts, action they take to prevent breaches of the contract and remedial actions should they occur.
- People's individual needs and preferences were central to the planning and delivery of tailored services. This was particularly evident within EOC and Resilience where services were flexible, provided choice and ensured continuity of care.

- We saw strong evidence of multi-disciplinary team working across all areas to support people with complex needs. For example EOC staff were trained to use type talk (which was a text relay service for patients with difficulty hearing or speaking) they could also use voice over internet protocol (VOIP) to receive 999 calls.
- We observed staff conversing with patients with mental health issues and interacting with them in a way that met their individual needs.
- Community First Responders (CFRs) within EUC services worked efficiently across the region particularly in rural areas to support ambulance staff with responding to life threatening emergencies. The trust used Rapid Response Vehicles (RRVs) effectively to ensure emergency treatment started as soon as possible.
- EUC's 'make ready' team freed up ambulance staff to attend to calls throughout their shift rather than spending time preparing and cleaning vehicles.
- The trust managed and reviewed patients' complaints appropriately and people who used services were involved with service improvements.
- Hazardous Area Response Team had been given additional staff and equipment in order to provide the trust response to bariatric patient's needs.

However, we also saw;

- Specialist bariatric equipment was not always readily available across all areas.
- Across EUC and PTS there were limited tools in place to assist patients with learning disabilities and people living with dementia staff felt that they would benefit from receiving training in regards to this.
- Information about how to raise concerns or make a complaint about services was limited on ambulances for EUC and we saw complaints information on most PTS vehicles. PTS Managers across some areas dealt with complaints at a local level, which meant there were missed opportunities for trust-wide learning.
- EUC staff we spoke with told us generally target response times were achievable and the only reason they would not meet some targets would be as a result of the wide geographical area. We saw these figures were being monitored internally, however more work was required to achieve the set targets so that people living in rural areas were not continually disadvantaged. For example, we observed the ambulance crew respond to a call in Rugby whilst they were in Coventry the journey time between the two areas was 35 minutes.

Well led

The overall rating for the well led domain was rated 'good'. The 'Good' rating was due to overwhelming evidence during the inspection period and information supplied by the trust before and after the inspection that supported strong senior leadership of the organisation.

- Staff were aware of the robust five-year strategic plan and the trust's vision and values were well in-bedded across all areas.
- Operational staff demonstrated passion and commitment to provide high-quality care and they 'lived' the strategy daily.
- Clinical governance, risk and quality management were effective. We were confident that the governance, risk and quality boards influenced and impacted services at an operational level.

Summary of findings

- The trust was focused on achieving response time performance targets, and this was reflected in the governance framework used to monitor performance.
- Through staff interviews and observations we saw that there was a high standard of leadership at the trust, with strong leadership from the CEO. All the executive directors were well engaged and interacted with each other appropriately.
- The vast geographical area covered by the trust, meant it was not always practical for the CEO and other executives to meet frontline staff on a regular basis. We saw that the leadership team recognised this and encouraged staff to engage with them in other ways such as direct email.
- The trust was actively involved in effective public engagement to recruit staff from Black and Minority Ethnicity (BME) population.
- There was a mostly positive, open and honest culture among all staff groups. In the main, managers supported staff well and staff told us they felt listened to.
- There were high levels of staff satisfaction across EOC, PTS and Resilience and staff were proud of being a part of the trust and their role within it.
- Staff at all levels were actively encouraged and supported to explore innovative ways of working with a common focus on improving quality of care and people's experiences.
- Across all areas staff gave examples of how they had worked together to support each other. They told us that they talked openly with each other and their managers and their managers were open and honest with them.
- Managers were extremely proud of the calibre and commitment of staff on the HART team. Managers were clear that they believed the success of the HART team rested with the ability of staff to perform professionally in extraordinary circumstances and situations, and their role was to provide them with the facilities and training to enable them to do so.
- The trust provided a counselling and support service for staff who required support following attendance at traumatic or upsetting calls. There was a 24-hour helpline, staffed by volunteers from within the service. All volunteers were trained before joining the team.

However, we also saw;

- A governance framework supported the delivery of the strategy and good quality care. However, we found this was not always effective or consistent across all areas. For example, there were instances in Coventry and Warwickshire and throughout West Mercia where staff were unclear of who had responsibility for tasks such as the checking of defibrillator test cables and auditing prescription only medicines management. Once escalated to the trust, remedial action was quickly taken and staff were advised accordingly.

- Risk registers did not always reflect each hub's risks. For example, there were insufficient middle managers across EUC to ensure staff were fully supported. We saw the impact of this as not all managers had the time to respond to their staff's concerns. This was particularly evident in the Worcestershire hub where the area manager was responsible for 196 staff and this was against the operating model of one manager to 100 staff-.This risk was placed on the risk register, however, there were no actions to reduce this risk.
- In West Mercia there were five area managers, two on sick leave and a third on annual leave with acting area managers in place. Bromsgrove hub also struggled to provide adequate managerial staff support and Lichfield hub had one area manager and no area support manager (ASO). Thismeant that the area manager was managing over 100 staff. This was a similar picture at the Donnington hub. Managing this large number of staff meant they were unlikely to be able to provide sufficient staff oversight and appropriate supervision.

We saw several areas of outstanding practice including:

- The trust was shortlisted in 2015 for two national awards including; Enhancing Care by Sharing Data and Information and Improving Outcomes through Learning and Development.

Summary of findings

- HALO's across all divisions had developed innovative and forward thinking ideas to reduce hospital admissions and ambulance call-outs which proved to be very effective. HALOs work in partnership with the Emergency Department practitioners to support the effective and efficient management of patient streams, particularly patient handover and ambulance turnaround times within the department, helping emergency crews to become available earlier to respond to the next incident.
- The trust encouraged online engagements with patients and provided patients with clear and concise tools to self-care and recognise life-threatening conditions.
- Paramedic availability throughout the service, and plans to increase this further meant that highly qualified staff could provide emergency care to patients.
  - The functions within the Regional Co-ordination Centre provided effective support for complex incidents within the trust's geographical region and externally through the Midlands Critical Care Network.
  - The trust looked at innovative ways of engaging with the local population, for example, the Youth Council Strategy and the Youth Cadet scheme.
  - All operational staff on the HART team were required to be qualified paramedics and to maintain their accreditation which was in line with NARU best practice. Not all trusts followed this guidance.
  - The only exception to protected training was if the team was required to deploy to a major incident to support the duty team [this is another area of best practice in the UK
  - Compliance with NARU and Joint Emergency Services Interoperability Programme JESIP guidance was seen to be very strong and reflected industry best practice.
- During 2015 the MERIT team were peer reviewed by the Trauma Network; and they were graded as providing recognised best practice in nine out of ten criteria, which is a recognition of best practice.
- The NHS England Core Standards return for 2015/16 was 100%, which is an area of outstanding practice.
  - The sharing of the trust forward planning for New Year's Eve represented an area of outstanding practice.
- WMAS was an integral part of the Emergency Response Management Arrangements (ERMA) and acted as the host and regional 'GOLD' - control centre for all Emergency Service providers during the first hour of any large-scale emergency incident. Gold Control plans were in place to assist in coordinating any such response. This is unique in an ambulance service and represents an area of best practice nationally.
- The trust provided staff with major incident aide memoire cards and were in the process of developing electronic versions. The aim was to increase efficiency and confidence of staff when dealing with major incidents.
- The HART staff were committed to improve their personal skills and provide a comprehensive service to exceed normal working practices in support of casualties.

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

Importantly, the trust must:

- Improve staff attendance at mandatory training ensuring it is monitored and actively supported.
- Safely store all medication on high dependency vehicles.

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	Good 	Overall, we rated emergency and urgent care services as good because: • We found there were reliable systems, processes and practices in place to keep people safe and safeguarded from abuse. • Equipment was safe and suitable for use, with processes in place to report any equipment found to be faulty. • Robust processes were in place across most areas to ensure that the storage and use of medicines kept people safe. • WMAS were consistently meeting national response times, performing significantly above the England average. • Staff were competent in their roles and provided with suitable appraisals and learning opportunities. • Within all the hubs we visited there were established pathways in place for patients suffering a stroke, heart attack or major trauma, and patients were transported to the most appropriate place to receive emergency care. • Across all divisions, staff consistently delivered genuine compassionate care and were sensitive to their patients' needs. • The 'make ready' system at hubs allowed ambulance staff to attend to calls throughout their shift rather than spending time preparing and cleaning vehicles. • Provision of a mental health care in some areas meant that patients could receive the right care for their condition. • There was a clear strategy in place, with associated visions and values supporting this. • Operational staff demonstrated passion and commitment to provide high quality care and they 'lived' the strategy daily.

Summary of findings

- Rural area response targets were a challenge due to the wide geographical area. We saw these figures were being monitored internally, however more work was required to achieve the set targets so that people living in rural areas were not disadvantaged.
- There was a mostly positive, open and honest culture amongst all staff groups.
- In the main, staff felt well supported by managers and that their concerns and issues were listened to and resolved.

However, we also found:

- Local risk registers were not robust and did not fully reflect each hubs risk areas.
- We saw that information about how to raise concerns or make a complaint about the service was limited on ambulances. In some areas managers dealt with complaints at a local level which meant that trends may be missed and trust-wide learning would not take place.
- There were insufficient middle managers in some areas to meet the needs of the service. Most staff expressed more middle management provision was required.
- Staff engagement in some areas was limited.
- There was a lack of local innovation in some areas. The trust did not always share innovation outside of the divisions.
- Medication management at the Worcester hub required improvement.

Patient transport services (PTS)

Requires improvement

We rated this service as requires improvement overall. We rated the service for requires improvement for safety, effective and being well led and good for caring and responsiveness. This is because:

- Equipment checks and sterile environments were not always maintained

Summary of findings

- Arrangements for controlled drug storage and vehicle security was not robust at PTS Stoke hub.
- Risk assessments were not always completed in line with organisational policy particularly around mental health, serious incident reporting, and understanding of the role in major incidents.
- Mandatory training rates did not meet organisational targets,
- There were ongoing improvements to manage delays.
- There was a lack of staff understanding of mental health problems.
- There was minimal evidence of learning from complaints related to delays.
- Staff had mixed knowledge about the trust's vision and values
- Senior operational managers had variable understanding of the risks associated with PTS service delivery.
- Staff felt there was a lack of visibility of senior management above senior operational manager level and variable quality and rates of appraisals.
- There was lack of timely response to management issues at one PTS site and poor staff engagement on surveys and performance issues at the same site.

However we also saw;

- Staff had a good understanding of incident reporting, safeguarding and the use of the patient digital assistant (PDA)
- Regular fortnightly non-emergency senior management meetings, close working with

Healthwatch Coventry and an effective transport monitoring and escalation process at Stafford

control centre

- Caring, compassionate staff

Summary of findings

- Robust five year strategic planning
- Good visibility of local managers and good support for staff
- Escalation process and planning for the next day's journeys.

Emergency operations centre

Good

We rated the EOC within West Midlands Ambulance Service NHS Foundation Trust as good for safety, effectiveness, caring and responsiveness and outstanding for being well led. We rated the service as good overall because:

- Staff understood their responsibilities to raise concerns and report incidents and the service had a good safety track record.
- There were robust systems and processes in place to keep patients and staff safe from abuse and avoidable harm.
- There was a good level of staffing and skill mix to meet the demands of the service.
- Mandatory training levels exceeded trusts targets and were above 95%.
- The EOCs were visibly clean and tidy and the environment and equipment was suitable for the operational activity in EOC.
- The service was the only ambulance trust in the UK to meet national targets for response times for the most serious 999 calls in 2015.
- The EOC consistently answered over 95% of all 999 calls within five seconds.
- There was a good consistent track record on performance and staff worked together at all levels to achieve this and safety was being regularly reviewed through investigating incidents, governance meetings and local audits.
- The EOC worked well with other teams internally and externally to improve and achieve good patient outcomes.
- We found the service to be caring towards their patients and each other.

Summary of findings

- The EOC had a clear vision and strategy to continuously improve this service.
- The EOC had an established and experienced leadership team who were visible and approachable to staff at all levels.

Resilience planning

Outstanding ☆

Overall, we rated resilience planning within WMAS as outstanding because:

- Resilience planning and services in the trust were based on National Guidance provided in the Civil Contingencies Act, Department of Health, NHS England, the National Ambulance Resilience Unit (NARU) and the Joint Emergency Services Interoperability Programme (JESIP).
- Performance showed an excellent track record and steady improvements in safety. When an adverse incident occurs, an appropriate thorough review or investigation involved all relevant staff and people who used services.
- Lessons were learned and communicated widely to support improvement in other areas as well as services that were directly affected. Opportunities to learn from external safety events were also identified. Improvements to safety were made and the resulting changes were monitored.
- Staff had received up-to-date training in all safety systems.
- Staffing levels and skill mix were well-planned, implemented and reviewed to keep people safe at all times.
- Risks to safety from service developments, anticipated changes in demand and disruption were assessed, planned for and managed effectively. Robust plans were in place to respond to emergencies and major situations. All relevant parties understood their role and the plans were rigorously tested and reviewed.
- All staff were actively engaged in activities to monitor and improve quality and outcomes.

Summary of findings

Opportunities to participate in benchmarking, peer review, accreditation and research were proactively pursued. Credible external bodies recognised high performance.

- The continuing development of staff skills, competence and knowledge was recognised as being integral to ensuring high-quality care. Staff were proactively supported to acquire new skills and share best practice.
- The systems to manage and share the information that was needed to deliver effective care were fully integrated and provide real-time information across teams and services. People's individual needs and preferences were central to the planning and delivery of tailored services. There were innovative approaches to providing integrated person-centred pathways of care that involved other service providers, particularly for people with multiple and complex needs. The services were flexible, provided choice and ensured continuity of care.
- The involvement of other organisations and the local community was integral to how services were planned and ensured that services met people's needs. A systematic approach was taken to working with other organisations to improve care outcomes, tackle health inequalities and obtain best value for money.
- Governance and performance management arrangements were extremely well embedded proactively reviewed and reflected best practice.
- The leadership drives continuous improvement and staff were accountable for delivering change.

West Midlands Ambulance Service NHS Foundation Trust

Detailed findings

Services we looked at
Emergency and urgent care; Patient transport services (PTS); Emergency operations centre (EOC); Resilience

Detailed findings

Contents

Background to West Midlands Ambulance Service NHS Foundation Trust

The trust was formed on 1 July 2006, following the merger of the Hereford & Worcester Ambulance Service NHS Trust, Coventry & Warwickshire Ambulance NHS Trust, and WMAS and Shropshire services. On 1 October 2007 the service merged with Staffordshire Ambulance Service NHS Trust. Seven years later, West Midlands Ambulance Service became a Foundation Trust on 1 January 2013.

WMAS operates from two Emergency Operations Centres (EOCs) based at: Millennium Point, Brierley Hill (Trust HQ) and Tollgate Drive, Stafford, taking around 3,000 emergency '999' calls each day.

The trust has over 800 vehicles, including patient transport services vehicles, rapid response vehicles, motorcycle response units, and ambulance crews.

The trust Serves a population of 5.6 million people covering an area of more than 5,000 square miles. The area includes the second largest urban area in the country (Birmingham, Solihull and the Black Country) yet over 80% of the area is rural. This is the second most ethnically diverse region in the country after London.

The services employs over 4,500 staff including Paramedics, Emergency Care Practitioners, Advanced Technicians, Ambulance Care Assistants and Nurse Practitioners). It is supported by approximately 1,000 volunteers, over 63 sites, provides services to 26 NHS trusts and is commissioned by 22 clinical commissioning groups (CCG's).

Calls from the public and urgent calls from healthcare professionals are received and triaged in one of the two emergency operations centres. 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.

From April 2015 to April 2016 the trust received 1,215,110 calls via 999.

Resources and teams include:

- 368 ambulances
- 106 rapid response vehicles
- 320 patient transport service vehicles.
- 90 Ambulance stations and one Hazardous Area Response Teams (HART), based in Oldbury, West Midlands
- Two Emergency Operations Centres located at Millennium Point, Brierley Hill (Trust HQ) and Tollgate Drive, Stafford.

Patient transport services (PTS) employed 400 staff and accounted for one tenth of the overall trust workforce. PTS provided non-emergency transport for adults and children across the West Midlands from seven PTS bases: PTS Walsall at Walsall Manor Hospital, PTS University

Detailed findings

Hospital Birmingham (UHB) at Kings Norton, Birmingham, and PTS Stoke near to the Royal Stoke Hospital in North Staffordshire, PTS Heartlands Parkway, Birmingham (HEFT), PTS Worcester, PTS Coventry and PTS Warwick. There were 33 call handlers for this service and 320 vehicles. PTS service performs more than 700,000 patient journeys per annum, amounting to over 3,000 journeys per day.

We inspected WMASFT as part of our planned comprehensive inspection programme. Our announced inspection took place between 27 June 2016 to 1 July 2016 and we conducted unannounced inspections on 13 and 14 July 2016.

In 2015/16 the trust's turnover was £227million with a deficit of £0.4m after the net impairment of fixed assets of £0.8m was applied.

Our inspection team

Our inspection team was led by:

Chair: Shelagh O'Leary,

Head of Hospital Inspections: Tim Cooper, Care Quality Commission

The inspection team of 48 included 20 CQC inspectors with acute and mental health backgrounds, an inspection manager, one CQC pharmacy manager and a pharmacy inspector, three assistant inspectors, an analyst, an inspection planner and variety of specialists. These included past and present directors and associate directors of ambulance services, advanced paramedics, paediatric emergency nurse consultant, national, regional and sector operations managers. The team also included a clinical educator, ambulance control dispatcher and an emergency call handler.

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 27 June to 1July 2016, with unannounced visits taking place on 13 and 14 July 2016.

The inspection team inspected the following services:

- Emergency operations centre (EOC)
- Emergency and Urgent care
- Patient Transport services (PTS)
- Resilience team

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); General Medical Council; Health & Safety Executive; Health and Care Professions Council; Nursing and Midwifery Council; NHS Litigation Authority; Parliamentary and Health Service Ombudsman. We also reviewed information from 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 both emergency operations centres at Brierley Hill and Stafford, ambulance stations. We visited the 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 spoke with managers across the services, directors and members of the executive board.

Detailed findings

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

We inspected ambulances for cleanliness, processes to ensure maintenance, servicing and MOT testing and reviewed patient records. We attended the Emergency departments within four neighbouring NHS trusts, where we observed the interaction between ambulance crews and hospital staff. We rode in ambulances on their way to emergency and routine calls in order to observe interactions between staff and patients and listened in to emergency calls in the operation centres.

Facts and data about West Midlands Ambulance Service NHS Foundation Trust

Demographics:

The area is made up of:

- approximately 5.6 million people
- covers 5000 square miles
- works with 26 acute trusts
- Commissioned by 22 Clinical Commissioning groups.

From April 2015 to March 2016 the trust:

- Responded to 934,424 emergency and urgent incidents
- Received 1,215,110 calls via 999.
- Completed approximately 700,000 patient transport journeys

Resources and teams include:

- 368 ambulances
- 106 rapid response vehicles
- 320 patient transport service vehicles
- Two Emergency Operations Centres located at Millennium Point, Brierley Hill (Trust HQ) and Tollgate Drive, Stafford.
- 90 Ambulance stations and one Hazardous Area Response Teams (HART), based in Oldbury, West Midlands.

The trust employs over 4,500 mainly clinical and operational staff, including Paramedics (1,652), Emergency Care Practitioners, Advanced Technicians, Ambulance Care Assistants and Nurse Practitioners) plus GPs and around 1000 volunteers (including community first responders.

Our ratings for this service

Our ratings for this service are:

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

Detailed findings

Notes

1. We have awarded an overall rating of 'outstanding' for effective, overriding aggregation principle 6 which states that the aggregated rating would normally be 'outstanding' where at least 2 underlying ratings are 'outstanding' and the other underlying ratings are 'good'. In this case the rating for PTS was 'requires improvement', but is proportionally a much smaller service, and therefore an overall rating of 'outstanding' was considered appropriate.
2. We have awarded an overall rating of 'good' for well led. Aggregation principle 7 states that an aggregated rating would normally be restricted to 'requires improvement' if 2 of the underlying ratings are 'requires improvement'. Aggregation principle 6 states that the aggregated rating would normally be 'outstanding' where at least 2 underlying ratings are 'outstanding' and the underlying ratings are 'good'. We have used professional judgement to apply the principles to the specific mix of underlying ratings, with an overall rating of 'good' considered appropriate.

Emergency and urgent care services

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

Information about the service

West Midlands Ambulance Service (WMAS) provides an emergency and urgent care service to a population of 5.6 million people across the West Midlands, which covers the counties of Staffordshire, Coventry, Warwickshire, West Mercia, Birmingham and Black Country. The main role of emergency and urgent care services is to respond to emergency 999 calls, 24 hours a day, 365 days a year.

The service covers a total area of over 5,000 square miles across the divisions, and on average responds to around 3,000 999 calls each day. WMAS employs approximately 4,000 staff who operate out of 16 hubs and 90 community ambulance stations, with two emergency operation centres in Brierley Hill and Stafford. WMAS works closely with other emergency services, including the police and fire service to provide emergency services during major incidents. WMAS are also assisted by voluntary organisations such as the British Red Cross, St. John Ambulance, BASICS doctors and water-based rescue teams.

We conducted focus groups with staff in each division prior to and during our inspection to hear their views about the service. This included frontline ambulance staff, managers and support staff.

During the inspection, we visited a number of hubs and community ambulance stations across all divisions, in both urban and rural areas, and we spoke with over 300 staff in various roles including paramedics, student paramedics, emergency medical technicians, emergency care assistants, area support officers, assistant area managers and area managers, and members of first responder groups. In addition, we spoke with support staff including ambulance fleets assistants and station domestic staff. We observed ambulance crews treating patients. We spoke with over 60 patients, where appropriate to do so, and their relatives.

We inspected ambulances and reviewed patient report forms. We visited hospitals in each division where we observed the interaction between ambulance and emergency department staff. We spoke with staff in the emergency departments and other areas of hospitals including minor injury units, outpatient departments and mental health wards about their experiences of working with WMAS.

Emergency and urgent care services

Summary of findings

Overall, we rated emergency and urgent care services as good because:

- We found there were reliable systems, processes and practices in place to keep people safe and safeguarded from abuse.
- Equipment was safe and suitable for use, with processes in place to report any equipment found to be faulty.
- Robust processes were in place across most areas to ensure that the storage and use of medicines kept people safe.
- WMAS were consistently meeting national response times, performing significantly above the England average.
- Staff were competent in their roles and provided with suitable appraisals and learning opportunities.
- Within all the hubs we visited there were established pathways in place for patients suffering a stroke, heart attack or major trauma, and patients were transported to the most appropriate place to receive emergency care.
- Across all divisions, staff consistently delivered genuine compassionate care and were sensitive to their patients' needs.
- The 'make ready' system at hubs allowed ambulance staff to attend to calls throughout their shift rather than spending time preparing and cleaning vehicles.
- Provision of a mental health care in some areas meant that patients could receive the right care for their condition.
- There was a clear strategy in place, with associated visions and values supporting this.
- Operational staff demonstrated passion and commitment to provide high quality care and they 'lived' the strategy daily.
- Rural area response targets were a challenge due to the wide geographical area. We saw these figures were being monitored internally, however more work was required to achieve the set targets so that people living in rural areas were not disadvantaged.
- There was a mostly positive, open and honest culture amongst all staff groups.
- In the main, staff felt well supported by managers and that their concerns and issues were listened to and resolved.

However, we also found:

- Local risk registers were not robust and did not fully reflect each hubs risk areas.
- We saw that information about how to raise concerns or make a complaint about the service was limited on ambulances. In some areas managers dealt with complaints at a local level which meant that trends may be missed and trust-wide learning would not take place.
- There were insufficient middle managers in some areas to meet the needs of the service. Most staff expressed more middle management provision was required.
- Staff engagement in some areas was limited.
- There was a lack of local innovation in some areas. The trust did not always share innovation outside of the divisions.
- Medication management at the Worcester hub required improvement.

Emergency and urgent care services

Are emergency and urgent care services safe?

Good

We rated the safety of emergency and urgent care services as good because:

- Incidents were reported in line with trust guidance and staff received feedback following an untoward incident. Staff were aware of the importance of being open and honest if something went wrong.
- We found there were reliable systems, processes and practices in place to keep people safe and safeguarded from abuse.
- Stations and vehicles had high levels of compliance with infection control guidelines and most staff adhered to appropriate hand hygiene practices.
- Equipment was safe and suitable for use, with processes in place to report any equipment found to be faulty. Equipment was well maintained and received suitable testing by engineers.
- Records were stored securely, with a clear audit trail to ensure they could be accessed when required.
- The Ambulance Fleet Assistance (AFAs) led a robust cleaning, restocking, equipment and vehicle checking service.
- There was a single point of contact for safeguarding concerns and referrals for staff.
- Major incident awareness and preparedness was embedded amongst staff.
- Mandatory training took place annually; staff were trained in all mandatory aspects to ensure patients received safe care and treatment.
- Staff were trained up to level two in safeguarding children and adult, staff demonstrated up to date knowledge and aware of the signs of abuse. Reliable systems were in place to ensure patients at risk were identified and kept safe. Policies were in place for safeguarding children, young people and vulnerable adults.
- Bariatric equipment provision was good across the service.
- Appropriate processes were in place to ensure that the storage and use of medicines kept people safe. Medicines management was robust across most areas. Staff were competent in how to check the controlled drugs which were regularly audited and checked.
- There was a good mentor to student ratio within all hubs to ensure sufficient support.
- Staff we spoke with in most areas had received their mandatory training or they were booked in to complete this.
- We observed ambulance crews provide appropriate information to hospital staff during handover of patients

However, we also saw;

- Out of area safety incidents were not routinely learnt from. Action that could be taken to prevent similar incidents from occurring in the future was not shared. Any themes or wider learning from incidents was not shared on a divisional or trust-wide basis. Incidents with no harm to patients were often not reported at all.
- In Coventry and Warwick prescription only medicines were not always stored and managed safely.
- Staff did not fully understand the process for duty of candour and who was responsible for sharing the information with patients. Frontline staff did not know the terminology, but were fully aware of the need to be 'open and honest' regarding incidents.

Incidents

- We saw that the majority of incidents and near misses were recorded using an electronic system. During 2016, the reporting process for the service had changed from paper to electronic reporting, some paper reports were still being submitted. Reported incidents were received by the relevant area manager who investigated the facts in the first instance. We saw that root-cause analysis (RCA) of each incident was recorded after the investigation process. Each incident report required the member of staff to document the managers on duty to ensure it was dealt with promptly and that a senior member of staff had ownership of the incident during its investigation.
- Strategic Executive Information System (STEIS) reporting showed 18 serious incidents had been reported between May 2015 and April 2016. The evidence demonstrated there were no themes or trends related to these incidents.

- Between April 2015 and March 2016 there were 2,040 minor incidents reported within the five areas; of those 534 scored as very low harm, low harm or moderate harm. Coventry and Warwickshire reported the lowest score of 62 incidents and the Black Country reported the highest score of 172 incidents. We were told by senior managers that staff in the Black Country had a positive reporting culture and tended to report all incidents including near misses.
- Between April 2015 and March 2016 1,506 no harm incidents were reported within all five areas.
- We heard that 'local' feedback and learning from incidents was consistent across the service. Staff told us and we saw that having access to the Electronic Patient Record Form (EPRF) they were able to see individual patient outcomes from incidents; staff told us this had improved communication and the culture in incident reporting. Clinical updates and shared learning was available for all the staff.
- We saw that trust newsletters were pinned to noticeboards, intranet notifications were updated and emails were sent to staff on a weekly or monthly basis. We identified that there was no confirmation process in place to ensure that all notifications had been read. Area Support Officers (ASO's) in Coventry and Warwick informed us that they spot checked staff to ensure the updates were being read and changes in practice understood. We saw that specific information about a serious incident, involving defibrillators, had been shared with staff via email and displayed on information notice boards.
- Duty of Candour (DoC) is a legal responsibility of care providers to inform patients' and apologise when an error has occurred in their care causing moderate or significant harm. DoC was undertaken by senior managers and evidence of DoC was seen in RCA's. Staff demonstrated awareness of being open and honest when things went wrong but were unsure of DoC and the process followed.
- Staff in Birmingham gave us examples of when they attended a training session relating to lessons learned from serious incidents (SI), about 'lessons learned' following incidents. They told us they felt supported; the session concentrated on how they could improve on some calls they attend, and how this session was not a 'finger pointing session'. We saw evidence of mandatory training day topics being related to lessons learnt from previous clinical incidents. One session included learning identified from a coroners regulation 28 report. A regulation 28 report, also known as a preventing future deaths report, is sent to people or organisations that are in a position to take action to reduce risks following a death.
- We saw evidence, and staff told us, of a recent SI involving a road traffic collision by West Midlands Ambulance Service staff. Following this immediate action was taken to issue a bulletin to ensure safe vehicle reversing procedures; we saw staff carrying out this 'two person' procedure during our inspection.
- We were told in Shropshire and Coventry and Warwick that where incidents had not caused harm but were a 'near miss' staff would often not report and therefore there was a lack of learning from these. Staff told us that if there was an issue such as equipment failure that did not directly affect a patient they would report it informally by verbally telling the Area Support Officer (ASO). We spoke with area managers and ASO's who were clear that it was the crew members' responsibility to report incidents and that they were encouraged to do so. Managers told us that learning review groups were held to consider incidents and regional changes were made through this process.
- In Shropshire, we saw that poor access to computers at some sites contributed to delays in reporting incidents, and to receiving email updates. Not all staff we spoke to knew how to complete electronic incident forms and told us that they would only report serious incidents to the manager.

Mandatory Training

- The trust organised mandatory training into three separate courses between 2014 and 2016. All staff, qualified and non-qualified, attended the same sessions. Courses included Infection Control & Prevention, Joint Emergency Services Interoperability Programme (JESIP) Emergency Prevention, Preparedness and Response Working Group (EPPR) and Mental Capacity training and a two day course was held for infection prevention and control and safeguarding (Domestic Abuse). The target for compliance for all three courses against those eligible for training was 85%. Birmingham achieved 84%, Black Country achieved 130%, Coventry and Warwick achieved 96%, West Mercia achieved 91.3% and Staffordshire achieved 91%. Corporate staff achieved 100% compliance in all areas.

- We saw that annual training plans were issued to each hub and alerted each member of staff to their dedicated training days and clinical support sessions.
- Managers told us that this annual training plan for each hub supported advanced booking of bank staff to cover the shifts. Training generally took place between March and September as we were told by WMAS trainers that historically this was known as the quieter period.
- Staff we spoke with told us the training had improved over time and was now formally structured, focussed on what was required and staff could ask for specific training and courses to take place in individual hubs. We heard from staff at the Lichfield hub that lunchtime learning had been arranged by the area manager including interactive training with the local hospital consultants and specialist doctors. Staff at Willenhall told us they had attended evening training sessions on subjects such as splint application and bariatric training.
- Training took place in the classroom and through e-learning modules. Where individual staff competencies were required to improve or refresher courses were needed these could be arranged through the training centre. Appropriate staff were available to mentor new staff.
- We saw the 2015-2018 mandatory workbooks that were signed annually through the personal development review.
- Emergency ambulance staff completed a four-week emergency driving training course in a new fleet vehicle to enhance their experience and make the training real. This training allowed them to drive on blue lights in an emergency.
- Student paramedics undertook a 30 month graduate course which was followed by six to eight weeks preceptorship.
- Advanced paramedics completed additional training to enhance their clinical skills, for example wound closure.
- Clinical team mentors completed a five day course at university to enable them to observe and sign off staff competencies as a clinical team mentor (CTM). Staff from Birmingham told us that they received their clinical support day last month and that mentors had observed their driving and patient's assessment. Staff in all hubs told us they had received support from their personal clinical mentor.
- Based at a police and military training centre throughout the UK, National Ambulance Resilience Unit (NARU) trainers responsible for training hundreds of ambulance personnel to respond to a range of urban search and rescue, chemical, biological, radiological and nuclear incidents throughout the UK. Senior managers had either attended or were booked to attend annually. The centre has a range of facilities available on-site with education based upon the integrity of safety critical systems such as standard operating procedures, the competency of staff to perform operational duties and the maintenance quality of educational products that were fit for purpose.

Safeguarding

- Safeguarding training was completed during the induction period for those joining the trust. The training was refreshed for all staff annually in the form of a workbook however, we spoke to staff in Coventry who said they could not remember the last time they had completed any safeguarding training but thought it was longer than 12 months prior to the inspection. Safeguarding mandatory training was provided at level two, in line with national guidance with a target of 85%.
- A single point of contact was available for safeguarding concerns and referrals 24 hours a day seven days a week. Fleet keyrings displayed single point contact numbers; some staff had attached this to their ID badge.
- Staff we spoke with in all areas were aware of the process to raise a safeguarding concern or make a referral and safeguarding policies were in place and up to date. We heard examples of telephone referrals being made to the single point of contact whilst the emergency staff were on the scene. However, since the Electronic Patient Report Form (EPRF) had been in use, the staff were able to report and refer safeguarding directly on the EPRF system.
- Within the reporting period April 2015 to March 2016 there had been a total of 23,173 children and adult safeguarding referrals generated from emergency and urgent care staff.
- Safeguarding referral feedback was consistent throughout Birmingham and the Black Country and staff felt supported when making a referral. We were told feedback was less consistent in other areas, for example Staffordshire and West Mercia.
- All staff showed awareness of Female Genital Mutilation (FGM) and were aware the World Health Organisation

identified four types and showed knowledge and understanding of how to refer to safeguarding if required. Posters were visible to raise awareness of FGM within local communities.

Cleanliness, infection control and hygiene

- We saw consistently high standards of cleanliness and infection control prevention in all of the ambulance hubs and community stations we visited. However, the dirty equipment/sluice area of Eddington was visibly dirty under the sink area and floors were soiled. At Eddington and Hollymoor, cleaning chemicals including chlorine based chemicals, glass cleaner and bactericidal chemicals were stored openly on a counter top in breach of COSSH regulations.
- Displayed records showed that toilet and shower facilities were cleaned daily; these records also showed that water sources had been run for 30 seconds at least every week as part of the Legionella risk management process.
- A private cleaning company was contracted to provide general cleaning duties at each hub. Managers told us that they observed that the cleaning check lists had been completed; if they found work to be substandard they contacted the company.
- Different coloured mops and buckets were available for different areas; advice as to which mop should be used in which area was prominently displayed at hubs.
- It was the ambulance crew responsibility to ensure the front of the vehicle was clean and clutter free at the end of each shift. The back of the vehicle cleaning was the responsibility of the ambulance fleet assistants (AFAs); a task manual was available for staff to refer to with cleaning frequency, detailing the required cleaning. AFAs followed a universal packing list.
- The trust had its own 'make ready' teams responsible for deep cleaning ambulances every 28 days. During this deep clean all of the equipment was removed, cleaned and checked. Before and after a vehicle was deep cleaned it was swabbed for micro-organisms such as methicillin-resistant staphylococcus aureus (MRSA) and clostridium difficile (C Diff).
- AFAs told us that when a vehicle became heavily contaminated, or had transported a patient with an infectious disease or condition, the staff would return to the nearest hub to allow the vehicle to be deep cleaned appropriately.
- The ambulance hubs had areas designated for vehicle and equipment cleaning, drying areas and storage of clean items. We saw that cleaning chemicals and equipment were stored safely on each station and locked away when not in use.
- Sterile equipment required on the vehicle and in kit bags was stored and packaged appropriately. We observed staff using disinfectant wipes to clean the vehicle and some equipment between uses.
- We observed ambulance staff adhering to the principles of 'bare below the elbow' as a way of minimizing the spread of infection.
- 50 hand hygiene audits were completed in each division each quarter. At least 20 of these were completed in each division as 'point of care' audits by Clinical Team Mentors. 'At hospital' audits were also completed as the member of staff enters and passes through the Accident and Emergency department. The elements assessed followed the 'Five Moments of Hand Hygiene', with observations of use of alcohol hand sanitiser, glove use, appropriate moments for hand hygiene such as after cleaning tasks and hand washing process, including removal of wrist watch. The elements in the audit were scored yes or no to give a score for each observation; the scores were added to give an average score for each division. The scores can be interrogated on the 'Audit system' to reveal trends to allow improvements to be made.
- Between July 2015 and June 2016 overall compliance for quarter one was 91%; there were 305 observations recorded across the region.
- All areas scored above 90% in infection control audits except Birmingham whose compliance was the lowest at 78%. Issues regarding not rolling up sleeves and removing watch, not using Ayliffe technique and not carrying hand sanitiser were noted and an action plan compiled. All four of these basics tasks were being complied with in other areas.
- A concerted effort throughout 2016/17 was recognised to be required to raise the hand hygiene compliance across the region. CTM and Hospital Ambulance Liaison Officer (HALO's) were given the task to ensure they reminded staff regarding point of care and hospital hand hygiene; we observed staff attending to their hand hygiene. A HALO works in partnership with the Emergency Department practitioners to support the effective and efficient management of patient streams,

particularly patient handover and ambulance turnaround times within the department, helping emergency crews to become available earlier to respond to the next incident.

- All vehicles we inspected had very high levels of cleanliness, with deep cleans being conducted every 28 days by the make ready team. Vehicle audits were completed once per quarter; compliance between April 2015 and March 2016 exceeded the trust target of 90%.
- All staff wore visibly clean uniforms, adhered to bare below the elbow principle and carried alcohol gel on their person. Staff told us they were never refused new uniform.
- Staff had access to sufficient supplies of personal protective equipment (PPE) in the form of latex gloves, aprons and sleeve protectors.
- At the Stafford hub we were shown the clinical waste process. We saw that clinical waste was disposed of appropriately in all areas we visited with the correct waste bags being used and labelled.
- We observed a lack of hand washing and using hand gels when staff were between delivering patient care in emergency departments by the Hereford and Worcester hub. Whilst observing staff at a major Birmingham emergency department, we observed 12 crews, of which only three washed their hands after patient contact.
- All staff were observed cleaning equipment including trolleys and tidying the treatment area of ambulances prior to coming available for the next call.
- The majority of staff were bare below the elbow or wore a wrist watch that could be washed easily; we observed several Birmingham staff members wearing fabric bracelets, rings with multiple stones or watches with non-washable straps and one person in Hereford and Worcester team wearing nail polish. This was escalated to senior management during the inspection.

Environment and equipment

- The vast majority of vehicles had identical layouts and equipment storage. This meant that crews from any station could easily access equipment without delay. Equipment including blood pressure cuffs, thermometers and blood glucose monitoring kits were standardised across vehicles which ensured staff knew how to use the equipment during patient treatment.
- A mechanic was available in the hub workshops seven days a week to ensure vehicles were maintained and safe to drive.
- Each vehicle based at community stations were rotated out of service every 24 hours for restocking of equipment and safety checks.
- Notice boards listed all vehicles based at the hubs, their mileage, the service due date and date of its last MOT Test. A colour coding indicated which vehicle was ready to be used using a green sticker. This meant that in an emergency the staff could quickly identify which vehicle was available.
- Staff complained about the use of 4x4 vehicles, and said the lift/ramp on the back is difficult to work and dangerous for staff to manoeuvre off the back of the vehicle. We observed two patients receiving uncomfortable transfer off the vehicle due to the mechanisms of the stretcher being fixed to the vehicle and the ramp. One patient told us the staff were "fantastic," but the vehicle and the transport to the hospital was "terrible."
- Staff told us that if there were any issues with a vehicle the ambulance crew would contact control and completed a vehicle defect form online. These were sent to the risk management team for action. All staff we spoke with said that the vehicles used by the trust were of high standard and any issues rectified quickly.
- In Worcester, we found there was confusion regarding whose responsibility it was to test the defibrillator therapy cable. A defibrillator is a portable electronic device that automatically diagnoses and treats life threatening cardiac arrhythmias through the application of electrical therapy, allowing the heart to re-establish an effective rhythm. This meant that the cable was not being safety checked. We highlighted this confusion to senior trust leaders who advised us it the matter would be cleared up with the Worcester team. All other teams were aware of their responsibility. AFAs checked the medical equipment for service dates and removed them from vehicles for the electrical and biomedical engineers (EBME). We saw that equipment requiring the attention of the EBME was placed in separate sections in a room and marked for repair.
- Medical devices were labelled with the required date of the next service, so AFAs could easily identify equipment due for service whilst undertaking vehicle checks.
- AFAs kept equipment servicing up to date by using a logbook. This logbook enabled the AFAs to log any vehicle defects so that repairs were tracked. Stock cupboards were well organised and secure. We

observed stock cupboards were locked with a code and swipe card facility for extra security. All items were labelled with a description of the item, size and the expiry date including the paediatric-sized items.

- Bariatric vehicles were available with one vehicle available for each region; all staff had been trained to use the specialist vehicle including the equipment.
- We observed staff using the seatbelt in the back of ambulance vehicles to keep secure through their journey.
- We observed staff utilising full restraints for a patient being transported on a stretcher to ensure the patient remained safe. Equipment was available to ensure the safety of paediatric patients during treatment and transport. Each vehicle contained a blood pressure cuff and oxygen saturation probe suitable for paediatric patients. All ambulances contained a suitable harness to allow children to be transported on the ambulance trolley safely; staff we spoke with knew how to use this harness.
- The 'make ready' team were responsible for ensuring that all medical devices had been appropriately tested within the specified time frame to ensure suitability and safety.
- Medical devices and equipment were part of a planned preventative maintenance (PPM) contract; in line with the manufacturer's guidance of frequency for servicing.
- Equipment was managed in line with the trust's medical devices policy which was implemented in November 2014 and for review in November 2017. The database was maintained by the medical devices team who kept a central record to identify the location of all devices and record annual servicing and repairs. This policy included the process for specifying, sourcing, commissioning, maintaining, repairing and decommissioning of all equipment.
- Staff we spoke with knew how to report faulty equipment and provided examples of when they had done so. For example, we were told there had been some issues with defibrillator batteries failing. The 'make ready' team would remove the batteries each day after use, they would be charged up and then a test cycle completed every six weeks. Each vehicle carried a backup battery to be used in the event that one failed.
- All equipment we saw was up to date with testing or in date with its use by label.
- Each hub had a signing in book for visitors and the fire safety procedures explained by a member of staff.
- Each hub had the appropriate fire-fighting equipment and signs to direct staff and visitors to assembly points. Managers told us that they had regular contact with the estates team to ensure fire test records were up to date and that alarms had been checked recently.The Stoke hub showed signs of wear and tear, although it was clean and tidy. We saw plans for the new purpose built hub, which was on track to be opened for relocation in 2017.

Medicines

- There was a strong culture of improving medicine safety with clear governance pathways to ensure any learning was quickly acted upon throughout the trust. In response to the NHS England and Medicines & Healthcare products Regulatory Agency MHRA patient safety alert: Improving medication error incident reporting and learning (March 2014), the trust had appointed a Medicine Safety Officer (MSO). A trust medicine management team also included a trust Pharmacist in order to maximise learning and guide practice to minimise harm from medication errors.
- The trust medicines management team met monthly to discuss all reported medicine incidents for the month and identify any trends for improvement in order to learn from mistakes. Reports from these meetings were presented to the trusts clinical steering group to ensure identified training was reviewed with appropriate action taken. We were shown several examples of action taken from previous reported medicine incidents to improve medicine safety. For example, following two reported medicine errors the use of colour coded medicine labels was introduced to ensure staff administered medicines from labelled syringes only.
- On-going learning about medicines was cascaded to staff in a 'Weekly Briefing' bulletin. For example, in the June 2016 'Weekly Briefing' information was provided by the trust Pharmacist about the correct storage of a medicine used to treat severe low blood sugars in diabetic patients. Further learning was also shared in the 'Clinical Times' newsletter. We saw these displayed on staff room noticeboards. During the inspection, we found that expiry date labels were peeling off some medicine containers. On making the trust aware about this issue a new labelling system was implemented immediately. We saw the new labels in place during this inspection.

- A Medicine Management policy (March 2016) detailed how medicines should be managed throughout the trust. An agreed list of medicines was available which detailed what medicines could be administered by ambulance staff. This included which grades of staff were trained to use each medicine. The trust had up to date Patient Group Directive (PGD's) which are written instructions for the administration of authorised medicines to a group of patients. This meant that medicines were administered to patients by staff with the legal authority to do so. Paramedics also carried a pocket book, the UK Ambulance Services Clinical Practice Guidelines 2016 which provides guidelines on national clinical practice including the correct dose and type of medicine to be used.
- Controlled drugs (as defined in the Misuse of Drugs Regulations 2001 and its amendments) are medicines that should be stored with extra security and recording arrangements in place. Regular checks on controlled drug records ensured any errors could be quickly identified and therefore dealt with immediately. Strong governance arrangements ensured that any problems with controlled drug recording were identified quickly. We found that the trust exceeded best practice guidance for the security and safe management of Controlled Drugs. For example, we were shown how CCTV cameras had been installed in all areas of controlled drug storage which helped to ensure security arrangements.
- The trust had appointed a Controlled Drugs Accountable Officer (CDAO) who regularly attended the Controlled Drugs Local Intelligence Network meetings in order to share information about controlled drugs with the network. They sent quarterly occurrence reports to the networks, detailing any concerns that the trust had regarding its management or use of Controlled Drugs with action points on how they had improved and changed practice. An example of improvement was when reports of ampoules of morphine sulphate breaking had led to an investigation. This found the supplier was putting the ampoules into a pouch the wrong way round causing the tip of the ampoule to snap easily. When discussed with the supplier the packaging was changed leading to a system which had prevented breakages.
- Controlled drug records on ambulances and within designated ambulance stations should be countersigned by a witness. It is recognised that when clinical staff work alone that obtaining a witness every time is not always possible. This is recommended as good practice by NHS Protect in order to ensure a robust audit trail of controlled drugs. Paramedics we spoke with recognised that it was important to obtain a second witness for accurate controlled drug records. The additional use of the CCTV camera supported the checking of controlled drugs. We found that the majority of controlled drug records we looked at were countersigned following trust policy. Regular checks were undertaken to ensure that all controlled drug records were accurate and kept up to date.
- Medicines were stored securely throughout the trust. Only delegated and authorised staff had access to medicine storage rooms.
- Each hub had a dedicated controlled drug (CD) rooms. There were two locked cabinets in each room, one contained CDs that were ready for use by ambulance staff, the other being a store for excess drugs. CD rooms were only accessible to paramedics and they used swipe cards to access the area. When the CD door was left open an alarm would sound to alert staff to the security of this area. CCTV was present within each room that could be viewed by managers on site and also remotely.
- Ambulance staff would remove two packs, one contained morphine and the other diazepam and oral morphine. Staff were required to sign these out at the start of their shift and back in when finished. We reviewed the CD record management to be accurate.
- The daily checks confirmed the pack number, the time out, seal intact, and the vehicle using the drugs, the users name and their Health and Care Professions Council number for identification.
- On the vehicles, controlled drugs were kept in locked cupboards within the locked medicines cupboards. Paramedics kept the keys to the Controlled Drugs cupboard on them at all times and were responsible for those drugs until they hand them back in Controlled Drug cupboard at the main hub.
- We saw evidence that Area Support Officers conducted weekly stock audits and temperature checks which were recorded in separate books and also stored in the CD rooms. Audits were discussed with each area when issues arose; CCTV footage was checked when errors had been made as a learning process.
- In Worcester, we saw evidence of several incidents where there was a missing return pack of controlled dugs. In line with the trusts policy these should have

been reported incidents however the ASO informed us this would only be done if drugs were found to be missing. Incidents in isolation may not require further investigation but it is good practice that these should be recorded and stored for future review and observe for trends. We also saw evidence that Prescription only Medicines (POM's) were often not signed in and out correctly by staff. For example, at one of the Worcester hubs we visited we counted 56 recording errors between the 13 April and 29 June 2016. We found that none of the discrepancies highlighted in the medicine management register had been reported as incidents. We spoke to the ASO of the Hub who confirmed that such discrepancies should be reported and that they would treat this discrepancy as a priority for remedial action. The AFA and paramedics were unsure as to who was responsible for reporting discrepancies as incidents. In one hub, we saw evidence of weekly audits being carried out on POMs by the AFA supervisor, however no evidence that the discrepancies were escalated or reported as an incident. We also found POM's misplaced in the wrong labelled boxes; with no evidence of audits being carried out this increased the risk of errors occurring. We saw the records of the online monthly checks which appeared to be well managed and included details of any non-compliance and the action taken.

- Medical gases were stored safely, securely and in line with guidance across all hubs. We saw signs to alert staff and visitors to the flammable nature of the gases.
- Medical gases were stored in appropriate fittings within all vehicles to ensure they were secure.
- Patients were informed about the medication being given; this was documented in the electronic patient record and discussed in handover to the hospital staff.

Records

- WMAS had two forms of patient report forms (PRFs); an electronic version (EPRF) and paper (PRF). The format of the forms followed Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidance.
- A copy of the PRF was provided to the receiving hospital and a copy retained by the ambulance crew. If a patient was treated and discharged at the scene or at home, a copy of the paper PRF was left with the patient. If the crew used an EPRF it was not possible to leave a paper copy but a discharge form was provided to the patient with post incident advice provided and a space to record if an appointment had been made with another health care provider, for example the patients GP.
- We reviewed over 100 sets of patient records all of which were clear, legible and had detailed information including the presenting condition, patient details and treatment provided.
- The EPRF enabled staff to document all clinical interactions including electrocardiogram (ECG) medications, patient's past and recent medical history as standard. This EPRF was able to connect to the A&E department prior to the patient arriving to A&E to inform the Doctors and Nurses about the patients. Staff told us that using EPRF allowed them to capture data and it was easy to collect data, share information and manage clinical audits.
- The trust was in the final transition stages of changing from paper to electronic patient records forms. In Worcester, we asked to see three patient records in paper versions those we requested were unable to be found and were therefore missing. Paper records were securely stored at the hubs in containers and could only be accessed by designated members of staff.
- Patients were assessed and their care planned against national guidance, including the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) which provides clinical specialty advice to ambulance services. Staff could refer to the JRCALC assessment and triage guidance. We saw staff checked patients vital signs such as respiration and pulse rates, blood pressure, heart rate monitoring and the patient's condition was recorded on the PRF or EPRF. Any changes or deterioration in a patient's condition informed the clinical decision-making process and urgency of the situation.
- Each hub had confidential waste bins to allow staff to dispose of any patient identifiable information that had been collected during treatment.
- When staff in the emergency operations centres (EOC) had access to information, such as end of life care or a patient's preference regarding 'do not attempt cardio pulmonary resuscitation' decisions (DNACPRs), they would alert ambulance crews to this information. When EOC were not aware of such information, front line staff demonstrated a clear understanding of how to respond

to end of life care should they be presented with or told of a DNACPR decision. Staff were aware that original copies of DNACPRs should travel with the patient to hospital or their destination.

- We saw that some patients had special notes attached to their record. Special notes were electronic, available to EOC staff and contained information relevant to the patient. These were shared with ambulance crews when available.
- Staff we spoke to at receiving hospitals told us that ambulance crew always handed over patient information to clinical staff. We observed handovers where ambulance staff handed over to hospital staff and the level of information was appropriate.
- In community stations, patients' records were stored securely in a room locked with key code access and were collected by ASO's and transported back to the hubs on a regular basis.

Assessing and responding to patient risk

- Staff in the emergency operations centres used NHS pathways to assess and prioritise emergency calls. NHS pathways prioritised and coded calls based on responses to questions asked by emergency medical dispatchers (EMD) in the operation centres. The priority, or coding of the call, determined the risk to the patient and therefore the type of ambulance crew sent by dispatchers to the patient.
- The service had clear pathways for ambulance crews to follow when responding to life threatening conditions such as cardiac arrest. There was a system in place for staff to seek clinical advice by means of a central clinical support desk (CSD). This desk was manned by qualified paramedics who had additional clinical training, they provided telephone advice and also could direct ambulance crews to appropriate pathways and hospital alternatives. All staff we spoke with told us they may also contact the on duty ASO or Clinical Support Mentor for advice.
- Ambulance staff told us if they could not manage a critically unwell patient, they could ask for support from another crew or a specialist resource such as the air ambulance or the medical emergency response intervention team (MERIT). The purpose of MERIT is to provide advanced medical care on scene at a range of emergency incidents, up to and including major and mass casualty incidents. This could include provision of advanced airway procedures, surgical interventions and critical care over and above current levels of ambulance clinical practice. MERIT also provided advice and support to emergency services staff already on scene.
- During our observations, we saw appropriate manual handling techniques used for the transfer of all patients. This ensured that staff and patient safety was well maintained and injuries were avoided.
- In Birmingham, we saw staff with excellent understanding of the sepsis marker and the need to be proactive and responding to patient risk. Sepsis markers include patient checks to assess the patient's risk of sepsis and any deterioration in their condition.
- The trust had policies and procedures in place to manage disturbed or unacceptable behaviour from members of the public; this included protecting staff who were lone workers. If acts of violence or aggression had occurred whilst ambulance staff were treating a patient this would be documented and a flagging note placed on the system to inform future staff of these actions.
- Birmingham hub delivered a Friday night and Saturday night additional service in the city centre called City Centre Treatment Unit. This unit allowed people to access the service when appropriate and avoided their attendance at the local ED.
- Staff felt that Community First Responders (CFR) eased the workload and supported the ambulance crew to manage their calls and targets when receiving support from CFR's especially in the rural areas.
- We observed the handover of patients to the care of the emergency departments in acute hospitals. Handovers included relevant brief details of the patient's medical history, current medicines, known allergies, present condition and details of observations. Vital signs such as respiration and pulse rates, blood pressure, heart rate monitoring and the patient's condition were recorded on the paper or electronic Patient Report Form (PRF).
- Staff told us that the trust dealt with any identified risks to staff immediately.
- Ambulance staff in the Coventry and Warwickshire area told us that if they were exceeding target times for handover to hospital staff the HALO would push for them to conclude the necessary work. Staff told us that at times this process felt rushed especially where there was detailed information to handover or the vehicle required considerable cleaning or preparation

- Staff told us that at times there were delays at acute hospitals for patients to be admitted and ambulance staff to be able to handover and leave. During our inspection within the Coventry and Warwickshire area we did not see any delays and the handover was efficient. Staff told us that HALO worked well to manage and divert vehicles when necessary.
- We observed a comprehensive verbal and electronic handovers between crews and hospital staff. The handovers carried out at hospital sites were performed thoroughly and professionally to relevant nursing staff. All handovers and post-handover process were completed within the 15 minute time scale.

Staffing

- Staffing numbers and skill mix in the divisions were monitored on a daily basis to ensure the quality of the service provided and to mitigate the risk to patients. Online scheduling and a forecasting system ensured appropriate levels of staffing were available for busier periods. 2,500 front line staff with the support of 1000 volunteers / community first responders maintained a safe service. No vacancies and a low staff turnover were reported.
- Staff we spoke with felt there was an appropriate number of qualified staff within their area.
- To allow funding for more paramedics, emergency care assistants were being phased out within the service. The trust was on target to have a paramedic on every emergency vehicle by December 2016.
- Frontline staff had phased start times to their 10 or 12-hour shift with lunch breaks between 30 to 45 minutes. At the time of report staff were encouraged to return to their hub to have their lunch break, however during our inspection staff told us that this was in the process to change and that the frontline staff were to have a lunch break at a nearest response point or community ambulance station (CAS). Staff were uncertain about this as this meant they would have to carry their meals with them. At the Staffordshire hubs we saw chilled drink flasks being handed out and we were told that chilled food bags were on order.
- Staff had access to area support officer (ASO) who they could contact 24 hours a day seven days a week if they needed support.
- When we asked staff about the sickness policy we received mixed opinions. Some crew members said staff that had regular sickness or patterns of sickness were now managed well and apparent problems were addressed. Other staff went on to say they were aware of the 14 days sickness per annum before a stage of the sickness policy was triggered One crew member said they had taken 12 days absent due to sickness and were frightened to be absent again in case it resulted in being on a 'stage' sickness. Many staff we spoke with told us the sickness policy was 'harsh but fair'. Staff told us an informal warning was triggered by a Bradford score of 16 which they felt stopped staff taking odd days of sickness and ensured there were enough staff at work.
- Area managers told us that staff received a daily welfare call depending on the reason for their absence. One example given was where they would contact a staff member if they were absent with short absent sickness only and they would contact staff absent from work on long term basis each week. We heard examples where an absence was due to musculoskeletal issues and physiotherapy was offered to staff. For stress related issues, referral to occupational health or counselling was considered for staff.
- We spoke with one paramedic in Shropshire who was on a return to work programme who said that they had been well supported by their line manager and the phased return to normal duties suited their personal circumstances.
- The trust supported both internal and external student paramedic courses. This meant crews usually consisted of a student paramedic and a paramedic or technician. Student paramedics were qualified as technicians whilst working as part of a crew. In some areas, retention of student paramedics once qualified was problematic; most managers felt this related to staff returning to other areas to be near families. All student paramedics we spoke with that intended to leave the service once they qualified as paramedics confirmed this was the reason for leaving.
- WMAS was supported to respond to acutely unwell patients within target response times, by utilising approximately 592 trained community first responders (CFRs). These were volunteers who were trained to attend emergency calls and provided basic care until the ambulance arrived.
- Staff either worked on an annualised or a managed basis. Managed rotas meant that staff managed their own annual leave. With annualised rotas annual leave was built in and these rotas meant that staff could see their shifts in advanced over a long period. Staff we

spoke with felt happy with whichever rota they were on, and that managers supported them with shifts. Those on annualised rotas could not request days off unless they swapped a shift with another member of staff. There was a robust process in place for managing this, with ownership on staff to arrange and inform managers. There was a right for managers to refuse if it left skill mix problems, but overall staff felt this was fairly accepted or declined.

- We were told and saw that many staff finished their shift late due to giving patient care. Data from the trust showed monthly additional hours worked because of late shift finishes were 8382 in March 2016 and 7147 in April 2016.
- Staff told us on occasions they also missed their assigned meal breaks because of high numbers of emergency calls. In March 2016, 54% (9,652 occasions) of staff missed their meal breaks and in April 2016 27% (7,274 occasions) of staff missed their meal breaks. Staff were offered overtime payment or time off in lieu.
- All managers told us that, whilst they manage with the existing number of ASOs, CTMs and AFAs, each hub would benefit from further support in these staff groups to enable efficiency and improved staff contact.
- Managers told us they encouraged all technicians and emergency care assistants (ECAs) to progress onto a paramedic training course. This kept the skill level of the workforce high.
- Where there were vacant shifts identified, this was covered with regular staff completing overtime or bank shifts. Managers told us the uptake of these shifts was good and were generally well covered. In Shropshire, we saw that a pool of relief staff worked every weekend. Staff told us that the rotas were set, however managers tried to be as flexible as possible to meet the needs of individuals and ensure a work/life balance.
- Area support officers (ASO's) in Shropshire told us that the role was particularly difficult due to the large geographical area that needs covering. They dealt with day-to-day operational issues that include staff shortages and any dynamic risk assessments to issues raised by the crews.

Anticipated resource and capacity risks

- There was a robust escalation process in place for deteriorating serious ill patients; this involved a message relayed in advance by the control room operator direct to the Emergency Department staff.
- We saw paramedic crew obtained specialist clinical advice when needed by contacting the clinical support desk or telemed supported by paramedics.
- Handover in hospitals occurred at a dedicated rapid assessment and treatment bay, we saw mix of different practice with ED and ambulance crew when handing over patients. Some staff handed the patient to the HALO's (Hospital Ambulance Liaison Officer) based in hospital ED who then took responsibility of the patient until a triage nurse in ED was available; other staff handed over their patients directly to the ED triage nurse. We saw and heard mixed thoughts about how effective this handover procedure was.
- Staff had access to the out of hours local triage GP for advice and information on patients condition as a preventative solution if a patient was not required to be conveyed.
- There was a mechanism in place to assess and manage risks when transporting patients and all staff received training about the Mental Health Act and received additional information from external agencies such as the police and social services.
- A global resourcing tool was used to compile a 'peak of day' analysis which mapped rota requirement in combination with the recording of dropped shifts. Staff had four to six weeks' notice of their rotas; some staff had blocked annual leave or had flexible rotas to work around the staff capacity and gaps in the service. When staff had a short notice shift change a small financial increment was paid .
- Business continuity management identifies and mitigates risks and disruptions that could affect the performance of an organisation. The trust had a comprehensive business continuity plan in place; we also saw how each hub had tailored this to make it relevant where applicable. For example, this included lock down processes, when all areas of the hub were locked simultaneously. Staff we spoke with knew contingency plans were available for issues such as loss of electricity/water, computer systems failing and extreme weather conditions.

Response to major incidents

- A major incident is any emergency that requires the implementation of special arrangements by one or all of the emergency services and will generally include the involvement, either directly or indirectly, of large numbers of people.

Emergency and urgent care services

- All of the staff we spoke with told us they had either received training or were booked in to participate in response to major incident training and that this was part of the mandatory training programme.
- All managers we spoke with had attended a level of national ambulance resilience unit training appropriate to the role they would play in a major incident. ASOs received training to bronze level; AAMs and AMs received training to silver level. All managers knew the escalation process and what actions would be required should a major incident be declared. All managers we spoke with had attended a major incident practice with the fire and police service, they felt these were useful to establish good multiagency relationships and working practices.
- Each manager's car and all emergency vehicles contained action cards and patient priority tags and it was the responsibility of the 'make ready' team to place these on each vehicle.
- Major incident vehicles were available and easily accessed within each area in an event of a major incident.
- Escalation plans were in place in each area for Emergency and Urgent care teams with other providers. These included local acute hospitals, NHS England and agreed health care providers.
- HALO's told us they would contact the emergency control desk should a major incident occur including gaining advice and support from the clinical advice desk and logistics desks.
- A new handbook had been issued for chemical, biological, radiological and nuclear (CBRN) hazards; however, we heard that no additional training had been completed for at least two years.
- Shropshire staff described the procedure for a major incident and understood the different levels of command. Paramedics told us refresher training would be useful in the area because major incidents occurred less than in urban areas.

Are emergency and urgent care services effective?

(for example, treatment is effective)

Outstanding ☆

We rated the effectiveness of emergency and urgent care services as outstanding because:

- WMAS were consistently meeting national response times and performing above the England average.
- Within all the hubs we visited there were established pathways in place for patients suffering a stroke, heart attack or major trauma, and patients were transported to the most appropriate place to receive emergency care.
- Outcomes for people who used the service were routinely better than expected and consistent high performance throughout the service was demonstrated by robust benchmarking.
- We saw patients suffering a myocardial infarction received an appropriate care bundle and compliance with this was above the England average.
- We saw suspected stroke patients were assessed face to face and received an appropriate care bundle and these numbers were in line with the England average.
- There was a strong commitment to developing skills, competence and knowledge of all staff. Staff were encouraged and supported by their managers to acquire new skills and share best practice.
- There were a wide range of training opportunities for staff with a focus on student development and staff who wished to become a paramedic.
- Staff received regular Clinical Supervision and had yearly appraisals with their manager.
- Clinical audits were regularly recorded and current clinical guidelines were implemented in a timely manner.
- Staff demonstrated a thorough understanding of the need to gain full consent prior to any treatment or interventions.
- Approaches to pain relief were consistent and solely patient focussed.

- Projects were in place to reduce unnecessary calls to the ambulance service, and reduce calls from high volume service users by using a multidisciplinary approach.
- There was an active participation in peer review and accreditation schemes and a recognised high achievement by credible bodies.
- We observed excellent multi-disciplinary Team (MDT) working with external services such as police and fire service.

Evidence-based care and treatment

- All clinical staff carried a pocket size copy of the Joint Royal Colleges Ambulance Liaison Committee guidelines (JRCALC) and utilised this when assessing and documenting patient care. We saw evidence of staff following this guidance during our observations such as administration of analgesia. Staff we spoke with were also aware of the National Institute of Clinical and Healthcare Excellence (NICE) guidelines and how this related to their practice and care of patients
- Paramedics we spoke with in Birmingham and the Black Country felt that the trust were up-to- date with evidence based practice and gave us an example of the adrenaline trial that WMAS were currently running. The adrenaline trial involved half of the paramedics being issued with pre-filled syringes of water, the other half being issued with pre-filled syringes of adrenaline. The objective was to understand if adrenaline improved cardiac arrest outcomes in pre hospital cardiac arrest. This trial was currently running in the Black Country, Birmingham, Coventry & Warwickshire, Bromsgrove and Worcester areas. The trial was funded by the National Institute for Health Research and was being co-ordinated by the University of Warwick.
- Clinical updates were sent to ambulance staff via email and displayed on stations notice boards. We saw these present in all hubs and they were easily accessible. Whilst there was no audit trail in place to ensure all staff had read these, all managers were aware of the limitations of communication via email/notices and were discussing ways to document which staff had read and understood information. Clinical Team Mentors (CTM) discussed any clinical updates with staff during their supervision.
- The trust was a partner in a mental health team led by West Midlands Police promoting national guidance. We heard many examples whereby the jointly agreed process worked well with the police, maintaining a safe and secure system of transportation for patients who had been detained under section 136 of the Mental Health Act 1983.
- During education sessions we observed staff in the Black Country Team discussing and critically analysing evidence based practice. Following discussions, the guidance used by the service was discussed with staff by the educational training officer to ensure they understood why it was important to following guidance and which areas were relevant to ambulance staff practice. We saw open discussion relating to newly published articles, and this was encouraged to facilitate learning. Staff in the Coventry and Warwickshire area told us that they often would telephone patient's GP to discuss the patients presenting complaints, however, there was no formalised pathway in place for this and so there was a reliance on the 'local knowledge' of the ambulance crew. Likewise, there was a walk in centre service in Coventry that ambulance crews referred patients to, however, there were no formalised pathways in place and no current work being completed to develop this.
- Local Key Performance Indicator (KPI's) information was gathered locally at each hub. There were KPI's for a range of clinical presentations, including asthma, limb fractures and chest pain relating to whether national guidance and evidence based care was followed. Birmingham and Black Country had the highest percentage of compliance within WMAS in each KPI. Where other hubs were underperforming in KPI's this was visible on noticeboards or televisions screens with actions put in place to remind staff of the importance of providing best patient care and documenting clearly when this had taken place.
- In West Mercia, staff we spoke to were not aware of the 'Non Transport and Referral' policy. This policy stated 'all non-transported patients must be left with a copy of the PRF and/or a copy of the trusts' conveyance advice leaflet'. Staff told us these were not given to patients.

Assessment and planning of care

- There were established pathways in place for patients who had experienced a stroke or a heart attack. The stroke care pathway involved the transfer of patients to a specialist acute unit, for rapid assessment and

intervention. For those patients who had experienced a heart attack, a pathway was in place to transport them to an acute unit that could provide percutaneous coronary intervention, (specialist heart procedure).

- We observed ambulance crews following a thorough assessment process and documenting their finding. The staff we spoke with demonstrated a clear understanding of the use of alternative care pathways. However, it had been recognised that arranging alternative pathways was challenging owing to the number of organisations involved across geographical areas.
- Ambulance crews treated a number of patients at home or on scene without the need to convey them to hospital for further care. This was known as 'see and treat'. The Trust had a non- transfer and referral policy to support staff to 'see and treat' without transporting them to an acute hospital.
- We observed staff within all areas were using the assessment process whilst documenting their finding on the Electronic Patient Record Form (EPRF). We saw staff were confident in using the available pathways and support including the use of telemed, District Nurses and GP's. Clinical advice was sourced from the clinical support desk in the Emergency Operational Centre (EOC) and senior paramedics when necessary.
- Staff told us guidance was available from the clinical support desk, however staff would often draw from their own experience and contact other services directly rather than use this provision. For example, if staff were considering referring patients to the local intermediate care team they would contact the team directly rather than gain advice about this from the clinical support desk.
- Ambulance staff within Coventry and Warwickshire told us that they had frustrations about many inappropriate calls that they attended and felt that 111 services was not working effectively alongside the ambulance service.
- The major trauma network was utilised regularly by ambulance staff; staff in Staffordshire told us they had close links with their nearest receiving unit.
- In Coventry and Warwickshire we observed a patient being conveyed to hospital because of a suspected ectopic pregnancy. The patient was taken directly to the gynaecology department, which is in line with the trust's guidance.
- In the Black Country there had been innovative projects conducted involving and ensuring the right clinician saw the patient. Attempts were made to treat the patient in their own home avoiding hospital admission, especially for elderly and frail patients who would not benefit from a prolonged stay in hospital.
- We saw collaborative pathways to reduce attendances to Accident and Emergency (A&E), providing further care for patients in their own homes/community. These pathways included access to a rapid response team, a falls team and a diabetic nursing home pathway which was run in partnership with community diabetic services.
- In Birmingham and the Black Country, crews had access to palliative care advice helpline. This was a service provided by local hospices and offered end of life care advice to ambulance crews to ensure the most appropriate care was provided to the patient.
- Procedures were in place for dealing with High Volume Service Users (HVSU). These are individuals who are aged 18 or over and have made five or more emergency calls related to individual episodes of care in one month, or twelve or more calls in three months.
- Several areas had implemented innovative and effective ways to manage HVSU; one (HALO) had developed the implementation of a training course to care homes that met the HVSU criteria. By training care home staff to an advance first aid level this reduced unnecessary ambulance call outs and was beneficial to patients as staff could provide immediate support to injured or unwell patients.
- In the area of the Black Country, a member of staff had been seconded to a role to manage HVSU locally. This individual facilitated full multiagency working, with GP's, police and mental health services, to effectively manage inappropriate calls to the ambulance service. In Shropshire and West Mercia, staff told us of their frustration in responding to 'frequent callers'. Staff in this area informed us there were not aware of any policies and procedures in place for dealing with these callers.
- Staff in West Mercia told us that out-of-hours support was often not always accessible. For example, there was no out-of-hours mental health support and staff said they could sometimes not get in touch with the out-of-hours GP service. Patients with mental health problems were conveyed to ED and staff said if they needed additional advice they could contact the clinical support desk.

Emergency and urgent care services

Response times

- Calls were categorised according to urgency and response targets were aligned accordingly, for example category Red 1 meant that there was an immediate life threatening, time critical condition requiring a response in eight minutes or less. Category Red 2 meant that there was a life threatening but less time critical condition requiring a response in eight minutes or less. Category A19 meant that there was a life threatening condition but required a response within 19 minutes. All NHS ambulance services must respond to 75% of Category A/Red emergency calls (immediately life threatening) within 8 minutes and 95% within 19 minutes of an ambulance being requested by the clinician on scene.
- To ensure patients of the West Midlands receive quality care from their Ambulance Service a set of key performance indicators and ambulance quality indicators have been set nationally. West Midlands Ambulance service is currently the highest target performer and has reached its target over the last 12 months for response times, with Red 1 at 78.5%, Red 2 at 75.1% and A19 at 97.2%.
- However, local performance data for emergency calls that were immediately life threatening were logged as Red 1. These showed variation across areas. Birmingham were at 83.5%; Black Country at 81.8%; Coventry and Warwickshire 72.3%; West Mercia 69.8% and Staffordshire at 68.0%.
- The trust had recently embarked on the Ambulance Response Project (ARP), which focussed not just on time from call to arrival of first resource on scene, but also on time from call to a resource that could transport the patient arriving at scene. This aimed to minimise the amount of time patients had to wait for definite care or treatment. We saw that staff had a clear understanding of the project and had been involved in the changes to facilitate it.
- In the Staffordshire region, unplanned delays at acute hospital in accident and emergency departments had at times reduced capacity of front line staff to handover the patient and prepare for the next call. Paramedics were required to stay with their patients to deliver care and support until they handed the patient over to hospital staff, the HALO when able would accept the patient to allow seamless process for the patients.
- During our inspection we visited a local A&E department unannounced, we spoke with a HALO from the Birmingham area and they told us that they will only receive patients from the paramedics that are stable or patients that the crew have no concerns about them deteriorating. We asked what would happen if it was a very busy day and crew brought in more patients that meant the HALO could be dealing with several patients. We were told they would escalate it within the department and if the HALO had more than three patients they would inform the A&E staff.
- We spoke with Birmingham paramedics and they said they do have issues at their local A&E due to the space at the department, and it normally experienced high demand.
- All staff we spoke with told us they generally felt the target response times were achievable and the only reason they would not meet some targets would be as a result of the wide geographical area. We saw these figures were being monitored internally, however more work was required to achieve the set targets so that people living in rural areas were not continually disadvantaged. For example, we observed the ambulance crew respond to a call in Rugby whilst they were in Coventry the journey time between the two areas was 35 minutes.
- We were told by staff that the area had a high numbers of Community First Responders (CFR's) who are volunteers living across the region. The CFR's were available to respond to a request and would assist patients prior to an ambulance attending to treat them further.

Pain relief

- Patients we spoke with during our inspection told us they felt the ambulance staff did everything they could to relieve their pain, and felt they were provided with adequate pain relief.
- We reviewed patient records forms (PRF) that showed patients were given pain relief appropriately in accordance with the NICE guidelines. We saw in the PRF's that patients were informed about the medicines and their side effect prior to administration of medications.
- We observed many staff were assessing patients for pain appropriately and relief was provided in accordance with the NICE guidance. We saw good examples of staff adapting pain relief to suit each patient, starting with

the most risk free medication and working up to morphine if the patient required it. Pain was reassessed at regular intervals by clinicians. Patients were also informed about their medications and side effects.

- Pain scoring and pain relief administration took place routinely and in a timely manner. For adults, staff asked patients to rate their pain on a numerical basis, ranging from zero to ten. For children and adults who were not able to verbally communicate they used the FLACC score system (Face, Legs, Activity, Cry, Consolability) and where necessary, crews could use pictorial representation of pained faces for patients to point at. In Staffordshire, we saw some staff using colour coded flash cards as another way of communicating.
- Allergies were checked consistently prior to administration of pain relief. The use of Entonox, paracetamol and ibuprofen was observed. The Trust provided paramedics with a wide range of pain relief including intravenous paracetamol, oral morphine and intravenous morphine.
- The trust policy was for two vials of morphine to be collected and held on the vehicle at the start of each shift. However, in Coventry and Warwickshire some staff felt that two vials was not always sufficient stock. Staff were working in line with the trust policy but felt this was inadequate amounts of morphine vials and were therefore were reliant on other types of pain relief. On a few occasions, the crews ran out of morphine vials and opted for oral morphine, which takes longer to release the patient's pain. Staff also gave us an example when they attended to a patient and no pain relief was available. They had to wait for more crews to attend with a pain relief. Crews had support from senior members for this decision-making.

Patient outcomes

- Following a cardiac arrest, the Return of Spontaneous Circulation (ROSC) (return of a pulse rate) is a main objective for all out-of-hospital cardiac arrests, and can be achieved through immediate and effective treatment at the scene. Birmingham performance for ROSC was 28.6%, Black Country 30.1%, Coventry and Warwickshire 32.4%, West Mercia 30.41% and Staffordshire 30.8% compared to the England average of 30%.
- 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 cardiac arrest was not witnessed and the patient may have gone into arrest several hours before the 999 call. The trust was below 45% in January 2016 for using the Utstein comparator group against the England average of 45%.
- The trust routinely collected and monitored information about patient's care and treatment and produced these as Ambulance Clinical Quality Indicators (ACQI). These measured the overall quality of care and outcomes for patients following treatment. Results for the Stroke care bundle locally for April 2015 to March 2016 were Birmingham 97.3%, Black Country 97.9%, Coventry and Warwickshire 95.3%, Staffordshire 95.5% and overall WMAS results were 96.7% Trusts National Average was 59.2% highest being 60.7%
- The result for STEMI care bundle compliance within each region was Birmingham 71.1%, Black Country 82.9%, Coventry and Warwickshire 73.4%, West Mercia 80.79%, Staffordshire 81.1%. Trust National Average was 77.8% Highest being 88%
- The audit team developed reports and snapshots of performance, publishing documents they called 'audit on page' with the summaries of the audits completed along with the outcomes and this was displayed on notice boards and on the intranet for all staff to see.
- All regions carried out internal audits for areas such as hand hygiene and cannulation. Clinical team mentors in each division observed cannulations and recorded a minimum of 20 in each area as an audit. The audit included visual assessment of correct and safe preparation of the site, and insertion using aseptic non? touch technique. The elements in the audit were scored yes or no to give a score for each individual observation and the scores were then added. For cannulation overall YTD compliance for WMAS was 93%, below the trust target of 95%.
- We saw evidence of a trust wide audit of 'discharge of paediatric asthma patients'. The aim was to identify if paediatric asthma patients that are discharged on scene by WMAS clinicians are clinically safe and within national guidance. Results of clinical audit standards out of 109 patients they achieved above 60% in all cases raging from moderate to life threatening asthma attack with only 6% discharged on scene appropriately and within national guidance.
- The results of this audit led to changes in practice, such as all patients had their initial respiratory and pulse rates documented along with a saturations reading.

97% of patients had a documented respiratory and pulse rate along with a saturations reading prior to discharge. 100% of all cases where refusal for transport by the patient or carer is made have a signature on the patient report form; A re-audit is due in November 2016.

Competent staff

- Paramedics were shown to be registered; Paramedics are required to re-register with the Health and Care Professional Council (HCPC) every two years. They are required to undertake continuous professional development (CPD) and receive clinical supervision. Individual appraisal and supervision in all areas were on target to be 100% for the 12 months period.
- Area support officers or assistant area managers were responsible for conducting an appraisal with each member of staff on their hub. We saw the documentation that was completed, and also discussed the content of appraisals with staff. The majority of staff felt their appraisal was productive, meaningful and allowed them to discuss concerns or progression wishes with their manager. Some staff in the Staffordshire area felt it was more of a tick-box exercise.
- An annual plan was developed to evidence relevant courses and updates to be attended, ensuring personal targets were achieved in a timely way, which were supported by their manager.
- Leadership training courses were available within the trusts for all managers to attended, to improve their understanding of leading and developing staff. Managers we spoke with told us they were supported to attend these leadership programmes and these were tailored to the level of the manager. Managers told us these were extremely beneficial and aided them in leading staff and encourage good working relationships.
- The trust organised its training into three separate courses in 2014-2016. All staff, qualified and non-qualified, attended the same sessions. Corporate staff were separate and achieved 100% compliance in all areas.
- In 2014/15 infection control and prevention (IPC), Safeguarding (domestic abuse) was run as a two day course with a target for compliance against those eligible for training being 85%, the trust achieved 100% compliance. The day two target for compliance against those eligible for training was 85% and the trust achieved 91.3%. The 2015/16 target for compliance against those eligible for training was 85% and the trust achieved 95.5% for the day one training session which covered IPC, Joint Emergency Services Interoperability Programme (JESIP) and mental capacity training.
- Some staff in the Staffordshire and Shropshire area felt there was a lack of career progression opportunities. Career progression in some areas could involve the person moving out of their local area to gain promotion or enhance their experience.
- We spoke with a student paramedic that had progressed from patient transport onto the training scheme and they told us they were supported to develop and learn throughout the programme.
- In each area, all members of the clinical staff had an allocated CTM. Staff were provided with a one day clinical supervision, support by a CTM and two days of mandatory and statutory training. All staff we spoke with told us they knew how to access their named CTM to seek clinical advice and they were displayed on the staff employee notice board with a staff photo to identify staff.
- We were told by a CTM in the Shropshire area that supervision was difficult to complete because they were being used as part of the crew and were unable to observe paramedics fully, however this was in line with trust policy.
- In Coventry and Warwickshire, CTM's supervised each staff member for one day a year and were also available for additional support throughout and staff spoke highly of this support. However, a CTM informed us that as three out of five working days were filled by the 'acting up' role as ASO's where required and this was very difficult to complete the supervisory responsibilities.
- We spoke with an Emergency Care Practitioner (ECP) in Coventry and Warwickshire who felt that they would benefit from more than two days of EUC mandatory training per year. They also said their extended competencies were not being checked regularly. When we asked about the frequency of these checks the last staff recalled was three years ago' we escalated this to the senior management team who assured us this would be looked into as a priority. ASO told us in all areas during our inspection that many staff in each region had completed dementia awareness training and as a result there were now 'dementia friend' staff available.

- We spoke with trainee technicians who informed us that they had found all of the staff helpful during their training period and they felt there were a lot of opportunities for further training and progression within the trust.
- In the Black Country we attended a training day being carried out by an educational training officer (ETO) with 11 staff in attendance. During this session a topic was presented as a learning point from a regulation 28 report. The Coroner has a legal power and dutyto write a report following an inquest if it appears there is a risk of other deaths occurring in similar circumstances. This is known as a 'report under regulation 28' or a Preventing Future Deaths report because the power comes fromregulation 28 of the Coroners (Inquests) Regulations 2013. The report is sent to trusts who are in a position to take action to reduce this risk. They then must reply within 56 days to say what action they plan to take
- The ETO discussed where learning points had been identified and also presented a variety of evidence based guidance for the group to discuss. Open and challenging discussions relating to the learning points were encouraged by the trainer and the group were engaged with the ETO at all times. Key points, areas of clinical importance and patient safety were emphasised to ensure staff understood their responsibilities in preventing any patient harm/deaths occurring.
- Paramedics we spoke with across all areas told us managers supported them to attend training sessions and external courses and the trust assisted with funding and would attempt to arrange shift cover for the member of staff.
- We spoke with staff in Birmingham and the Black Country who were on light duties due to being pregnant and were soon taking maternity leave. All those we spoke with told us they would be supported on their return to ensure their clinical skills were up to date. Staff returning from maternity leave were provided with keeping in touch days; these allowed staff to come and observe with no clinical responsibility to phase them back into their roles.
- Staff were able to access their work email from their personal mobiles which helped them access new information or send emails to colleagues asking for assistance on certain topic this was password controlled.

Coordination with other providers

- WMAS was part of the national memorandum of understanding concerning the provision of mutual aid. This is a framework through which NHS Ambulance Trusts jointly agree to provide mutual assistance on a national scale in the event of a major incident.
- Staff worked closely with the Police and Fire service, especially during serious or large-scale car accidents. During our inspection, we saw ambulance crew worked closely with Police when dealing with a mental health patient within the mental health triage service.
- Operational managers and HALO's met with other NHS trusts to discuss concerns and issues including delayed handover times and working relationships. HALO's represented the trust at bed meetings when possible, to discuss capacity and flow issues. This reduced the impact on patient waits in ambulances or in accident and emergency areas of the hospital.
- During our inspection, we saw patients were transported by ambulances to the appropriate service based on their needs. Locally agreed care pathways were embedded with other providers to ensure patients were managed in a way that would achieve the best outcome for them. For example, we were shown a 'regional hyper acute stroke management map'. This displayed the availability and access, including out of hours and the provision of care at the regional hospitals.
- In Coventry and Warwickshire area managers had attended meetings and training days led by the local Clinical Commissioning Group (CCG) to share ideas and issues across a range of services and to look at building stronger working relationships to improve patient care.
- Staff at the NHS hospital trust informed us that they found WMAS crews to be helpful and efficient with their working practices; their responses to clinical issues were prompt and the service escalated issues appropriately.

Multidisciplinary working

- Most staff we spoke with at A&E departments throughout our inspection were highly complementary about the ambulance service and felt that the crews worked well with them. Some hospital staff told us they felt there was sometimes confusion during busy times over who was clinically responsible for patients; however, we saw no evidence of untoward incidents relating to this.

- Telemed supported the staff when patients remained in their own home. We heard of good working relationships and genuine advice and support being valued.
- Staff told us and we saw evidence that crews had support and advice available from social services, community matrons, mental health teams and district nurses.
- We observed staff working effectively with other organisations including the police service at the scene of a road traffic accident. The two services shared appropriate detailed information and displayed a good working relationship.
- We observed a patient being treated by the ambulance crew at a train station; the crew obtained appropriate information from staff at the train station including the details of the incident.
- All ambulance staff we spoke with including management praised the 'make ready' teams and their working relationships with them. Staff stated that equipment was always suitable for use and if they had problems they could easily approach the AFAs and have a discussion on how to resolve it. We were told there was mutual trust amongst ambulance staff and AFAs which helped the service run smoothly and efficiently.
- Worcester staff told us they received good support from General Practitioners between 8am and 10pm during weekends.

Access to information

- Policies and procedures, JRCALC ambulance guidelines (2016) and clinical practice guidelines were available in hand held booklets and on the intranet sites. Performance information and advanced care plans were also easily available and discussed at meeting and briefings.
- Within the Shropshire area, we spoke with four staff within Donnington and Market Drayton. They told us they had difficulties in accessing computers within their shift times due to time of changeover of shift and most of their shift were 'on the road' and so there was less opportunities to read updates on new guidance and policies.
- We saw staff reading information at all hubs and community ambulance stations (CAS) and ASOs told us they would spot check staff understanding on the information issued. One staff member told us that they felt all of the information was disseminated from a regional level and that more local information was not shared effectively.
- We saw staff throughout the CAS and Hubs had access to computers and information was displayed for all staff to read on notice boards.
- Staff were able to access a team in their control rooms for advice on the directory of services and alternative pathways for patients.
- Ambulance crews were notified by the EOC if a safety issue was 'flagged' for an address. Staff discussed that as the 'flag' was on the address rather than the patient this could sometimes create issues as they would be unaware of concerns when arriving to care for the patient. Staff also told us that the vast majority of the time the information was accurate and refreshed on a six monthly basis to ensure it was still relevant.
- Knowledge of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) records was consistent. Staff knew about the DNACPR policy and knew how to access information if required. Staff gave us the requirement of information to look for such as its' written, valid, original and in date of the record. If the DNACPR was not completed appropriately they would call the clinical desk for support.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Ambulance staff had a thorough understanding of the need to gain full consent prior to any treatment or interventions. Staff told us they acted in the 'best interest' of patients who were critically unwell or unconscious, being unable to consent.
- During our observations, we saw staff gained verbal consent prior to treatment given at each step of a patients care, and also observed staff tailored their communication to enable patients to fully understand what was going to happen prior to consent.
- Staff told us they involved family and carers where possible if they had not been able to obtain consent of the patients, or if the patient wished for them to be involved in the decision making process.
- Staff we spoke with had a good knowledge of assessing capacity and what to do if a patient lacked capacity to consent to treatment.

Emergency and urgent care services

- There was space for ambulance staff to document the outcome of capacity assessments on both the PRF and EPRF.
- For staff attending a patient with mental health needs, staff risk assessed the situation and asked for police assistance if a patient was or may become aggressive. Staff we spoke with understood the legalities in relation to transporting patients experiencing a mental health crisis.
- In Shropshire, we observed ambulance crews dealing well with patients that had mental health issues, but they did not fully understand the differences between the Mental Capacity Act (MCA) and the Mental Health Act (MHA) and said that they needed more specific training for this.
- Staff had participated in training regarding MCA and Deprivation of Liberty Safeguards (DoLS) and showed a good understanding of this.
- In West Mercia, staff told us that there are no alternative pathways for mental health patients and therefore they sometimes take these patients to ED even when they know it is inappropriate to do so due to a lack of alternatives. We saw this was an issue within the West Mercia area only and all other areas had mental health support 24 hours a day, seven days a week.

Are emergency and urgent care services caring?

Outstanding ☆

We rated the caring domain of emergency and urgent care services as outstanding because:

- Across all divisions, staff consistently delivered genuine compassionate care and were sensitive to their patients' needs.
- People were treated and valued as individuals and were empowered as partners in their care.
- There were several examples of care provided when staff went beyond expectations.
- Ambulance staff explained treatment and care options in a way that patients understood and fully involved them and their relatives in decisions about whether it was appropriate to take them to hospital or not.
- Staff were highly motivated and inspired to offer care that was compassionate and consistently promoted dignity.
- People's emotional and social needs were recognised and valued by staff and were embedded in care and treatment. This included patient's family or carers.
- Feedback from patients and those close to them was consistently positive about the way staff treated them.

Compassionate care

- During our observations of care delivery, staff across all divisions delivered compassionate care to all patients in ambulances, patient's homes and in emergency departments of hospitals. We heard staff asking if they could make patients more comfortable during the journey to hospitals and placing extra blankets over patients to maintain their dignity. We observed several examples of staff holding patient's hands to provide them with reassurance during frightening and distressing circumstances.
- We saw staff maintained the dignity of patients, only removing as much clothing as was needed to undertake tests. Staff used blankets to cover patients within the ambulance and when transferring from vehicles to emergency departments.
- Staff took the necessary time to engage with patients. Staff communicated in a respectful and caring way, taking into account the wishes of the patient at all times. Staff asked personal questions in a consistently professional manner.
- We observed sensitive and compassionate history taking in an unhurried approach, with care taken to check that the patient understood their medical situation.
- All the interactions we observed demonstrated that staff respected patients and relatives as individuals, including those from vulnerable groups such as the elderly and those with mental ill health. We saw one example where crew reassured a patient living with dementia and explained the care and treatment provided in terms they understood.
- We saw ambulance staff reassuring an elderly patient because they were worried about personal belongings and their family member who was travelling separately.
- We observed staff assisting patients by gathering belongings and aiding them to get dressed before taking

them to hospital. Where patients did not require conveyance to hospital, we observed staff making elderly patients hot drinks and ensuring their comfort before leaving their address.

- We saw examples of appropriate care to the needs of children and young people on several occasions and throughout the divisions. Staff appropriately adjusted their height level to speak with individuals at their height, used simple language, gave clear explanations and allowed the child to hold equipment before using it. We saw staff providing reassurance and comfort for distressed children by encouraging them to play with toys or discussing their favourite TV programmes.
- When a patient became distressed, staff responded in a timely and sensitive way. Staff gave time for this patient to explain the reasons for their distress and treated these reasons respectfully by actively listening and asking further questions where appropriate in order to provide emotional support.
- The NHS friends and family test (FFT) is a way NHS trusts gain patient feedback about care received however, ambulance trust response rates are commonly low and therefore there is no meaningful data for this trust to report. During our inspection, patients and relatives across all the divisions told us they were happy with the treatment and care they received from ambulance staff.
- Patients from the Black Country told us the staff did "a fantastic job" and were "great" throughout their care and treatment. A relative from the Birmingham area stated that the staff were "fantastic" and they had used the service on numerous occasions with their relative. They told us staff were always friendly, caring and passionate about their job.
- Staff within four of the divisions, consistently introduced themselves to patients on arrival however, few staff did so within the Coventry and Warwick division. Ambulance staff in this division did not always ask their patients what their preferred name was. We observed this when a patient's son had to introduce himself and tell the crew his mother's preferred name after the staff called the patient something different for several minutes. The staff did not introduce themselves to either the patient or relative. Ambulance crews in the other divisions, consistently asked patients how they wished to be addressed.
- We observed staff attending to the public. Staff were professional polite and courteous and considerate, always putting their patients' needs first.
- Staff considered the wishes of their patient's and actioned these when possible. An example of this was when a patient stated they did not wish their spouse to hear all of the conversation and staff tactfully engaged the spouse in another room before continuing the discussion with their patient.

Understanding and involvement of patients and those close to them

- Patients we spoke with told us they felt involved in their care and ambulance staff had fully informed them of their treatment. We observed ambulance staff explaining potential treatment options where possible, to allow patients to have input into their own care and sought consent at every stage of treatment. Staff gave patients time to ask questions and answered these clearly and thoroughly.
- We saw Birmingham staff inviting and welcoming escorts for patients with mental health problems and other vulnerable group patients. Staff acknowledged that escorts played an important role for patients. Carers were involved where possible to ensure staff met the social, religious or cultural needs of patients.
- Staff involved patients of all ages in their own care, for example, a staff member asked a two year old if they could take their blood pressure. Parents and families were involved in care and treatment plans of children.
- In the Staffordshire area, we observed a patient who, despite medical advice and the advice of their spouse, declined conveyance to hospital. Staff explored the reasons for this, and rechecked the patient's decision. Staff respected this decision and put into place alternative arrangements for care, staying with the patient and their spouse until confirming arrangements. Staff kept the patient and their spouse fully informed of these arrangements. Staff clearly explained what steps the spouse would need to take next, including re-contacting emergency services if the patient's condition deteriorated, and ensured understanding of this before leaving the patient.
- We observed ambulance staff discussing the best treatment facility to patients, which was not necessarily the local ED because a speciality centre was the most suitable place for treatment. Patients in the Black Country area told us they valued ambulance staffs' opinion on the best place for them to go but were pleased staff discussed this with them.

- Where a patient did not require hospital treatment, we observed ambulance staff discussing this with the patient and their family to ensure they were happy to remain at home or be referred to another care provider, for example their GP.
- Staff showed respect towards relatives and carers of patients. Staff were aware of their needs and explained in a way they could understand to enable them to support their relative.
- Patients were involved in the handover process between ambulance staff to ED staff and were encouraged to add any further information or ask questions. Staff maintained patient confidentiality by handing over patients at hospital's as privately as possible.
- A patient in the Birmingham area admitted to a local emergency department told us that the paramedics gave a thorough explanation what was happening with clear explanation and involvement. The patient said, "the paramedics treated me with dignity, respect and they were very good with me."

Emotional support

- We saw staff consistently checked patients' wellbeing, in terms of physical pain and discomfort, and emotional wellbeing.
- We saw staff provide high levels of emotional support to relatives of a patient who had become very distressed, demonstrating a kind and empathic response and listening to concerns.
- In the Shropshire area, we saw in one case, a staff member held the hand of a patient living with dementia to provide reassurance and comfort when they were feeling anxious and distressed.
- We saw examples of staff going beyond expectations. One staff member arranged for a patients' cat to be cared for whilst the patient was in hospital, which alleviated the patient's concerns. Another, involved staff ensuring an elderly patient living with dementia was comfortable, taking extra time that she needed and ensured their carers would be visiting before they left.
- Staff told us of the importance of also caring for a patient's family members during distressing events. Staff informed us they would support relatives as much as they could during or just after a death of a patient whilst in their care.
- One patient told us they had used the ambulance service before and that crew had been very caring and supportive during the wait to be handed over at hospital, ensuring they remained comfortable and calm.
- There were messages of thanks and appreciation from patients on hub notice boards. One card read, "Thanks for your care and kindness in my hours of need" and "your swift response to our S.O.S was unbelievable. Very satisfied customer."

Supporting people to manage their own health

- We saw staff promoting patient health and wellbeing verbally during interactions, including advice for smoking cessation and appropriate alcohol intake levels. Staff also advised patients on how to access information about wellbeing advice.
- There were several examples within the divisions of how staff provided support to high volume service users. Management arranged meetings with these individuals to assess their needs and signpost them to the appropriate services such as mental health or GP. High volume service users were those who called the service on a frequent basis. Managers and staff at hubs across the trust worked with such callers to identify support required to reduce non-emergency calls to the service.

Are emergency and urgent care services responsive to people's needs?

(for example, to feedback?)

Good

We rated the responsiveness of emergency and urgent care services as good because:

- Community First Responders (CFRs) worked efficiently across the region particularly in rural areas to support ambulance staff with responding to life threatening emergencies. Rapid Response Vehicles (RRVs) were used effectively to ensure emergency treatment started as soon as possible.
- The 'make ready' team freed up ambulance staff to attend to calls throughout their shift rather than spending time preparing and cleaning vehicles.
- The service had a range of triage processes to try to ensure that patients received the most appropriate initial provision.

- There were 4x4 vehicles available to reach patients in very rural areas.
- Some hubs had posters providing comprehensive information about different religions to assist ambulance staff when working with patients of different faiths.
- There were specific services available for patients with mental health issues in Birmingham and the Black Country area including triage, specially trained staff members and cars. Staff had received training in the Mental Capacity Act and showed good knowledge of this when working with patients.
- Specialist bariatric equipment was readily available across most areas, with a minor exception across the more rural areas.

However, we also found:

- There were limited tools in place to assist patients with learning disabilities and staff felt that they would benefit from receiving training in regards to this.
- We saw that information about how to raise concerns or make a complaint about the service was limited on ambulances. In some areas managers dealt with complaints at a local level which meant there were missed opportunities for trust-wide learning.

Service planning and delivery to meet the needs of local people

- A telemed service was in place for crews to discuss the patient's case when remaining at home and staff working on the telemed desk had a minimum of five years' experience as a paramedic and rotated on a 10 week duty rota which consisted of 10 weeks at the clinical support desk and 10 weeks on the ambulance. They had access to current drug information, local district nurse contacts and the 'hospital at home' team (a care team made up of different types of health professionals such as community nurses and consultants). During busy winter periods the clinical commissioning group (CCG) funded a GP for several months to support the staff at the desk.
- The clinical assessment team (CAT) assessed and triaged patients through a 'see and treat' service. Paramedics attended to patients and travelled in an RRV. This provided medical assistance without sending an ambulance and avoided conveying patients to hospital, enabling more patients to be treated and assessed in their home.
- Staff told us the trust had a positive focus on supporting patients to remain at home when they do not need to attend hospital. The trust had a non-conveyance policy however, some staff told us they felt it was unclear as they were unsure of what type of patients they were permitted to leave on scene. Staff said they felt further training in basic wound management and carrying out urinalysis tests might prevent a patient being admitted to hospital.
- We saw staff verbally promoting patient health and wellbeing. Not all staff in the five divisions had patient information leaflets to provide ongoing support or advice following discharge at scene. The divisions that did not have this information were West Mercia, Coventry and Warwick, and Staffordshire. The Black Country division staff gave patients information leaflets in relation to cardiac health and general fitness and dietary advice. Some staff wrote advice on paper patient report forms however, the trust were moving towards electronic patient records and would not have this option in the future.
- General managers were proactive in meeting with the local commissioners to discuss current demand, admission avoidance strategies and high volume service users.
- A triage service for mental health calls was in place for the Birmingham and Black Country area. This service had no age restriction and accepted referrals for all patients suffering from symptoms of mental health problems such as confusion/delirium, agitation/ aggression, extreme acute anxiety, psychotic symptoms, unusual behaviours, enduring mental illness, suicidal thoughts and paranoia.
- Hubs and Community Ambulance Stations (CAS) were strategically sited to ensure response times could be met and local communities did not experience any detriment following the closure of ambulance stations. Staff told us that there were some concerns about some rural areas in Warwickshire as it would not be possible for ambulance crew to attend within the target response times.
- A 'make ready' team was responsible for cleaning, restocking and ensuring roadworthiness of ambulances at each hub. This ensured that vehicles were ready for staff to take straight out when they commenced their shift and staff were free to attend calls rather than preparing vehicles.

- WMAS used Rapid Response Vehicles (RRVs) which allowed staff to solo respond and provide rapid patient care prior to a double-crewed ambulance arriving.
- The trust had a Community First Responder Scheme which involved volunteers based in a range of areas trained to respond to life threatening emergencies in rural areas where ambulances may take longer to arrive. At the time we inspected there were 592 WMAS CFRs of which, 79 were based in Birmingham, 21 in the Black Country, 118 in Coventry and Warwickshire, 16 in Herefordshire, 89 in Shropshire, 212 in Staffordshire and 57 in Worcestershire. Between May 2015 and May 2016 CFRs responded to a total of 24,121 calls across the West Midlands.
- We saw an example of where a CFR was first on the scene to attend to a patient whose condition had deteriorated. The CFR communicated vital details of the patient to the EOC, allowing this information to be passed to paramedics prior to the arrival of ambulance on scene. Between April 2015 and March 2016, CFRs were first on the scene in 18,486 calls out of a total of 88,4408 across the trust (2.1%). We met and spoke with four CFR members who told us there was varied acceptance of their role amongst paramedics. Some staff told us their team had pride in this service and saw what a valuable addition the CFRs were, particularly in the rural areas. However, CFRs told us that they did not always feel part of the service and that there was a lack of recognition by the trust. We heard that due to remoteness of their working CFR's were not always integrated in to the teams by other ambulance staff.
- The majority of the WMAS fleet were no more than five years old, had been serviced regularly and were in excellent condition. The 'make ready' ambulance fleet assistants (AFAs) were responsible for the efficient turnaround of vehicles, ensuring the vehicles were in good condition, had all the necessary equipment on board and were cleaned to a high standard. Ambulances were accessible with both ramps and steps.
- Hubs had access to 4x4 vehicles which meant that support could be provided during extreme weather conditions and in more rural areas where a regular ambulance may not be able to access. However, some staff in Worcester and Hereford expressed concerns for the use of the 4X4 vehicle for routine calls. The vehicle was sent to urban area jobs even though its purpose was for rural areas.
- The Stoke Hub was an old building which was no longer fit for purpose, for example there was no heating in certain areas which made conditions in winter difficult for the team to work restocking vehicles. Plans were in place to relocate to a new purpose built site in 2017.

Meeting people's individual needs

- For patients whose first language was not English, staff used a telephone translation service. Staff told us it could take a long time to connect through to a translator and so would often not use this but would instead ask relatives or friends of the patient to translate where possible. A staff member told us that the translation service was better used when the Emergency Operation Centre had organised it so it was ready to use when the ambulance staff arrived. We did not see this used during our inspection however, we saw staff adjusting their language and involving relatives to ensure that patients had appropriate understanding to make informed decisions. Senior managers were supporting a member of staff in the Black Country area to explore opportunities in developing a phone translation app.
- Contact details for British Sign Language interpreters were available when required.
- Some hubs contained posters titled 'pause for thought'. These contained comprehensive information about different religions, including: beliefs, dealing with death, when entering a home and dress. These were informative and relevant to the ambulance service, however were not available on all hubs across the division.
- We found attitudes towards patients from ethnic minorities and different cultures varied widely. Some staff and managers had poor attitudes about adjusting care and communication based on people's beliefs, and did not feel there was a need to learn about equality and diversity. However, in other areas we saw extremely positive and understanding attitudes about inclusion of diverse groups in the community, and a full understanding of the population that was served along with the trust make up of staff from ethnic groups.
- In some areas discussions around ethnic diversity and different beliefs occurred during appraisals. Managers felt this was beneficial to ensure staff knew about the community and the patients they may be providing services for.

- One assistant area manager had been investigating an incident that had occurred at a local temple. Following this they were in the process of arranging meetings with leaders at the temple to improve relationships and assess how the ambulance service could best serve the community.
- Staff had received training in relation to mental health conditions. Data provided by the trust showed that 96% of staff had attended this training in 2015/16 which was better than the trust target of 85%. We observed staff conversing with a patient with mental health issues and interacting with them in a way that met their individual needs.
- There were limited communication aids or tools to assist ambulance staff when providing care to those living with dementia or other complex needs such as learning disabilities. We saw that some staff in Staffordshire had colourful 'explanation cards' to support children with learning disability needs. Staff felt their understanding of these areas could be improved to enhance their care. Throughout our observations we saw staff attended patients living with dementia and learning disabilities; we observed them communicating well and involving patients in their care. Some staff had accessed additional training to increase their knowledge.
- Some nursing homes in the Black Country area used patient passports. This system made sure any healthcare professionals caring for those patients would have a better understanding of their needs.
- Managers met with local organisations such as the local authority, housing associations, the police and the patients care agency to discuss how they could support local patients to reduce the number of inappropriate calls they made regularly to the ambulance service.
- All double crewed ambulances had bariatric capability (increased weight limit and adjustable trolleys to transport patients up to 50 stone). Bariatric patients are those with excessive body weight which is dangerous to health. Specialist bariatric vehicles were also available throughout the service. The specialist bariatric vehicles was able to transport patients and also carry moving and handling equipment to enable crews to move patients safely. For most people in this group, the first crew on the scene would provide immediate support for the patient's physical needs and request support or specific manual handling equipment.
- Bariatric specialist equipment, including hoists, was stored at the hubs and was maintained and serviced ready for use as necessary. Staff were trained to use the equipment and refresher training was available as necessary. The trained staff would be called to assist the first responding team. Staff told us that at times equipment was unavailable as it was in use or trained staff were unable to attend as they were already engaged with other patients. This problem was mainly in rural areas and staff told us that in such places they could be waiting for over an hour for this equipment. Specialist bariatric vehicles were available for those who could not be transported in a bariatric capable ambulance due to weight or size. Within the Shropshire area there was only one available and at the time of our inspection, we were told the hoist on this vehicle had required repair for two years. When the specialist bariatric vehicle was not available to transport a bariatric patient, staff would request a bariatric vehicle from out of area, request more staff for assistance or request Hazard Area Response Team (HART) assistance to provide the required level of assistance. We highlighted this to the trust post inspection and we were sent information to confirm the hoist had been removed, repaired and was operational on 24 July 2016.
- In Birmingham, additional services were available in the city centre on Saturday nights called the 'City Centre Treatment Unit' which prevented patients attending the local A&E where appropriate.
- The Birmingham and Black Country Hub had access to the Mental Health Triage car, a service that was first established 18 months ago working alongside the local police with community mental health nurse to support patients who require mental health support. Ambulance crew said if they came across an incident that required mental health speciality support they were able to access this service. Staff in these rural areas told us it was difficult to access mental health support out of hours and a vehicle based at all of the hubs would be useful.
- We heard examples of staff being responsive by dealing appropriately with difficult situations. For example, early escalation of the support from the police mental health car to escort a patient to be detained under section 136 of the mental health act and transported to the appropriate facility.

- WMAS had a zero tolerance to abuse policy and staff were encouraged to report and potentially to prosecute. Managers supported staff when dealing with aggressive or abusive members of the public.

Access and flow

- The trust was working towards a target that all vehicles were staffed with at least one paramedic by December 2016 to reduce the treatment times at scene. Although this was the 'gold standard' the trust had set itself, managers told us until December 2016 double technician crews would still be sent to calls to reduce waiting times. The EOC would prioritise calls based on a needs assessment, which would determine which crew they sent to calls.
- Patients had timely access to initial assessment, diagnosis and urgent treatment. Response times for WMAS were largely the best in the country. The aim of a qualified paramedic on every ambulance ensured that patient's clinical needs were met in line with national best practice and delays to treatment, diagnosis and assessment were minimised.
- The trust had recently embarked on the Ambulance Response Project (ARP), which focussed not just on time from call to arrival of first resource on scene, but also on time from call to a resource that could transport the patient arriving at scene. This aims to minimise the amount of time patients had to wait for definite care or treatment. We saw that staff had a clear understanding of the project and had been involved in rota changes to facilitate it. The service was monitoring its own response times to improve on its performance.
- On calling 999, patient's care and treatment needs were triaged and responses were prioritised for those with the most urgent needs. For time critical, life threatening emergencies, further resources, including managers, were made available if they were the nearest resource. This ensured that those with the most urgent needs received treatment as fast as possible.
- Staff were aware of 'hospital bypass' which is when patients who required specialist care would be transferred straight to a specialist centre instead of the local emergency department. For example, when a patient required care at a hyper-acute stroke unit. This was to ensure patients received the right care at the right place.
- Some staff we spoke with felt that relationships between EOC staff and emergency care staff could be improved. We saw several examples of EOC staff radioing crews within 15 minutes of their arrival on scene to ask what the situation was. Staff felt this was interrupting their patient care and was unnecessary so soon after arrival on scene.
- Prolonged delays at some of the local acute hospital's emergency departments reduced the capacity of front line staff to respond to emergencies. This was because ambulance staff needed to stay with their patients to deliver care and support them until they were handed over to hospital staff. This was a continued issue affecting capacity and flow for the service however, the senior management were in regular contact with the hospitals to discuss how they could work together to reduce pressures.
- Staff had access to the out of hours local triage General Practitioner (GP) for advice and information on a patients condition as a preventative solution if a patient did not require admission to A&E. Each area also had contacts with GP surgeries to help with a 'see and treat' service. Staff told us they were supported clinically to make decisions and this allowed them to use alternative care pathways.
- There was minimal use of RRVs, with double-crewed ambulances mainly used across hubs. This meant there were not prolonged periods of times where RRVs were waiting for back up. Staff told us that if another vehicle was required this was readily arranged by EOC and there were not usually extensive waits.
- We observed the mental health triage service respond to calls using emergency vehicles during the night. Referrals were received from the police and ambulance service and therefore if a call was attended by staff from either of these services and felt further support was required they would contact the triage service.

Learning from complaints and concerns

- The trust received 1,505 complaints between April 2015 and April 2016; 51% of these (791) related to emergency and urgent care services.
- Birmingham accounted for 201 of these complaints; the majority of which (59) related to attitude and conduct of staff. The Black Country accounted for 158 of these complaints; the majority of which (48) related to lost or damaged property. Coventry and Warwick accounted for 127 of the complaints of which the majority (39)

related to the attitude and conduct of staff. Staffordshire accounted for 141 of the complaints the majority of which (46) related to attitude and conduct of staff. West Mercia accounted for 164 of the complaints the majority of which (48) related to lost or damaged property.

- Staff were aware of the trust's complaint process, however information about this or the Patient Advice and Liaison Service (PALS) was not always available to patients or relatives on vehicles. On some vehicles there were posters with the relevant contact details however although the posters informed users of the service to ask for a leaflet, there did not seem to be leaflets available on any of the vehicles we saw. The AFAs told us they used to be on the 'make ready' kit list for each ambulance but were no longer listed.
- Guidance to support patients to make a complaint was available on the trust's website. It detailed how to contact the ambulance service, how to raise a concern and make a comment or compliment. The website also directed patients to advocacy services if they required advice.
- Regarding the mental health triage service, patients were able to put forward concerns to the individual service used such as the mental health provider, police service or ambulance service.
- Administrative staff logged complaints onto an electronic incident reporting system and the complaint acknowledged as received within three working days of receipt. An investigator was assigned and the trust aimed to investigate and respond to complaints within 25 working days. Feedback letters were sent to the complainants directly from the PALS team after complaints had been investigated.
- Area Managers told us that when they received recurrent complaints about individual staff regarding their attitude these staff were sent on a customer service course to improve their communications and interactions with patients.
- We were told by managers that complaints received locally were dealt with within that area rather than being shared wider. Therefore, these complaints would not be logged, trends could not be analysed and trust-wide learning would not take place.
- One area manager told us they visited complainants in their own home or invited them to the hub to explain the complaint investigation findings and when complaints had related to the transfer of patients from care homes, they visited the care home manager to feedback the investigation findings and improve working relationships.
- There were variations across the region with how staff received feedback from complaints that involved them. Some staff in Shropshire told us they did not always receive feedback when complaints that involved them had been investigated. There was limited learning following complaints and learning was shared by working with different ambulance crews and via the weekly newsletter. Staff in other areas such as Birmingham and The Black Country felt that they were involved through the process and that there was learning from complaints raised. Some examples of lessons learned from concerns in Staffordshire included the wearing of tabards to distinguish those in charge at a major incident scene, initiating a parking officer at a major incident to ensure traffic flow and access was clear and also participation in 'inter-service exercises' for major incident training.

Are emergency and urgent care services well-led?

Requires improvement

We rated well led of emergency and urgent care services as requires improvement because:

- There were insufficient middle managers in some areas to meet the needs of the service. We saw the impact of this through staff concerns not being responded to in a timely manner by their managers :.
- Visibility of senior management was poor.
- Some staff believed there was a disconnect between management and clinical staff.
- There was variation in staff opinion of the organisational culture from 'good' to 'awful'. However

there was a mostly a positive, open and honest culture amongst staff groups.

- Most staff expressed more middle management provision was required
- Executive leadership was described as 'hierarchical' and 'target driven'.

- Risk registers were not robust and did not fully reflect each hubs risk areas.
- Not all staff felt able to raise concerns.
- Staff engagement in some areas was limited.

However, we also found:

- There was a clear strategy in place, with associated visions and values supporting this.
- Operational staff demonstrated passion and commitment to provide high quality care and they 'lived' the strategy daily.
- In the main, staff felt well supported by their line managers and that their concerns and issues were listened to and resolved.
- The trust engaged with the public via several social media platforms.
- Effective public engagement to recruit staff from Black and Minority Ethnicity (BME) population
- Steps were taken to mitigate risks throughout the service.

Vision and strategy for this service

- The trusts vision was to deliver the right patient care, in the right place, at the right time, through a skilled and committed workforce, in partnership with local health economies.
- Large poster displays of the trusts vision and values were visible within all the hubs and the community ambulance stations we visited. Staff told us the trust's vision, objectives and values of the service were included in the weekly news brief. The majority of staff we spoke with were aware of the trusts values and its vision going forward.
- A 2016-2018 quality strategy was in place within the trust, which aligned with the trusts' five-year strategic plan. This document discussed the importance of monitoring and evaluating quality to ensure the trust meets the needs of patients, carers and staff.
- The trust's five year strategic plan detailed achieving quality and excellence, accurately assessing patient need, establishing market positions as an emergency healthcare provider and working in partnership. The majority of staff were aware of the strategic plan although staff awareness was variable. Although staff could not explain the strategy, they could explain their role in delivering it in their daily work.
- Ambulance staff were positive about the trust strategy to have one paramedic on each vehicle, which they would meet by Christmas 2016. All of the operational staff we spoke with demonstrated their high level of commitment to provide a good quality and safe service.
- The staff at the Stoke hub showed us plans for the new purpose built hub where they were due to be relocated in 2017. The current hub showed signs of wear and tear, although it was clean and tidy. The trust have shown us that this is on track to open as planned.

Governance, risk management and quality measurement

- There was a systematic programme of clinical audit and regular reports produced including actions taken for improvement. However, local management were not always sighted on poor audit performance. We asked a local manager in the West Mercia region about the recent poor audit results but they could not provide evidence this had improved. This manager did not access the audit IT system regularly but instead relied on audit takers to report concerns.
- A trust-wide risk register for 'business continuity' and 'emergency planning' recorded the current risks within the organisation. There were 25 risks identified four of which were highlighted as high risk and related to major incidents that may result in large number of patients who required treatment at the same time. All risks were identified to be reviewed in January 2017. However, local risk registers across hubs were not consistent or robust as they did not reflect the risks identified.
- The lack of management support for the Worcestershire hub was an item on the risk register since December 2015 and was risk rated as red (maximum risk rating). This highlighted that the area manager at this hub was responsible for 196 staff and this was against the operating model of 1:100. This risk had reached board level but continued to be on the risk register because of the lack of available funding. There was no record of other actions to mitigate the risk.
- Clinical governance was robust in Birmingham and the Black Country. We found that regular staff meetings took place during which staff discussed incidents, complaints, staffing, sickness and quality issues and actions required. However, the sharing of this information with staff in other areas was variable across the trust. There was a governance framework to support the delivery of the strategy and good quality care.

However, we found this was not effective or consistent across all areas. For example, there were instances in Coventry and Warwickshire and throughout West Mercia where staff were unclear of who had responsibility for tasks such as the checking of defibrillator test cables and auditing prescription only medicines management.

- A delay handing over patients from ambulances to hospital accident and emergency departments may mean that ambulances cannot respond to other emergencies. If there were delays in patient handovers we saw information that these concerns were highlighted with the trust and the local clinical commissioning group. This had resulted in actions such as the increased availability of a HALO in accident and emergency departments.
- There were appropriate systems in place to monitor secondary employment to ensure that staff had the ability to meet the terms of their employment.

Leadership of service

- Each hub had a similar leadership structure consisting of an Area Manager with support from an Area Support Officer (ASO). Larger hubs also had an Assistant Area Manager. Clinical support was provided by clinical team mentors.
- Each of the three divisions had a general manager responsible for its operational management. Their role included both a corporate and divisional focus. Staff had mixed views about the support provided by this level of management.
- The general manager for Birmingham and Black Country had been in post for three months at the time of inspection, and was still establishing working relationships with people based in and out of the trust. All staff and managers we spoke with felt supported by the general manager and felt they had provided a positive influence on the division since their time in post.
- Staff throughout West Mercia said they rarely saw senior managers. One staff member said, “We wish they would pop in to meet us and a have a coffee.”
- In West Mercia there were five area managers. At the time of the inspection there were two on sick leave and a third on annual leave with acting area managers in place.
- In the Hereford hub, there were five whole time equivalent (WTE) ASOs and five WTE ASOs to cover both the Worcester and Bromsgrove hubs. ASOs and other staff told us this was insufficient cover especially for the Worcester and Bromsgrove hubs. Staff said that ‘Acting’ ASOS were unable to provide the full role such as undertaking staff appraisals but did provide them with day to day support.
- Staff generally felt well supported by their line managers and told us they could always approach them as they had an ‘open door policy’. However, staff in one hub did not feel supported by their manager.
- Several staff within Shropshire gave us examples that the trust value to ‘strive to maintain a positive, safe, supportive and enjoyable environment for all our staff’ was not met. Staff told us they were reluctant to raise concerns about practice and other staff, for fear of reprisals. Some staff told us if they raised concerns they were targeted and threatened with dismissal. Other staff told us they raised concerns about sickness management and being threatened with dismissal if they did not return to work. We shared these concerns with the trust who responded appropriately to investigate staff concerns.
- Ambulance staff and AFAs in the Black Country told us there was good leadership visibility at a local level and this helped the effective and efficient running of the service.
- Staff in Shropshire told us there were five ASOs all based at the Shrewsbury Hub. There were no ASOs to provide day-to-day staff management at the Donnington hub. At the time of our inspection, there were two ASOs in post in Shropshire with three acting into this role. ASOs said that there was a need for more substantive ASOs. Several staff working at both the Shrewsbury and Donnington Hub highlighted the lack of management availability at the Donnington Hub.
- The Lichfield Hub had one area manager and no ASO which meant that the area manager was managing over 100 staff. Managing this large number of staff meant they were unlikely to be able to provide sufficient staff oversight, supervision or support.
- A paramedic in West Mercia said, “senior managers lean heavily on middle managers so they don’t have any time for us” and also told us “managers are too busy to care and fear more senior managers”. One staff member said that ASOs were “hammered and put upon.” Another staff member said that all managers were put under pressure from above and they pushed pressure down.

- Several staff in West Mercia said that some but not all managers were supportive. Staff told us they choose carefully whom they would approach with concerns because of a failure to ensure that information given remained confidential.
- ASOs in West Mercia told us they also had to attend the hospital accident and emergency department when the HALO was not on duty during busy times. Whilst this meant faster ambulance turnaround time as they were frequently the only ASO on duty they told us they were not available to provide support to staff whilst undertaking this role.
- One area manager told us they spent most of their time managing hospital issues or dealing with the 'fleet' because of lack of management support. They felt they only did 10 - 20% of their job well and regularly worked more hours than should reasonably be expected. They said that their lack of recognition and reporting of poor medicines management was because they did not have enough time to do everything well.
- Managers told us that whilst the executive team were not always visible due to the large geographical areas of the trust, they would feel happy to approach them and contact them for discussions if necessary.
- Feedback regarding the executive team was widely positive and many staff felt that the CEO had changed the service positively and he took pride in the service.
- All managers we spoke with told us they enjoyed their role and felt valued as part of the WMAS leadership team.
- Leadership style was corporately led which some staff felt did not give an individual approach to certain situations such as sickness. The sickness policy was effective in reducing sickness levels yet some staff felt they were harassed when called to discuss their return to work.
- Area managers were responsible for the management and handling of their individual staff stress and anxiety. We heard a variety of cases where debrief was excellent through to non-existent. Some staff felt they were well supported, had been made 'unavailable' to attend a debrief session and had been able to discuss the incident. Others felt they were rushed from the scene of an incident, had a short break and were sent to another call.
- The trust monitored staff secondary employment to ensure that staff did not work excessive hours. . All staff completed a declaration about other employment and only if agreement was given could they undertake any secondary employment. Staff were then frequently reminded about informing managers about secondary employment within newsletters and staff meetings. The clinical quality and safety group met and shared both regional and individual locality themes with recommendations for action.
- Due to the nature of the work, communication was an issue for the senior managers with most staff communication being via email. There was no system in place to monitor whether staff had read the emails or updates. The trust was not assured that staff had seen and read any of the emails, which may include team briefs and newsletters. Some clinical updates were signed as being read.
- We were told about and we saw leaflets advertising various courses available for leadership development. 'Engaging leaders' involved individuals completing a leadership development plan based on their own insight with a 360 degree feedback and action learning plan. 'Step up to management' was a development programme for new supervisors and first line managers. 'Manage for performance' was a development programme for existing managers with management experience in leading teams.
- A Staff Advice and Liaison Service (SALS) was in place to provide confidential support to staff in a variety of circumstances, relating to work or personal issues/ concerns. Staff we spoke with in the Black Country told us they valued this service and it helped them if they had been struggling.

Culture within the service

- Each member of staff from all areas of the division we spoke with told us they enjoyed their roles providing a service to care for and keep people safe and well.
- We saw that staff worked towards providing patients with a high standard of service and their attitudes and behaviours reflected the values of the organisation.
- We found that staff morale was mostly good with the exception of West Mercia where most staff reported low morale.
- The vast majority of staff spoke positively about their line managers and told us they were approachable and available. Union representatives told us they generally had positive working relationships with managers and that this enabled quick and suitable resolutions to any staff or operational concerns.

- We heard examples of a lack of support from another team such as a EOC not understanding the pressure the road crew had and vice versa.
- We heard that managers were generally supportive and interested in their staff and their welfare. At the Lichfield hub, we were told that the area manager listened to what the staff had to say and was approachable.
- Area managers and senior staff knew their responsibilities in relation to 'duty of candour' and its application within their respective roles. Managers in the Black Country and Stafford told us how they had visited people in their own home to apologise and give explanations if necessary.
- The majority of emergency staff we spoke with were proud to work for WMAS and had done so for many years.
- Staff we spoke with in Staffordshire were extremely proud that they met their targets and maintained a high percentage response rate.

Public and staff engagement

- The trust worked with high volume callers to assist the reduction in calls and find the right support for the caller. We heard an example of an area manager in Staffordshire attending a local nursing home to discuss reduction in hospital admissions.
- A WMAS Facebook group updates the local public on incidents and safety issues. With over 10,000 likes, it was a good source of public engagement.
- We saw a wealth of thank you cards and letters displayed at each hub. The area managers told us, and we saw letters in staff files that thanked and congratulated staff when they had been specifically named.
- Public engagement varied across areas. We saw some evidence of communication and engagement with the Muslim and Sikh communities in the Black Country but this was not consistent. Some senior managers were aware of the need to improve engagement across communities, but we did not see any action plans in place relating to this.
- We found that staff meetings were either infrequent or poorly attended. Staff told us they did not attend the hub meetings as they were either working or on their days off. Staff told us they read the paper version of the minutes off the staff room board or via the intranet.
- All staff told us the main communication methods were the weekly briefing and notice board memos to communicate updates and practice changes however, there was no system in place to monitor if staff read these. Local managers said they were reliant on motivated staff reading them.
- The CEO wrote to each member of staff who achieved a Return of Spontaneous Circulation (ROSC); a certificate was issued and displayed at the hub where they were based.
- Staff in Staffordshire told us that the emergency crews attended their children's local schools and clubs when possible to let children see the ambulance, learn about the service and ask questions.
- In Birmingham, we spoke with some of the Black and Minority Ethnicity (BME) employees. The BME staff were positive towards recruiting staff from different cultures and backgrounds. WMAS had taken active steps to support the recruitment of BME employees and it was clear that these steps were beginning to enhance the diversity of the workforce.
- WMAS provided extensive public information videos on its main website; this included how to recognise a stroke, CPR instructions and improving wellbeing.
- Staff in all areas told us that debrief was available following traumatic calls. Some staff in Staffordshire felt this was an excellent process whilst others had experience of being sent to the next call before having chance to debrief. Managers in all areas told us they encouraged staff to take debrief time including support from counselling if required. We heard examples of staff not wanting to attend a debrief about certain incidents which was their personal preference. We saw a child death pack had been collated to work through debriefs in a systematic way.

Innovation, improvement and sustainability

- We saw some areas of forward thinking and innovative ideas to improve patients care and effectiveness within the service; however, these were not always shared across divisions.
- Staff told us that the make ready system had improved and sustained good practice.
- In the Black Country, successful pilot projects had been carried out to reduce attendances to A&E departments over the winter period. This involved a specialist paramedic with advanced clinical training attending to specific patient groups and providing care in the

community. The pilot ran in conjunction with commissioning groups and received good feedback; however, there were no plans to share this across other divisions.

- Managers in Birmingham and the Black Country told us they were encouraged to improve and innovate within their role, and often supported to implement an idea if it was beneficial to patient care and the service.
- We spoke with an area manager who we asked to see evidence of driving licence checks and he was able to show the evidence of a new system where a third party provider completes a range of checks and provides compliance and exception reports.
- Staff told us that the trust takes part in clinical trials, including the on going 'Paramedic2 trial' which is looking at whether adrenaline is helpful or harmful in the treatment of cardiac arrest which occurs outside of hospital.
- We met and spoke with a HALO at Tollgate who had trained 40 people within their local community on CPR and his local pub now held a defibrillator.
- Senior managers in West Mercia gave an example of local innovation as the out of hours GP provision and the 'make ready' process for trust-wide innovation.
- Some staff members we spoke with had ideas that could be implemented to improve services for patients however, they seemed to have low motivation for pushing these forward as they felt that they would not be put into practice.

Patient transport services (PTS)

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

Information about the service

West Midlands Ambulance Service provides a non-emergency service for adults and children who are unable to use public transport or other means of transport due to their medical conditions through the Patient Transport Service (PTS). This includes transportation for outpatient appointments for treatment or consultations, and back home, and planned discharges from hospital wards. Patients are able to use the PTS service 24 hours a day, seven days a week.

West Midlands Ambulance Service is commissioned to provide PTS across the West Midlands from seven PTS bases: PTS Walsall at Walsall Manor Hospital, PTS University Hospital Birmingham (UHB) at Kings Norton, Birmingham, and PTS Stoke near to the Royal Stoke Hospital in North Staffordshire, PTS Heartlands Parkway, Birmingham (HEFT), PTS Worcester, PTS Coventry and PTS Warwick. All PTS bases are separate sites from the hospitals they serve, although Walsall is based in the hospital grounds.

The Trust employs nearly 400 PTS staff. The PTS has a regional control centre at Stafford with a smaller centre situated at Brierley Hill. There are 33 call handlers for this service and 320 vehicles.

PTS service performs more than 700,000 patient journeys per annum, amounting to over 3,000 journeys per day.

During our inspection, we visited six of the sites, spoke with 29 members of staff, four patients and carers and viewed eight sets of records.

Summary of findings

We rated this service as requires improvement overall. We rated the service for requires improvement for safety, effective and being well led and good for caring and responsiveness. This is because:

- Equipment checks and sterile environments were not always maintained
- Arrangements for controlled drug storage and vehicle security was not robust at PTS Stoke hub.
- Risk assessments were not always completed in line with organisational policy particularly around mental health, serious incident reporting, and understanding of the role in major incidents.
- Mandatory training rates did not meet organisational targets,
- There were ongoing improvements to manage delays.
- There was a lack of staff understanding of mental health problems.
- There was minimal evidence of learning from complaints related to delays.
- Staff had mixed knowledge about the trust's vision and values
- Senior operational managers had variable understanding of the risks associated with PTS service delivery.

Patient transport services (PTS)

- Staff felt there was a lack of visibility of senior management above senior operational manager level and variable quality and rates of appraisals.
- There was lack of timely response to management issues at one PTS site and poor staff engagement on surveys and performance issues at the same site.

However we also saw;

- Staff had a good understanding of incident reporting, safeguarding and the use of the patient digital assistant (PDA)
- Regular fortnightly non-emergency senior management meetings, close working with Healthwatch Coventry and an effective transport monitoring and escalation process at Stafford control centre
- Caring, compassionate staff
- Robust five year strategic planning
- Good visibility of local managers and good support for staff
- Escalation process and planning for the next day's journeys.

Are patient transport services safe?

Requires improvement

We rated this service as requires improvement for the safe domain because;

- Equipment was not always in date and stored in a sterile environment and the recording of equipment checks was not consistent across PTS sites.
- Unattended vehicles in use were not always secured in line with the trust's policy.
- Controlled drugs were not always stored securely on vehicles;
- Staff had limited knowledge and understanding of risk assessments for patients with mental health illness.
- Mandatory training rates were not consistent and were below the trust target of 85%.
- The trust had a system in place for reporting serious incidents; however, one incident had not been reported in line with trust policy.

However, we also saw;

- Staff had a good understanding of the incident reporting system.
- Staff had a good understanding of safeguarding and knew what to do to report it.
- Good use of the patient information system (PDA) to inform staff about patients' specific travel requirements.

Incidents

- Staff had a good understanding of their responsibilities to raise concerns and report incidents. There was a good track record of safety.
- From May 2015 to April 2016 there were four serious incidents related to PTS reported to the National Reporting and Learning System (NRLS). These incidents were in relation to the alleged abuse of a patient living with dementia, a fall, and two related to failure to accurately diagnose patients when they became unwell. We saw that the trust had investigated each incident and a detailed root cause analysis had been completed.
- There were 118 patient safety incidents recorded for PTS from October 2015 to April 2016; of these, 19 were related to delays, 18 were related to falls/wheelchair injuries and eight were due to no crew being available.

One of the falls resulted in serious injury and subsequent death; the trust reported this as a serious incident. There were no additional themes. There had been an internal review of the main themes carried out by the trust with recommendations for future prevention. This included the trust working with hospices to introduce a process where they got the patients to wait for the PTS staff to collect them. Before this, staff handing over patients did not always stay with patients and they would sometimes try to make their way to the vehicle unaided if the crew were busy with other patients. The trust also worked with the vehicle design group to review the design of the PTS vehicle, specifically the side door, wheelchair retained access and access to the ramp. The trust also reviewed the planning of journey efficiency in relation to delays.

- We spoke with ten members of staff who told us that their manager informed them about outcomes from incidents they had personally raised verbally or by email. With the exception of four staff at PTS Stoke, all of the other 29 staff we spoke with told us they had access to the 'weekly briefing' in paper format that contains information about learning lessons from incidents. We saw this on the staff noticeboards in the five sites we visited. Staff at PTS Stoke told us the new interim manager had recently put the briefing on the staff noticeboard. Staff told us it was easier to keep up to date if they had a paper copy.
- The organisation was working towards an electronic incident reporting system for all areas. PTS was using a mixture of electronic and paper based incident reporting. All staff we spoke with were able to show inspectors the incident reporting forms and describe the process for reporting. The senior operational mangers for all sites were able to describe how they managed incidents at the bases and that the site manager or supervisor would be directly involved in resolving any issues with staff and patients.
- Most of the staff we spoke with about outcomes from incident reporting, were able to tell us about a change in the way things were done following a serious incident. One member of staff was able to tell us about a safeguarding incident where the trust had put measures in place to prevent a reoccurrence. Another member of staff was able to describe a serious incident they had reported relating to witnessed physical abuse of a patient. They were able to tell us that the trust had fully informed them of the outcome. There had been a change in the mandatory training handbook in relation to managing a patient living with dementia. A third member of staff told us about a physical attack from a patient with mental health problems which led to a change in policy that an escort would be required to travel with anyone with known aggressive tendencies. There was also a case involving manual handling where staff did not move a patient correctly. The trust disseminated the findings of this to the base and staff attended further manual handling training. The fifth incident related to a faulty wheelchair, which the manager discussed with the team. This revealed a more widespread problem with the model of the wheelchair. The trust escalated this to the manufacturer and the matter was resolved. Staff told us about an incident that they had been involved in on 15 September 2015. This involved a threat made against them by a patient. They told us and we saw they had completed an incident form. This staff member said they received no acknowledgement or feedback from the incident and there was no record of this incident according to the trust's serious incident report for 2015/16. The trust did not report this incident to the NRLS. The trust told us that they did not follow the trust process for incident management at the time. We raised this with the trust during the inspection period and the trust has now rectified this error.
- The senior managers in the service were aware of their responsibilities of being open and honest with patients when things went wrong. One of these managers showed us that they had completed a presentation for their staff for their learning. Another manager described being open and honest when things went wrong, and talked about their involvement in the process. The manager described their direct involvement with the patient and family and support for staff including one to one time with the manager and support for debrief. Staff at one of the PTS sites were aware of duty of candour. The senior operational manager at the same site told us about a case of a patient who fell and subsequently passed away, that was involved in PTS. They described the process that ensued. The trust also supplied inspectors with duty of candour information regarding this case. This information included the letter of apology to the family of the patient.

Mandatory training

Patient transport services (PTS)

- Mandatory training for all staff was delivered through a combination of online learning, classroom study and a mandatory training workbook.
- All staff including volunteer drivers received a copy of the trust's mandatory training workbook at corporate or local induction.
- Mandatory training consisted of 17 core modules: including topics such as, health and safety, manual handling, safeguarding, conflict resolution and infection control. The trust provided induction training package information that corroborated this.
- The trust supplied inspectors with mandatory training updates figures for the last three years for PTS broken down by locality. The trust target for mandatory training updates was 85%.This showed that in 2013/14 all sites apart from PTS Stoke achieved between 85% and 94%. There were no figures for PTS Stoke. In 2014/15, all sites apart from PTS Stoke achieved 88%-93% with PTS Stoke achieving 54%. The figures for 2015/16 were more variable with a significant reduction in Birmingham (PTS UHB) and PTS HEFT at 67% and 80% respectively. PTS Stoke achieved 34%. The trust told us that they had made changes to management at PTS Stoke, which would rectify the mandatory training attendance rates. The interim locality manager provided inspectors with the mandatory training update plan for PTS Stoke. This showed that the trust had allocated all staff a place for the current year. In addition, the trust provided information that showed by 3 August 2016 18 out of the 49 PTS staff had undergone a mandatory training update with 31 booked to attend by the end of the current financial year.
- Following the inspection, the trust provided us with updated training figures which showed PTS Stoke had achieved 100% and PTS HEFT had achieved 96%.
- Inspectors saw the mandatory training workbook at all sites and staff told us that there was a rolling programme of topics taken from the workbook each year. The trust provided inspectors with the 2015/16 mandatory update topics.
- We saw the PTS mandatory training refresher for 2015/16, which contained the topics: moving patients in special circumstances, life support (adult), patient report forms, chairs and carrying equipment, patient transfer techniques and equipment, infection control, mental health, capacity and consent and joint emergency services interoperability. The trust supplied us with a copy of their dementia training handbook, and the complete PTS mandatory training update pack. The trust training department showed us the mental health session, which is part of module seven of the non-emergency training package.
- We saw mandatory training records for staff posted on the staff information boards at all of the five sites we visited and managers showed the inspectors staff logs at the control centre and at PTS Stoke. Managers and supervisors explained that they monitor each staff members due date for refresher training and plan the date of attendance against the duty rotas and inform the staff member when they are planned to attend. All staff we spoke to supported this.Staff who worked with the mental health contract at PTS Stoke said four out of the seven staff had received conflict resolution training once. No one had received any update training.
- The trust training department trained all staff in conflict resolution in 2012/13 and that PTS staff were due a refresher this year. The trust supplied inspectors with conflict resolution training figures for 2012/13 when the trust implemented a plan for all trust staff to be trained in this topic. This showed us that 72.53% of PTS staff received this training. The trust told us they had 100% of PTS staff booked for a refresher this year with 17.2% delivered.
- Staff worked within mental health contracts and worked with patients who had been assessed as 'low risk', staff described occasional situations where they felt restraint was required or felt they needed to support the escort with a patient in restraint procedures but could not. They told us that there was no restraint training or restraint policy within the trust. The trust training department clarified that the trust provided mandatory clinically related challenging behaviour training. They told us this training aimed to give staff an understanding of the reasons for challenging behaviour in certain patients. This was a theoretical session not practical one in restraint techniques. The trust also told us that there was not a stand-alone restraint policy but conflict resolution and risk assessment of challenging behaviour was cited across a number of other policies.
- We met with the trust post inspection on 25 July 2016 in response to concerns raised by staff. Following the meeting, the trust had arranged four training dates held between 11 July and 4 August 2016. The sessions were aimed at increasing the knowledge of the Combined Health Care and High Dependency staff in mental health issues and subsequently their confidence in dealing

with such patients. The sessions consisted of formal educational delivery, followed by question and answers, and the opportunity to discuss specific cases and scenarios. The subject matter covered by the sessions were;

- Combined Health Care Transport Policy and the risk assessments carried out before transport is arranged with the University Hospital North Midlands Booking Office
- Safe transportation of patients and the scope and remit of ambulance staff
- Dynamic Risk Assessment process
- Incident Reporting
- Mental Health Act
- Mental Health Sections
- Transporting patients under the Mental Health Act
- Restraint and reasonable force

Safeguarding

- All staff knew what to do if they suspected a safeguarding issue. We saw staff had a key ring fob with the safeguarding contacts and access to the trust's 24-hour single point of access referral line PTS made 45 referrals for adult safeguarding from April 2014 to March 2015 and no referrals for child safeguarding in the same period.
- Staff were able to give examples of where they had intervened when they had taken a patient home and were not happy with the environment. They described issues where they were able to take action themselves, such as putting the heating on and they described occasions when they felt the patient would be at significant risk if they left them at home. Staff explained how they tried to rectify problems and make contact with the relevant professional at the home, however if they were not able to leave the patient safely they would return them to the hospital they have collected them from to await support. Staff told us children with any additional needs, such as learning disabilities, were accompanied by an escort as well as patients.
- Staff at HEFT, Walsall, and Coventry sites were able to tell us they had regular team meetings and the 'weekly briefing' was always put up promptly, which contained feedback from safeguarding incidents. They also advised their managers gave them updates verbally as and when if a safeguarding referral had been made by them.
- Safeguarding training was completed during the induction period for those joining the trust. The training was refreshed for all staff as part of the mandatory training update day, and the training uptake rates for safeguarding were incorporated in the figures above. Safeguarding mandatory training was provided at level 2, in line with national guidance.

Cleanliness, infection control and hygiene

- The trust supplied hand hygiene audit data for the period January to June 2016. The trust had a target of 90% of good hand hygiene observed. Each of the PTS sites scored above this with an average across the trust for PTS of 98%.
- We saw hand hygiene posters sited at all of the five bases we visited along with hand gel in the bathrooms, staff rooms, and offices.
- We inspected seven vehicles and all vehicles were clean. We saw gel, decontamination wipes, clean linen and clean seating and trolleys in all of the vehicles.
- Staff told us about the external company cleaning schedules for the vehicles at the sites we visited. There were different local companies for each site. The staff were happy with frequency and quality of the service delivered by the cleaning companies at each site apart from Walsall. The supervisor and senior operational manager advised us that they were currently reviewing the contract at Walsall.
- Staff were responsible for cleaning at PTS UHB. The locality manager carried out spot checks to monitor compliance to infection control processes. Any areas for improvement were identified and staff received feedback. The locality manager told us there was no vehicle wash down facility at this site because there was no foul water drain. They explained that dirty water from washing the vehicles had to go down a separate drain. They told us that they washed them down using the normal water drain. They also told us about the plan to relocate to another site, which would rectify this problem.
- All staff were able to tell us about the vehicle checks/ cleaning they did each day before taking a vehicle out. We saw this being completed and the information entered on the PDA, which was carried by each member of staff. This was the formal record kept by the trust of the daily vehicle check. These checks were in accordance with the trust cleaning policy for PTS vehicles.

- All of the site managers/supervisors told us that they did a daily check and additional checks and the staff supported this. The staff at Coventry base told us specific details of when the manager had carried out additional checks that week.
- Staff advised us that the referring trusts did not always give information about patients who may have an active infection. Staff advised that they reported this to their managers/supervisors at the site. Managers told us that they raised this at the monthly contract meetings with the referring trusts. Where staff had been advised, this was recorded in the 'special notes' by the call taker and was available instantly on the crew's PDA. We observed crew referring to this information when they collected patients.
- Staff were able to tell us about the deep cleaning policy following contamination. They would not use the vehicle again until this had been completed.
- Staff did not have clinical waste bags on the vehicles. Staff put clinical waste into domestic waste bags then deposited in clinical waste bins at the next clinical area they visited or back at base. They told us that their manager said they had to do this, although the trust did have yellow waste bags. The trust cleaning policy for PTS vehicles stated, "two spare yellow clinical waste bags should be available in a cupboard for use if clinical waste is produced." Staff adhered to all other standards in the policy.

Environment and equipment

- We checked the equipment on eight vehicles across the PTS service. This was five PTS vehicles and three HDU vehicles.
- All PTS vehicles carried resuscitation equipment. We checked HDU vehicles at the Coventry, Warwick and Stoke PTS sites. We found some issues at Coventry and Warwick sites which were: single use airways were kept in open packets when they should be stored in sterile packaging and opened only when used, and a number of consumables were out of date including dressings and alcohol swabs. One item was out of date in 2012, two items were out of date in 2013, five in 2014 and 2015, and one this year. In the third vehicle at Stoke, all consumables were in date.
- In the other five PTS vehicles we checked all consumables and equipment were maintained and in date.
- We were advised that other than the vehicle check recorded on the PDA no other record of checking of specific items of equipment or consumables was recorded in four out of the five sites we inspected. The vehicle check record cited 'stock checked against standard load list', however there were no standard load lists completed at these sites. There was one completed at PTS Stoke. The senior operational manager for Coventry and Warwick advised they were aware this needed to be done and had started planning for it.
- Vehicle faults were recorded at all PTS sites. All staff we spoke with advised if there was a vehicle fault the vehicle would be taken off the road immediately. Staff felt supported by managers to action this.
- Each site had a maintenance contract with a local garage for the upkeep of the vehicles. All staff advised that this was very effective with immediate repairs for simple issues such as bulbs or flat tyres. The senior operational managers advised a fleet supervisor maintained the contract with the garages. The fleet supervisor confirmed this.
- The clinical equipment working group audited medical devices, and the learning review group monitored trends from the audits. The manager/supervisor of each site carried out daily checks. All devices we looked at were in date for maintenance checks.
- Oxygen and consumables were stored in locked cabinets at all sites we visited. All sites were clean and tidy. The PTS Coventry site was based in an old GP practice, which was in a state of disrepair, the senior operational manager advised, and we saw that there were plans to relocate to a new purpose built site. The PTS UHB site was in a state of poor repair, no foul drain for the washing of vehicles, no staff car parking and no computer access for staff. Plans to address this situation were on hold until the trust had agreement that the contract would be renewed; it was out to tender at the time of our inspection.
- The vehicle fleet was dated with individual vehicles totalling more than 200,000 miles. Staff at PTS UHB reported frequent breakdown of vehicles. The trust gave the inspectors information that confirmed that PTS UHB had less availability of vehicles than the other sites for the period from April 2015 to March 2016 PTS. Stoke had the highest availability of vehicles across the PTS teams

of 98.9% and in contrast, PTS UHB had an availability of 88.3% for the same period. The information the trust gave the inspectors does not go deep enough to say that breakdowns was the reason for this.

- Staff at all of the sites we inspected described a range of seating types, we observed this in the PTS sites, and on the vehicles, we inspected. Bariatric stretchers were seen at PTS HEFT and PTS Coventry and staff at PTS Stoke advised that they were accessible at the main Broomhall hub for them. All long wheel base vehicles in the PTS fleet are bariatric capable and the floor is strengthened to take Bariatric 'Megasus' stretchers.We observed child restraints, wheelchair grooves, winches, retractable steps, low seats and seating with additional harness seat belting for those requiring upper body support.

Medicines

- The only medicines carried and administered on PTS vehicles was oxygen. The trust told us only suitably trained staff were able to convey patients on oxygen. Oxygen information was recorded at the time of booking the journey so that specific crew could be assigned. A dynamic risk assessment was carried out for each patient on oxygen at the time the patient was collected. If the correct crew had not been assigned, the risk was deemed too great and the journey postponed until arrangements could be made for crew who could administer oxygen. We saw oxygen information recorded at the time of booking, however we did not see any patients with oxygen being transported.
- The HDU vehicle, which was based at PTS Stoke, always had a paramedic crew on board who carried additional medicines in line with their registration and the trust's policy on medicines management.
- Only band 3 PTS crews carried out oxygen administration on the transport vehicles. If a patient had oxygen with them and the referrer had not advised the call handler of this, the journey may need to be cancelled or delayed if going home. Senior managers advised us that covering journeys for patients with oxygen sometimes proved challenging. The senior manager at Coventry and Warwick sites described how they had been doing some work looking at skill mix and shift patterns to ensure that they would not have to cancel journeys.
- There were 118 patient safety incidents recorded for PTS between October 2015 and April 2016 and none were related to oxygen cancellations.
- PTS staff told us they asked for and received oxygen information at handover from hospitals or at the time of booking. This would include type of device and how much the patient should have. We saw spare masks and cannulas in all of the vehicles inspected.
- We inspected a HDU vehicle at PTS Stoke and spoke with staff who manned the vehicle. On inspection of the vehicle, we saw that the intravenous controlled drugs used by the paramedics on the vehicle were stored correctly in the controlled drugs safe. Other forms of controlled drugs were stored in the locked glove compartment and the key remained with the driver. The staff advised these items were too large to fit into the controlled drugs safe, and as they felt they should be locked away this was the only other alternative. There was a sealed bag containing other medication, in an unlockable cupboard in the vehicle. We saw staff had not locked the vehicle. We were advised that although the trust had a policy, which we saw, stating that vehicles should be locked when unattended, staff told us that this did not always happen either when parked at the PTS site or when parked for pick up and drop off of patients. The trust responded immediately to concerns we raised about the unlocked vehicle and the storage of drugs. The trust changed the controlled drugs safe so that all controlled drugs could be stored in it, and sent out a reminder to all staff about locking unattended vehicles.

Records

- We reviewed records at the main Stafford control centre, the liaison desk at Walsall Manor Hospital and University Hospital of North Staffordshire and on three PDA devices held by crew. We also observed staff taking calls at the three call taking sites.
- There was a computerised call-taking system used across the trust that generated electronic patient records that were accessible to responding crews and staff in the control centres.
- In all cases the journey information, patient identification, escort information, special notes, and patient condition sections were complete. The oxygen therapy tick box was completed where required. Do Not Attempt Resuscitation was recorded.

- All crews carried a PDA to receive records relating to the patient and the journey.The trust carried out audits of quality of call taking at the Stafford control centre and staff showed these to the inspector. This included assessing the quality of information recorded for patient identification, GP, contact details, language and ethnicity. The records in the audit were rated excellent, good, satisfactory or below standard from a score for each item recorded.

Assessing and responding to patient risk

- The trust had a standardised procedure for dealing with people who become unwell unexpectedly. We saw this on noticeboards in the staff rooms of the PTS bases we inspected. Staff talked readily about the procedure and knew where it was located. Some staff we spoke with described instances where they had used the procedure and explained what their actions were which was in line with the trust's procedures.
- Staff gave a good response regarding assessment of patient risk apart from mental health illness. Some staff understood the need to risk assess each patient against the journey plan, for example they advised that they would read the journey plan, special notes and discussed the patient at handover and assessed risk for themselves.
- Seven staff felt unable to carry out risk assessments for the mental health contract at PTS Stoke with North Staffordshire Combined Healthcare trust (CHC). Staff at other sites also said that this was difficult in relation to people with mental health problems. This was because they felt they did not have enough information on the PDA from when the call was taken about the patients' mental health issues, they felt the training they had on mental health was not adequate and they felt unsure about restraining patients.
- Staff at PTS Stoke told us patient transport non-emergency crew and vehicles were responsible for transporting patients who may be informal or may be sectioned under the mental health act. Managers, however, told us that PTS staff did not convey patients sectioned under the mental health act. Staff did not seem to understand about sectioned and informal mental health patients being conveyed. Staff said:

They transported between hospitals with an escort.

They transported patients home from acute mental health wards without an escort.

They transported people from home to day centres without an escort.

They transported from acute wards to outpatients appointments with no escort.

The escort arrangement was dictated by CHC.

- Staff did not know if CHC carried out transport risk assessments. They sometimes were given verbal information about aggression but not always. CHC did not supply risk assessment documentation and PTS Stoke staff did not ask for any.
- The trust did not have an algorithm for mental health risk assessment but would ask if the patient had a mental health problem and if there was history of aggression or confusion. We saw this at two of the liaison desks we visited.
- There had been incidents of alleged abuse from patients towards PTS Stoke staff. Managers advised there was never any pressure on staff to transport a patient who may pose a risk to them. Staff supported this.
- We raised the issue of staff stating they did not have enough information to enable them to risk assess effectively. The trust responded quickly and held a meeting on 28 July 2016 to discuss the information and past history of patients that can be recorded on the transport booking system. This would improve access to appropriate and detailed information to the benefit of Combined Health Care and High Dependency staff via their PDAs so that they are appropriately informed of the condition, history and state of patients whilst under the transportation and care of WMASFT staff. The outcome of the meeting was that the PDA system would be updated to include relevant patient information, however the trust had to consider how this would be implemented and an agreed date for the update had not been confirmed prior to the writing of this report.

Staffing

- Senior managers reported no vacancies. There were no current vacancies for PTS on the trust's website. Staff and managers told us they felt there was enough staff as long as people were flexible and worked hard to cover

the rota. Managers covered shortfalls such as short-term sickness and annual leave with regular bank staff if regular staff could not cover the shifts themselves. We saw this at PTS Walsall and Stoke.

- PTS staff that provided routine transport consisted of band 2 crew members and band 3 crew members who received additional training to deliver oxygen therapy.
- The senior operational managers advised that it was their role along with the site manager/supervisor to plan shifts against demand. The senior manager at PTS Stoke advised that there were limited staff at band 3, therefore they and the interim base manager worked closely together to manage staff skill mix. They looked at the planned regular journeys for the team against availability of staff. This had recently started at PTS Stoke and Walsall but had been in place for a considerable time at Coventry and Warwick.
- We saw the trust had an escalation policy for each contract area. The escalation plans included use of bank staff, overtime, transfer of staff between bases, liaison with referrers to negotiate changes in pick up times and the use of external agencies if required.
- The induction for bank staff was the same as that for regular staff. Regular bank staff were used wherever possible and we observed this during the inspection.
- The trust had a lone worker policy; however, staff at different sites told us that they did not always feel safe. Three members of staff advised that they had been in situations where patients had been physically aggressive towards them and they did not feel there was an adequate system to call for help. They said they had told their managers and one staff member knew there was a plan to have a new PDA with a call for help option.
- Staff at PTS Stoke advised that, at times, they may have to travel long distances with an acutely ill mental health patient and, on occasions, there had been aggressive behaviour. They said that there was no emergency call system. Senior managers advised that the trust was rolling out a new emergency call system; however, a date for them to commence was not yet known.
- New staff at PTS Walsall, PTS Coventry, and PTS UHB felt well supported during their initial induction phase. They described that the manager paired them with experienced staff and that they had daily support from their line manager. Staff also described mentoring sessions regularly with their manager.
- Staff told us that some days were very busy and times for breaks were limited and on other days, they had adequate break times. There was varying demand for their service on different days and they were happy that on balance they felt they had adequate breaks. Apart from some low levels of sickness the service was staffed fully.

Anticipated resource and capacity risks

- We spoke with senior operational managers, staff and referrers into the PTS service regarding capacity and demand. The senior manager at Coventry and Warwick described how they regularly reviewed audit results relating to fluctuations in demand and reported delays. They advised they were meeting all their key performance indicators with an achievement of 98% against target. The targets were in relation to waiting times for the collection of patients, cancellation of journeys and aborted journeys.
- Managers used an electronic system to observe and review cancelled and aborted journeys, discharges, and renal waiting times.
- PTS Coventry had an adverse weather plan. The senior manager sent out regular text alerts advising crews of local routes that were affected. In addition, the senior manager had a list of volunteer drivers with 4x4 vehicles who could offer support during heavy snow. They also had a priority plan for renal and cancer patients to get them home.
- The trust would implement the PTS escalation plan for any capacity risks.
- We saw that the trust had business continuity plans. These plans included a number of situations such as loss of power supply, loss of heating/air conditioning, loss or disruption to water supply, severe weather, disruption to transport systems and staff shortages.

Response to major incidents

- Staff told us that in response to a major incident PTS would only become involved in transportation away for the affected area. The trust major incident plan 2015-17 stated that PTS participated in the hospitals' emergency discharge programme, participated in hospital-to-hospital transfers, transport at the scene for walking wounded and may be deployed to other treatment centres.
- The trust had a training package for PTS staff and supplied information relating to PTS on call officer training for major incidents.

Patient transport services (PTS)

Are patient transport services effective?

Requires improvement

We rated effective as requires improvement because:

- Variable performance regarding delays in transportation
- Lack of training for staff on understanding of mental health problems

However, we also saw:

- Regular fortnightly non-emergency senior management meetings held
- Close working with Healthwatch Coventry
- Good call handling and transport monitoring process at Stafford control centre.

Evidence-based care and treatment

- The trust provided transport across the seven sites against different contracts. The trust worked with the local clinical commissioning group (CCG) for the locality. Each CCG had a different contract for each PTS site. All of the senior operational managers and the director for commercial services told us details of the contracts and the trust provided each contract to the inspectors.
- All of the contracts detailed the requirements set out in the Department of Health Eligibility Criteria for Patient Transport Services (PTS) 2007. Each contract specifies acceptable times for collection and drop off for outpatient and day cases but does not take account of the National Institute for Care Excellence quality statement 6. This states that adults using transport services to attend for dialysis are collected from home within 30 minutes of the allotted time and collected to return home within 30 minutes of finishing dialysis. This target was not set by the CCGs for the trust to achieve.
- The senior managers were able to describe regular fortnightly non-emergency senior management meetings (NES). At this meeting, they reviewed the key performance indicators of each contract.
- The senior operational manager for Coventry and Warwick described how they had been involved in developing eligibility criteria for the two localities. They told us that there was close working with the CCG, Healthwatch and local patient groups.
- The senior manager for Walsall advised that financial considerations were included in the eligibility criteria for that locality which the local CCG directed. This meant that people claiming the mobility portion of Personal Independent Payments (PIP) were not eligible. The director for commercial services confirmed this. The trust met all of the criteria of the department of health guidelines. This is where the medical condition of the patient is such that they require the skills or support of PTS staff on/after the journey and/or where it would be detrimental to the patient's condition or recovery if they were to travel by other means. Or where the patient's medical condition impacts on their mobility to such an extent that they would be unable to access healthcare and/or it would be detrimental to the patient's condition or recovery to travel by other means. In addition, they met the escort eligibility criteria of recognition of a parent or guardian where children are being conveyed.
- The trust had a service specification for each contract. These were locally agreed specifications or protocols based on the CCG contracts. The trust showed us that the service specifications were based on activity for the locality from the previous year. The specification covered requirements in relation to local need. These included training for staff, vehicle type, cleaning and equipment, management of bookings, communication, cancellations, delayed and aborted journeys. It also took note of patient categories in relation to mobility, dignity and collection and set down. It laid down the performance management, quality standards, and patient satisfaction. The service targets were then based on these guidelines.

Assessment and planning of care

- Call handlers assessed patient's needs at the time of booking by using a standard referral process. This process included asking specific questions about mobility, dementia, need for an escort, medical conditions, bariatric needs, and communication needs. We observed this at Stafford control centre, Walsall liaison desk, and University Hospital of North Midlands liaison desk.
- Managers and call handlers told us and we observed the recording of journey specifics in relation to journey planning. For example, the supervisor at PTS Walsall advised that the liaison desk was asked to book a bariatric patient with a particularly difficult mobility problem. They went to A&E and personally assessed the

patient's journey needs. The call handler then recorded this accurately on the electronic booking system so that the crew attending would have up to date specific information.

- Family members and referring staff at handover gave additional information verbally to the attending crew. This was not always thorough and staff reported that sometimes they felt they did not have enough information to plan effectively. For example, staff told us that there had been cases where escorts wished to travel with patients and this had not been booked in advance. This meant that the booking had to be cancelled if the attending crew risk assessed and there was a need for an escort as there was not room on the vehicle to take them.

Nutrition and hydration

- There was not usually a need to support patients with food and drink for short distances. For any long journeys, staff stopped at shops or service stations if required. They did not carry water or food.
- Staff told us that if a patient was on a long journey and required help to eat and drink this would meet the criteria for an escort and one would be booked in advance.

Patient outcomes

- The PTS service measured patient outcomes by targets in relation to transport times, cancellations, and aborted journeys.
- The PTS operated individual contracts for the seven sites it covered, directed by the local CCG. Each contract contained performance indicators for a range of parameters. Senior managers told us they were responsible for their own contract performance monitoring.
- There were performance indicators for pick up, drop off, and call answering times for all contracts.
- The threshold against all indicators was 98%.
- The trust supplied data for the period from March 2016 to June 2016, which showed that the trust was achieving between 95% and 98%. The trust had an action plan in relation to those areas falling below 98%. For example, the trust showed us the exception report for the PTS Stoke contract. This report detailed key performance indicators for each day and showed where the indicator was not met. The report for the date 26 April 2016 showed that for the standard – '100% of patients collected within 30 and 60 minutes after being booked ready' the contract for that day only achieved an overall performance of 50%.PTS Stoke was different from the other contracts as it had continual problems in meeting its targets. The provider sent the inspectors this information and regarded this as a typical day. The trust was aware of this and was working towards improvement.
- We observed the electronic screens at Stafford control centre and three liaison desks, which displayed information about delays. The control centre staff were able to explain the information on the screen and they told us that performance against time is monitored and managed by:

Local on-site screens On –site controls

Regional control teams with screens high lighting patients booked ready and waiting

times

Communicate with relevant clinics to make aware of any delays

Communicate with patients

Escalation emails to operations managers/senior operations managers about

management of activity/delays throughout each operating day as required.

Competent staff

- Staff who manned the high dependency units (HDU's) received comprehensive training, which consisted of: one week BTEC Level 2 First Person on Scene, four week Level 3 Certificate in Emergency Response Ambulance Driving (if driving the HDU high-speed vehicle), local Induction, and corporate Induction. The trust trained HDU staff to First Person on Scene level. The trust did this to ensure that if staff were required to give first aid, they would be able to do so.
- For those PTS staff who did not man HDU's the training consisted of three days PTS programme, two days driving programme, local induction and corporate induction.
- Staff had mental capacity training and one new member of staff showed us a fob with mental capacity act questions. They had this on their key chain at all times. The mandatory training workbook confirmed that this

training is available alongside learning disabilities, although staff advised they did not have training for learning disabilities. Newer staff said that they had received dementia training, but staff who the trust had employed for more than 12 months said they had not. Some staff said they had conflict resolution training once and some said they had never received it.

- The trust supplied inspectors with information that told us the trust target for annual appraisals was 85% for 2015/16. All PTS sites achieved this target apart from support to clinical staff non-emergency control UHB that was 81.82%, support to clinical staff at PTS Stoke, which was 80.7%, and support to clinical staff at PTS Worcester, which was 84.1%.
- The trust showed us sickness figures for the trust as a whole for the period April 2016 to date. Rates were within target for all months apart from December and January. The trust supplied sickness rates for PTS staff for the same period, which showed no areas of high short-term sickness over time.
- Managers told us about and we saw appraisal information on the noticeboards at Stafford control centre, PTS Walsall, Stoke and Coventry. Staff at Stafford, Walsall and Coventry told us that they knew when their appraisals were due because they were emailed and informed by their manager of the date. They felt their appraisals were meaningful and were able to have time to discuss any issues, progress and development. Staff at Stoke said that they had not had regular appraisals and if they had, they were not meaningful. They felt it was purely a paper exercise. Staff told us that the appraisal information on the noticeboard had only very recently been put up. The interim locality manger told us that the PTS Stoke site was behind on appraisals and the new manager would address this when they started.

Coordination with other providers

- Senior operational managers had monthly contract meetings with the other providers of services and the local CCG. They told us that they had a direct contact with the contract manager for the trusts, both at the meetings and on an ongoing basis. The other provider trusts were involved in development of the information that goes into the call taking template.
- We spoke with two patient transport managers and one contract manager, for providers that the trust worked with and they felt concerned about the effectiveness of the contracts. This was in relation to PTS UHB and PTS Stoke. The managers felt more could be done to manage delays. One of the managers said this was an ongoing problem; another stated that there had been a recent change in locality management and felt that communication and responses to issues were getting better. A manager from one of the provider organisations told us that monthly contract meetings revealed that the key performance indicators for the PTS Stoke contract were continually under achieved. One of the managers had escalated this to the director of commercial services.
- We spoke with eight other staff from other provider trusts. There was a mixed view of the effectiveness of their collaboration on a day-to-day basis. Some staff reported good communication and a willingness to address delays and others stated that there were difficulties particularly regarding pick up of renal patients and other patients from a neighbouring trust. Thursdays and Fridays were particularly bad with patients being collected well into the evening. At another neighbouring trust), we were told that no target times were given when booking discharges, which made planning for medication, care packages at home, and family arrangements difficult. At one local hospital, there was a particular problem with cancellations if home access information was not available at the time of pick up. Staff advised that the crew would cancel and ask the staff to rebook once the information was made available. They felt that the crew could have handled this more effectively with a more collaborative approach to trying to rectify the problem at the time.
- Stafford control room monitored delays and communicated between the crews and the other providers if there appeared to be a delay.
- Staff at the Stafford control centre advised that pick-ups for appointments had priority over discharges.
- There was an agreement with the other provider trusts that Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms were shared. Staff told us that this was always the case and had never had any missing forms. The referring trust provides this information at the time of the first booking.

Multidisciplinary working

- Staff described good working relationships with providers and said they would always ask about any changes regarding the patient they were picking up that were relevant.

Patient transport services (PTS)

- Staff said that other providers did not always offer up this information themselves.
- Senior operational managers had regular meetings to discuss handover with other providers. One senior operational manager told us that they had provided workshops for staff at the local acute hospital regarding the importance of a good handover.

Access to information

- Information received from other providers such as care homes, acute hospitals and family/carers was recorded in the referral screen and available to the crews at the time of pick up. This included information about mobility, health conditions, communication issues and any other information that was important at the time, such as, if the patient had an infection.
- Staff gave examples of this, such as DNACPR orders, where the trust would retain this information on the referral system for future use. Staff were aware that there was trust guidance to follow for patients with the appropriate forms and the inspectors saw the PTS Guidance for DNACPR Forms.
- Staff also told us that there was not a set of questions relating to health conditions that was consistently asked when the journey was booked. A general question asking if the patient had any health issues was asked, but there was not a direct check for certain conditions, such as diabetes, asthma, epilepsy or heart problems.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Mental Capacity Act training formed a part of the trust's induction programme.
- Staff at PTS Stoke told us that they needed more mental health training to support them with the mental health contract with North Staffordshire Combined Healthcare NHS Trust. The trust responded very quickly when we advised them that staff did not feel they had enough understanding about mental health problems. The trust put four training sessions on for staff immediately after we raised this with them.

Are patient transport services caring?

Good

We rated caring as good because:

- Staff consistently showed compassion when with patients and carers.
- Staff went out of their way to build relationships with patients.
- Good verbal communication

Compassionate care

- The latest friends and family showed that 79% of PTS users were extremely likely or likely to recommend the service. In addition, Healthwatch Coventry carried out a patient satisfaction survey (May 2016) which showed 14 people rated their overall experience as excellent, 19 as good, two as poor, five as very poor and five did not answer.
- We spoke with four patients/carers and observed interactions with these and two other patients. We spoke with seven staff from referring trusts about compassionate care. They all told us that staff greeted patients and carers in a very friendly manner, and we observed good interactions throughout.
- Staff ensured that patients were covered and dressed appropriately before going outside. They did not rush patients when they were putting on coats and assisted them where needed. We observed staff ensuring blankets were secure.
- All of the patients and carers told us they were happy with the PTS staff. One patient advised how he had a good relationship as the same crew attended him regularly. They were all on first name terms.
- Staff got to know the regular patients as they were all small teams and patients could sometimes travel with them up to three times per week.
- Staff were very passionate about the relationships they had with patients. They felt valued by the patients and talked about the difference they made in people's lives. They described that they were sometimes one of only a few contacts the patients have with the outside world and they tried to make the experience a good one.
- Staff were aware that occasionally patients found it difficult to travel with other people. They talked about positioning of people within the vehicle and advised us that a volunteer car or single transport vehicle could be used. They felt proud of how well they knew patients and felt that they put them at ease and were able to manage sensitive situations well because of this. Staff

told us they asked for as much information as possible during handover and check their PDA before departing with patients. We observed this happening for all of the patients we observed them transporting.
- For long journeys, staff told us that they would inform patients when they were nearing a service station to ascertain if the patient required food or drink or to use the toilet.

Understanding and involvement of patients and those close to them

- Call handlers advised people calling in to make a booking of the eligibility criteria at the time of the call. We observed this at the Stafford control centre and Walsall liaison desk.
- All communication with patients, families, and carers was verbal.

Emotional support

- Staff told us it was important to keep patients informed of reasons for delays in picking them up. They felt that if they were open and honest, in general patients and escorts understood.
- Most of the staff understood that for some patients, such as those who attended for chemotherapy or renal dialysis may not feel well and were tired after their treatment. Only one staff member had been involved in a death of patient whilst transporting them. This was a patient with a DNACPR in place. The staff member described the actions he took and the communication with the family. The staff member received an employee letter of thanks from the chief executive in relation to his handling of the situation.

Are patient transport services responsive to people's needs?
(for example, to feedback?)

Good

We rated responsive as good because:

- Good escalation process and planning for the next day's journeys.
- Good awareness of patients having individual needs.
- Good process to alert patients and hospitals about delays in picking up people for appointments.

However, we also saw:

- Learning from complaints about delays in patient journeys needed to be improved.

Service planning and delivery to meet the needs of local people

- The senior operational manager for each contract was responsible for managing capacity and demand. Managers told us they based the number of vehicles on the population needs. For example, at PTS Stoke there were seven vehicles for the University Hospital of North Midlands contract; five based at Stoke and two based at Stafford. This was because the hospital the contract was with operated from a large site in Stoke and a small site in Stafford.
- All of the managers across the five sites we inspected reviewed planned journeys for the day and staff confirmed this. If there were any areas, where they felt they may have breached transport times the managers contacted each other and they redeployed staff to assist another team. We saw this in operation at PTS Coventry and PTS Stoke.
- The trust had an escalation process for each of its contracts for PTS. The trust supplied the inspectors with a copy of the escalation plan for each contract. The plans detail monitoring of transport times, cancellations and aborts, action they take to prevent breaches of the contract and remedial actions if they occur.

Meeting people's individual needs

- For anyone requiring an escort this question was asked at the time of booking, however if this was not arranged at the time of booking an escort could not be added at the point of pick up.
- At the Stafford control room and the hospital liaison desks, we observed call handlers asking if the patients had any specific seating requirements. We saw this information recorded in the patient journey details. We saw there were adaptions to seating when we inspected the vehicles.
- We were given examples of how journeys were planned to take account of specific patient needs, such as for a patient with incontinence they would be picked up last and dropped off first as long as this did not lengthen the

journey overall excessively. Staff told us information about bariatric needs was given at the time of booking and the journey would be planned to accommodate bariatric seating and the number of crew required.
- Staff did not make any special arrangements for people with learning disabilities or mental health issues, other than to try to communicate clearly and get to know the patient and their specific needs.
- Call handlers told us if pick up journeys for outpatient appointments were running late, they would call patients and advise of this and also liaise with clinics. This was done to alleviate concerns that people would miss their appointments and to help the clinic staff move time slots for patients where possible.
- The trust used language line solutions for interpretation for anyone who's first language was not English. This was a telephone interpreting service that enabled the trust to communicate in over 200 languages 24 hours a day, 365 days a year. Staff told us they could access this from any phone at the pick-up unless this was the patient's own home. At the patients home staff relied on family members or carers.
- The trust used a text messaging relay service. The trust trained all call assessors to use the text relay service. This service provided a relay assistant to act as an interpreter for people with hearing difficulties. The relay assistant typed what the call assessor said, so that the caller could read their words in real time. The relay assistant then spoke the words the caller typed, so the call assessor could hear the caller's words in real time.
- There were no patient information leaflets at the PTS sites to advise patients of what to expect about the service, and they told us they did not feel patient leaflets were required as the verbal communication appeared to be effective. They also said there were no alternative language leaflets or easy reading/pictorial written information, but they could obtain easy read information if required. Escorts were booked for any patients with known communication issues and we saw evidence of them asking questions about communication at the control centre and liaison desks.
- The trust delivered services across the West Midlands, which is the second most ethnically diverse region in the country.

Access and flow

- Staff at the control room told us there were sometimes requests for same day journeys. This was difficult to accommodate and staff told us for PTS University Hospital Birmingham they only carried this out for hospital discharges, dialysis, and oncology. Staff never had to cancel any same day bookings once they had arranged them, as they liaised with the PTS service involved. They said that hospital discharges had to wait until the evenings, which was corroborated by staff from the provider trusts who said patients being discharged often had long waits to be collected. We saw the trust monitored discharges in the discharge activity and performance reports. As previously reported, most contracts were achieving 95% to 98% with the exception of one.
- Control room staff ran the following day's journey plans at 3pm and if they highlighted any problems, they advised the local PTS site who would look to alter shifts for the road crews. We saw this at PTS Walsall and Stoke.

Learning from complaints and concerns

- We saw complaints information posters on all vehicles we inspected. These were clear with contact details. All of the staff we asked knew what to tell patients about how to make a complaint.
- All of the senior operational managers told us about how the trust handled complaints. They received complaints and discussed them with the locality manager/supervisor. They worked with patients and other complainants directly to resolve issues. They also worked with staff on an individual basis. They told us they discussed specific issues raised about a member of staff with them and an action plan of things that needed to be done to prevent a reoccurrence. If there were any themes identified that would benefit the team, the manager would email the team or discuss in meetings.
- The trust aimed to process complaints within 25 days. The trust average for the period from April to March 2015/16 was 26 days with the PTS average at 26.7. The trust also told us that PTS had 479 complaints for that period.
- The trust provided data that told us that response/ waiting times (delays) accounted for 44.1% (211), other at 18.6% (89), attitude and conduct at 12.3% (59) and call management at 10.2% (49).
- All of the staff we spoke to about complaints said they knew that delays were the main reason for complaints but this remained unresolved.

Patient transport services (PTS)

Are patient transport services well-led?

Requires improvement

We rated well-led as requires improvement because:

- Mixed understanding of the PTS service risks amongst senior operational managers
- Lack of visibility of senior management above senior operational manager level
- Lack of timely response to management issues at one PTS site
- Lack of leadership and staff engagement on surveys and performance issues at PTS Stoke

However, we also saw;

- Strategic plan well was embedded.
- Close working with Healthwatch on patient feedback
- Good management support for staff at most sites.

Vision and strategy for this service

- We saw the trust vision and values posters on display at all of the sites we visited. The managers had positioned them in the staff rooms, although staff gave a mixed response about the trusts vision and values, with some staff aware and others not. Staff from four out of the five sites we visited us told us that they had regular updates from their locality manager/supervisor or the senior operational manager. They said this was either verbally as and when, during team meetings and emails from their manager. We saw information on display about the new vision for PTS Coventry; we saw that the managers had involved staff in the development of this. Most staff had a clear understanding of their own service area and how they fitted in to it. All PTS staff had a base which they went to on a daily basis and this is where information was sited and the senior operational manager visited regularly.
- The trust provided inspectors with a copy of their 2016/17 priorities and they told us about specific ones relating to the patient transport service (PTS). This included the plan to have mentors and apprentices on the PTS vehicles. The trust also told us about their strategic plan to increase PTS contracts and all of the senior operational managers were aware that growth was a strategic objective. The senior operational manager involved in the new contract for Cheshire told us about the progress on this contract. They described their role and that the contract was due to go live imminently. Senior managers also told us that there were plans to raise the profile of PTS, for example, they had a plan to provide PTS staff with the same uniform as emergency staff. There was a new operating model the trust had proposed for 2017 that involved PTS taking on urgent care.
- Managers described that the clinical commissioning groups had awarded contracts on a short-term basis and that they were involved in reviewing their contracts continually to ensure they were meeting targets. The senior operational manager and the locality supervisor for the University Hospital of Birmingham (UHB) contract told us the contract for their service ended in April 2016 They said that the new contract was currently out to tender and they hoped that they would know the outcome by autumn this year. The trust had made staff aware the contract had ended and provided information to staff on the progress on the new contract. We saw the information posted on the staff noticeboard. The senior operational managers knew what the key performance indicators (KPIs) were for their contracts, they were aware of the need to be financially stable as a service and that the success of attracting renewed contracts was based on meeting the journey KPIs, quality, and safety.

Governance, risk management and quality measurement

- The trust provided information that showed the PTS service had nine risks recorded. All of the senior operational managers had daily access to the risk register and were able to show us this. There was a live feed so that they were aware of any new risks in a timely way. The senior manager for Walsall and Stoke advised the trust had told them that there were no risks against the contracts and could not tell us any risks they were aware of locally. The senior operational manager for Warwick and Coventry showed us the PTS risk register.
- All of the senior operational mangers told us that they discussed risks at each non- emergency service meeting. The meetings were fortnightly and the trust had supplied inspectors with 13 sets of minutes. We saw the director of commercial services, senior operational

managers and other key individuals in the trust attended them. We saw they regularly discussed risk at these meetings. The trust supplied inspectors with the PTS risk register.

- The trust governance team analysed risks for PTS and reviewed these at a more senior level. The trust supplied inspectors with the risk team report on incident reporting trends that they presented to the health safety and risk committee – June 2016. This contained specific information relating to PTS.
- Managers maintained governance procedures for the volunteer car scheme, which included MOT, insurance, tax, and DBS checks. They monitored a spreadsheet that contained all of the vehicle and driver information on a monthly basis. The trust supplied the inspectors with this information they had completed up to the 20 June 2016.
- The executive team displayed a clear understanding of managing risk in their response to issues of risk that we raised with them at the time of the inspection.

Leadership of service

- All of the senior operational managers told us about the PTS structure. The trust supplied inspectors with a PTS structure chart, which confirmed what managers told us.
- Staff at PTS stoke saw the senior operational manager for their area on average, fortnightly. Staff said this was partly due to shift working and they told us that they might visit more often than that. Only one staff member told us that they did not know who the chief executive was. The acting manager was based on site. Staff at Walsall site saw the senior operational manger regularly, as did PTS UHB, PTS Heart of England (HEFT) and PTS Coventry. Staff gave a mixed response about visibility of the senior team above this level. Across all of the sites, some staff had met the chief executive, some had not, and they gave the same message about other more senior managers.

Culture within the service

- Staff at PTS UHB, HEFT, Coventry and Walsall told us that culture within the teams was good. People gave examples of how they had worked together to support each other. They talked openly with each other and their managers and their managers were open and honest with them. Managers told us at all sites that there was an open door policy for anyone that wanted to discuss issues or ask for information.
- Staff at PTS Coventry, PTS UHB, PTS HEFT and Stafford control centre told us that they were well supported by their managers. They gave examples of health problems that managers were supportive of without hesitation. One staff member told us about good support they got for religious beliefs. Staff at PTS HEFT and PTS Coventry told us of examples of where managers had supported them regarding issues relating to sexual orientation. We saw a staff diversity board on display at PTS Coventry in the staff room. Staff at PTS Stoke told us that there was a negative culture, but felt that there had been a recent improvement. They had told senior managers about this and the issues surrounding it. They told us it took a very long time for senior managers to act upon the issues.
- People stayed in their jobs long term and the trust supported this with information. This information showed that there was less than 2% turnover from April 2015 to August 2016.

Public and staff engagement

- Staff at PTS Coventry told us they had been involved in the planning of their new base, and we saw the suggestions and comments staff had made during the consultation phase of the project. The senior operational manager for PTS Stoke told us she and the locality manager had asked staff what improvement they would like to see about their work environment. They showed us they had acted upon this as they had provided staff with new sofas and a TV in the mess room. Staff at PTS UHB knew the contract for their service had ended and that a new one was out to tender. This information was in the team briefing.
- Staff at PTS Stoke said they had no involvement in discussions on the contract. They said they knew it was failing to meet its key performance indicators but they do not get chance to put their point across about this.
- The trust carried out several patient surveys from April 2015 to March 2016. This included the friends and family test on a quarterly basis. The trust told us that 79% of PTS users were extremely likely or likely to recommend the service. The senior operational manager for PTS Coventry and Warwickshire had been involved in a patient experience survey alongside Healthwatch

Coventry. They described the survey in depth and told us how they had used the results of the survey to make improvements in the planning of transport for renal patients.

- The trust took part in the 2015 NHS Staff Survey and had developed an action plan in response to the results. We saw the June 2016 version of the action plan where six out of the 11 action points were green and on target, three were amber and two were un-coded. Most of the PTS sites were aware of the staff survey; however, PTS Stoke told us they had never been involved in surveys until the new interim manager was appointed. They said there had been a recent survey about shirts across PTS sites but they had not taken part. The trust provided us with responses to the shirt survey with only 10% of PTS staff having taken part. In contrast, emergency staff made up 75% of the returns.
- Following a meeting with the trust post inspection on 25 July 2016 to discuss concerns raised by staff from PTS stoke, senior trust members visited the area on 27 July 2016 and met with staff.
- The meeting was attended by Combined Health Care and High Dependency staff and provided an opportunity for a general Trust update, Commercial Services and PTS update, actions currently being taken, and 'open house' discussions on matters pertinent to the Combined Health Care and High Dependency operations. Monthly meetings have been established.
- Additionally, Open & Informal Staff Mess-room meetings have taken place with the PTS and Commercial Services Director on the 25, 26, 27 and 28 July 2016 on a range of matters and staff observations – subjects have been matters of interest or concern to the staff within the Combined Health Care and High Dependency contracts.
- Senior management explained the sessions were informative and helpful, and have paved the way for better management understanding and communications going forward.

Innovation, improvement and sustainability

- The senior manager for PTS UHB and HEFT and the senior manager for Coventry and Warwick knew about the trust five-year strategic plan for commercial services. The trust supplied inspectors with a copy of the plan and the board papers for December 2015, which clearly showed that they discussed and approved the plan. The plan took note of objectives, outcomes, marketing, strategic partnerships and joint ventures and risks. The trust had a clear understanding its position in the current market and the need to grow the commercial services to ensure success of the service and reduce risks of sustainability.
- The senior operational managers told us that the patient advice and liaison service (PALS) gave weekly feedback to themselves and locality managers. They would then deal with the issues individually with the relevant staff. Staff at PTS Stoke told us that they did not get feedback about complaints. Staff at other sites said that they had feedback by individual discussion.
- The trust training team told us about the learning review group and their role in influencing training for staff. They reviewed incidents to identify any themes in skills gaps. The training team then incorporated the recommendations into the development of training for the following year's updates.

Emergency operations centre

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

Information about the service

West Midlands Ambulance Service NHS Foundation Trust serves a population of approximately 5.6 million people across the West Midlands (Shropshire, Herefordshire, Worcestershire, Staffordshire, Warwickshire, Coventry, Birmingham and Black Country), covering approximately 5,000 square miles.

From April 2015 to April 2016 the trust received 1,215,110 calls via 999 to their single virtual Emergency Operation Centre (EOC) which is split into two operations centres located in Dudley and Stafford meaning all calls were routed to the next available call assessor.

The EOC dispatch functions were based at both EOCs and co-ordinated a variety of resources to respond to calls, which included double-crewed ambulances, rapid response vehicles, community first responders, specialist units and air ambulances.

The EOC provided a 24/7 service throughout the year.

The trust received and triaged 999 calls from members of the public, other emergency services and healthcare providers. They also received requests to convey patients from the community into care facilities or transfers between hospitals from health and social care professionals.

The EOC also provided assessment and treatment advice to callers who do not need an ambulance response, a service known as “hear and treat” through their Clinical Support Desk (CSD) and triage process.

The EOC also provided specialist operational support for specific incidents including mass-casualty incidents, and an overview of capacity in the local area through the EOC Regional Co-ordination Centre located in the EOC at Dudley.

Each EOC had facilities and equipment for staff and operated from a single Computer Aided Dispatch (CAD) system, which meant that all safety, performance, quality and activity data was reported as one single EOC. Throughout this report, data and evidence relates to both EOCs unless specifically stated otherwise.

We visited both EOCs during our inspection, spoke to 42 members of staff and looked at 12 patient records.

Emergency operations centre

Summary of findings

We rated the EOC within West Midlands Ambulance Service NHS Foundation Trust as good for safety, effectiveness, caring and responsiveness and outstanding for being well led. We rated the service as good overall because:

- Staff understood their responsibilities to raise concerns and report incidents and the service had a good safety track record.
- There were robust systems and processes in place to keep patients and staff safe from abuse and avoidable harm.
- There was a good level of staffing and skill mix to meet the demands of the service.
- Mandatory training levels exceeded trusts targets and were above 95%.
- The EOCs were visibly clean and tidy and the environment and equipment was suitable for the operational activity in EOC.
- The service was the only ambulance trust in the UK to meet national targets for response times for the most serious 999 calls in 2015.
- The EOC consistently answered over 95% of all 999 calls within five seconds.
- There was a good consistent track record on performance and staff worked together at all levels to achieve this and safety was being regularly reviewed through investigating incidents, governance meetings and local audits.
- The EOC worked well with other teams internally and externally to improve and achieve good patient outcomes.
- We found the service to be caring towards their patients and each other.
- The EOC had a clear vision and strategy to continuously improve this service.

The EOC had an established and experienced leadership team who were visible and approachable to staff at all levels.

Is emergency operations centre safe?

Good

We rated the EOC overall as good for safe because:

- Incidents were reported appropriately via an electronic system and investigated swiftly with identified improvements made.
- There were clear systems and processes in place to protect children and vulnerable adults from abuse.
- Robust systems were in place to assess and respond to patients' risks.
- The service had robust processes in place to monitor and respond to anticipated and unplanned capacity risks.
- Mandatory training rates exceeded the trust's target of 95%.
- 99% of staff had received regular meaningful appraisals.
- The service had a comprehensive plan to respond to major incidents.

However, we also found

- Staff were not aware of incidents that had affected change so learning was not always shared.

Incidents

- From March 2015 to February 2016 there were no Never Events reported for this service. A never event is described as wholly preventable incidents, where guidance or safety recommendations that provide strong systemic protective barriers were available at a national level, and should have been implemented by all healthcare providers.
- From October 2015 to April 2016 there were 43 incidents reported for this service. The main theme of incidents was categorised as delay in ambulance response.
- From May 2015 to April 2016 there were two incidents categorised as serious and reported to the Strategic Executive Information System (STEIS). We saw that serious incidents were robustly investigated with a comprehensive root cause analysis, recommendations and action plans.
- Staff at all levels understood their responsibilities to raise concerns and had access to the trust wide electronic incident reporting form. The trust's policy on

reporting and investigating incidents stated that staff could report the incident directly using the electronic form or they could report the incident verbally to their supervisor or line manager (who was then required to fill out the form).

- Incidents related to EOC were identified in a number of ways: through routine 999 call and dispatch audits, via operational colleagues, complaints received through PALS and enquiries from other emergency service and other healthcare providers. We saw there was a robust process for investigating incidents and managers tasked with investigating incidents were able to describe this to us.
- Staff who had reported incidents told us that they received individual feedback and we saw evidence of this when an incorrect location entered on a call led to a delay in arriving to a patient. There was no harm to the patient and the member of staff received full feedback and support and advice to minimise the risk of this re-occurring.
- Two members of staff we spoke with felt if details about an incident were known then this may cause undue distress to a colleague who had made an error. This suggested a small number of staff were not fully aware of the concept of learning from the factors that contribute to incidents in order to improve patient safety; alternatively, the trust's policy on 'no blame' culture surrounding incidents may not be fully embedded at all levels.
- We saw evidence of changes to practice as a result of incidents; for example, the EOC had developed their own tool to help call-assessors assess a patient's rate of breathing and help identify agonal respirations (an inadequate pattern of breathing associated with pre cardiac arrest states). Staff were aware of the change and the new tool; however, no staff we spoke with were aware of the incidents or circumstances related to the change. This meant that they were not able to put context to the change, understand the factors that had contributed to the change and apply the learning in an informed manner.
- We saw that incidents from national patient safety alerts were discussed at local and trust wide meetings.
- Staff told us that they were encouraged to report instances of verbal abuse using the incident reporting form; however, staff told us that these instances were very rare. All staff told us that they recognised the difference in the language and terms used by an emotional or distressed caller and language that could be termed as abusive or inappropriate. Staff gave examples of abusive behaviours that included any racial or sexually inappropriate language or threats of violence to a member of staff. Staff told us that they would report any incidents they deemed to be inappropriate or abusive and their managers supported them.
- The trust had a learning review group, which consisted of senior managers from each area including EOC. The group held quarterly meetings and reviewed incidents to identify trends or issues and discussed ways to disseminate learning. The learning review group was responsible for providing assurances to the board of directors that incidents with opportunities for learning were identified and appropriate action was taken; we saw evidence of this in minutes of meetings.
- Following major incidents or incidents of high media interest, comprehensive debriefs were conducted which involved all staff who had been involved in the incident. Call-assessors and dispatch staff were invited to these debriefs. We saw how these resulted in improvements to the service. For example, an incident at a theme park where assumptions had been made regarding attendance of other emergency services. Standard operating procedures had been changed to ensure that other emergency services were always contacted to ensure that they were aware of the incident and to ascertain what if any deployment they were making.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- Staff were aware of the trust's duty of candour 'being open' policy. Staff we spoke with understood the importance of being open and transparent and gave examples of when they had offered patients an apology when things went wrong. For example, we saw written evidence of patients being offered an apology and reasonable support when an ambulance was delayed in responding to patients.

Mandatory training

- Mandatory training was delivered to staff in EOC through a mixture of self-directed online learning, a workbook and classroom teaching. Some staff told us that they attended at least one day training per year at the trust's training facility.
- Training was designed to meet statutory and legal requirements and also to raise staff awareness of specific areas of care such as communicating with patients with complex needs or topical learning identified through incidents.
- Training for all staff in EOC included safeguarding level one and two for adults and children, Infection control, fire safety, information governance and systems updates.
- All staff we spoke to told us that there mandatory training was up to date and the figures received from the trust showed that 97% of staff had completed their training for 2015/16; this exceeded the trust target of 95%.
- The Clinical Support Desk (CSD) was staffed with paramedics who were able to provide clinical advice for patients and staff. The mandatory training for CSD was the same as EOC and included specific clinical updates in line with the trust's policy.

Safeguarding

- Robust systems, processes and practices essential to keep people safe from abuse were put in place and communicated to staff through mandatory training. There were systems and policies in place to safeguard those in vulnerable circumstances; for example, the trust had a comprehensive safeguarding policy, which included how to manage 999 calls for children accessing the service who were aged 16 and under. The call-assessors protocols included guidance on how to manage 999 calls from patients with complex needs like dementia and staff had received specific training on communicating with patients with learning disabilities.
- The intercollegiate document 'Safeguarding children – Roles and competencies for healthcare staff' published by the Royal College of Paediatrics and Child Health (RCPCH) 2014, states that all ambulance staff including control staff should be trained in safeguarding children levels one and two. Safeguarding training was included, as part of mandatory training and 97% of all EOC staff had completed safeguarding training. When we asked staff what level they were trained to they were unsure, however, the trust's safeguarding lead confirmed that all staff were trained to level two.
- Staff showed a good awareness of how to identify concerning situations, for example background noises, silent and terminated calls. Staff were able to describe their actions in these situations and we saw that this was included in call assessing guidance.
- Staff in all positions in EOC were aware of how to make a safeguarding referral and told us about the single point of access, which was a safeguarding referral line that all staff could call to make a referral or ask for advice and guidance. Most staff had the details on a plastic card, which was kept with them or knew where to find the information on the trust intranet. We also saw the referral process was on display in the EOC.
- From April 2014 to March 2015, there were 41 adult safeguarding referrals and four safeguarding referrals made for children through EOC.
- Each individual team had a designated safeguarding lead and staff told us that they could liaise with them if they required advice or support.
- Staff we spoke to displayed good awareness of situations that would need to be reported to local authorities in the case of children and adults.

Cleanliness, infection control and hygiene

- Infection control policies and procedures formed a part of EOC staff's mandatory training. Staff told us that this incorporated their own work environment and that of the responders, for example, staff told us what the requirements were for a crew to disinfect their vehicle and equipment if they transported patients with specific categories of infection.
- The EOCs were visibly clean and tidy and staff had access to sanitising wipes and alcohol gel at each workstation and at the entrance to the EOCs.
- We saw the cleanliness and infection control in EOC was discussed at governance meetings and was regarded as integral to staff welfare and delivering operational objectives.
- Infection control audits for EOC premises were carried out quarterly in line with the trust's policy. The trust provided us with data that showed from October 2015 to September 2016 the EOC at Millennium Point achieved an average of 84% and the EOC at Tollgate achieved an average of 89% - the trust target for

compliance was 90%. We saw that when areas were identified for improvement appropriate actions were taken. For example, we saw the EOC at Millennium Point scored 76% compliance in April 2016, an action plan was developed which included replacing furniture and reminding staff to store food items correctly in fridges and lockers. A verification audit was conducted in June 2016 which showed that compliance had increased to 97% after all actions had been completed.

- The trust had a comprehensive cleaning policy with an external company that outlined the daily cleaning scheduled for equipment such as computer keyboards and workstations. We also saw the trust had a policy to manage the outbreak of an internal outbreak of an infectious disease which included a deep cleaning process.
- Staff assessing calls and dispatching resources had a good understanding of infection control procedures. Staff told us that if they had any queries about infection control they could liaise with the clinical support desk (CSD) or a supervisor.

Environment and equipment

- The EOC and staff facilities at both locations were visibly tidy and well organised with suitable access for staff with additional mobility requirements.
- Staff told us that the kitchen facilities were appropriate and they had enough space to have comfortable rest breaks. There were also appropriate facilities to have a stress break or debrief if they experienced a distressing call or situation.
- We saw evidence of regular environmental audits and fire risk assessments for the EOCs and improvements and changes were made when necessary. For example, we saw that a fire risk assessment had been completed in December 2015 and had highlighted that there were no signs in place to highlight 'no smoking' on entrances and external areas of the EOC at Millennium Point. We observed there was appropriate signage during our inspection.
- Each workstation in the EOCs had appropriate storage under the units to keep electrical cables secure and minimise the risk of trip hazards or exposed wiring.
- Both EOCs activities included call assessing and the dispatching of resources to calls. Call assessing was managed on one side of the room and dispatching was arranged based on geographical areas on the other side. Staff accessed the systems they needed based on the position they sat in, this meant that all staff accessed the main CAD system and used the systems they required for their roles. For example, staff working in dispatch would access systems, which allowed them to see which resources were available and what calls were coming into the area they were working on as the calls were being assessed.
- Staff workstations were grouped in call-assessing and geographical dispatch teams and each team had a supervisor to support and advise the group. Each control room also had a manager's station where senior managers could monitor the activity in the room and provide overall support and an escalation point for supervisors.
- Electrical equipment had all had electrical safety testing in line with national health and safety guidelines. We saw that there was an annual schedule in place to ensure that all equipment was checked.
- There were clear processes in place in the event of single and multiple equipment failure. Staff were able to describe the processes and their actions. For example, staff in dispatch told us that if they had a technical problem their supervisor or colleague would be able to monitor their radio channel, resources and incoming calls while they moved to another workstation and contacted IT engineers.
- The EOC undertook fallback exercises when they would switch off the computer aided dispatch system (CAD) system and revert to paper records, to allow staff the opportunity to practice and remain familiar with the process.
- All staff we spoke to were aware of what to do if they had equipment failure and there were spare items of equipment kept in EOC, such as headsets.
- The trust had a Display Screen Equipment DSE policy in line with current legislation, which required staff to complete an annual self-assessment questionnaire online, which was to be discussed at their annual appraisals. All staff received training as part of their corporate induction and DSE was also covered in Health and Safety mandatory training. Staff told us that they were aware of how to adjust their equipment in line with HSE guidance. If they had any concerns they would highlight this to their line manager and the trust's health and safety department would conduct a further assessment and additional equipment could be provided such as adjustable desks, specialised chairs and financial support for prescription glasses required

for visual display unit (VDU) use. Staff also had access to the trust's physiotherapist for assistance and advice. We saw evidence of DSE assessments being completed and support for individual members of staff where it was appropriate.

- The EOC used various computerised systems to carry out their work. These included a CAD, an electronic triage system and radio transmission systems, which were periodically updated. When changes and updates were made to the systems, staff received full briefings and support, which was recorded on their personal training records.

Medicines

- Call assessors who received 999 calls and had not received clinical training were able to give limited advice regarding medications; they advised patients to use medications that they had been prescribed for specific conditions and how to take simple analgesia in line with NHS Pathways guidance. Staff also recorded details of the patients' medications in their medical records.
- Clinical staff on CSD were able to give advice on specific medications and had access to a dedicated intranet page where they could find advice for to give to patients.

Records

- Staff managed patient's care records in a way that kept people safe. Call details and patient's records were entered into the electronic computer aided dispatch (CAD) system and access to this system was password protected.
- Staff were required to log into the CAD system with their own personal passwords to access records and log back out whenever they left that position. We saw staff following this procedure at all times.
- Calls into EOC were triaged using NHS Pathways, which is a nationally approved evidence based telephone assessment system. Call-assessors asked specific questions based on the patients presenting symptoms and calls were prioritised on the CAD system based on the level of response determined through triage.
- All information entered onto patient records was electronically time stamped with the individual user's login details as an identifier; this meant that if there were any queries regarding the call it was easy to see what actions had been carried out and by whom.
- All calls were recorded and these recordings were only available to specific staff for completing investigations, checking information and completing routine audits of calls.
- There were daily audits of records, conducted by continuous quality improvement auditors for both clinical and non-clinical records. We saw evidence that showed that when areas were identified for improvement, these were shared internally with individual members of staff and externally through national user groups. For example, we saw that through auditing records and feedback from staff the EOC had improved telephone instructions for assisting with a breech delivery (when a baby is being born with buttocks or feet presenting first); this had been shared with other users in the NHS Pathways national user group.
- Records were held and maintained for 'flagged addresses', these could be addresses where the service held specific information about a patient's care needs and there was a specific plan in place for responding to these calls, or a location where staff responding may require further assistance from another emergency service.Records and information was passed to responders via a mobile data terminal and radio transmissions.
- There was an area in the electronic call records where special notes could be added by the call-assessor. For example, call-assessors could add access details or specific information about the patient's care and treatment.
- Call-assessors could also highlight on the records if there was any potential scene safety issues for the responding crew.

Assessing and responding to patient risk

- All staff in EOC used NHS Pathways to triage and assess patients' conditions. The electronic system allowed call-assessors to establish at the earliest point of a 999 call if the patient's condition presented an obvious immediate threat to life.
- On receipt of a 999 call, staff were immediately required to establish if the patient was conscious and breathing, answering 'no' to either of these questions would automatically alert the dispatcher through the CAD system that it was a potentially immediately life-threatening call. After confirming the location of the incident, the call-assessor was then required to

establish the nature of the call. If the patient was at risk of going into hypovolemic shock (a serious life-threatening condition which can occur as a result of uncontrollable or serious blood loss) or was experiencing severe breathing problems that may be indicative of respiratory or cardiac arrest, dispatchers would be alerted of this immediately. There was a list of conditions that appeared at the beginning of the call on a drop-down list and if specific conditions were selected this would automatically be highlighted to the dispatch area. If none of these priority symptoms or conditions were immediately identified the call-assessor was required to ask the caller what the main reason for the call was and utilise probing questions to identify the correct pathway to triage the call. This area of the call was called 'module zero'. It was a requirement of NHS Pathways that all 'module zero' questions were answered on the system but did not need to be asked by the call-assessor if the answer was obvious.

- During our inspection, we found that a small number of call-assessors were not clear on when they should use probing questions or record answers as obvious. We saw no evidence of negative impact for patients. However, failing to question effectively presented a potential risk. We raised our concern with the Head of Training for EOC and we were shown the guidance that all staff received which was in line with NHS Pathways requirements. We were also assured that routine audits addressed 'effective questioning' and we saw a specific training session for EOC staff dated April 2016. After our inspection, we received a copy of updated guidance for call-assessors to provide further clarity for staff.
- On completion of an assessment, the triage system would arrive at a decision or 'disposition' based on the information provided by the caller. This could mean dispatching an ambulance, referral to an alternative care pathway such as a minor injuries unit or a GP, or a further assessment by the EOC CSD. Each disposition was mapped to a nationally agreed response level and colour coded red, amber or green to reflect the priority level with red being the highest. This meant that dispatchers were able to identify higher priority calls with ease.
- There was an exclusion criteria attached to the dispositions that resulted in a referral to an alternative care pathway; this meant that patients who were living with specific conditions such as dementia were not routinely referred to an alternative care pathway if they called 999. If an ambulance response was not required; these patients would always receive a call back from a clinician. Staff on CSD told us that invariably, they would arrange a face-to-face assessment for patients with complex needs to rule out the need to go to hospital.
- Staff also told us that if they had any concerns about a disposition they could seek advice from CSD staff, for example, if a patient had a complex medical history and they were unsure if it was safe to refer to an alternative care pathway due to lack of knowledge about the specific condition.
- There were processes in place to check individual patient's welfare while they were waiting for a response to arrive during busy periods. This included CSD making calls to patients and checking on their condition, giving further advice and upgrading priority levels when appropriate.
- For all calls when a disposition required an ambulance response or a call back from a clinician, callers were advised to call back immediately on 999 if the patient's condition worsened. If a call-assessor received any additional calls from a location, they would establish if there was any change in the patient's condition and re-triage if the condition seemed worse or there was new information. If the priority of the second call was higher than the original call, the call-assessor would alert the dispatch area and the crew would be updated. If the re-triage suggested a referral or alternative care pathway, the call would not be downgraded but the additional information would be passed to the responder. This was in line with the trust's policy.
- One of the roles of the dispatcher was to ensure that all resources were logged onto the CAD system for the start of their shift. Dispatch teams received daily crew availability sheets, which outlined shift times for crews and their skill level. This meant that dispatch staff were able to task the most appropriate crews to meet the care and treatment needs of the patient.

Staffing

- The EOC was staffed with 999 call-assessors, call-assessing supervisors, dispatchers and controllers. There were clinical staff working on CSD and in dispatch on specific desks. Support staff included auditors (who were also trained to handle 999 calls), trainers and administrative support workers.

Emergency operations centre

- During our inspection, we observed that there was a good skill mix and level of staff to meet the needs of patients and keep people safe.
- There were no vacancies in the EOCs at the time of our inspection. The service employed 473 staff who worked a combination of full and part time hours, which equated to 447 whole time equivalent (WTE) staff in post. The service had a budget for an establishment of 376 WTE staff. Senior staff told us that they had recruited over establishment to meet demands on the service.
- Staffing was planned based on robust long and short-term analysis of a number of factors including historical demand, seasonal trends relating to workforce data and environmental factors such as the weather. We saw information was collected and collated by the trust's EOC performance cell, which was a designated department that produced detailed reports in all aspects of operational delivery including workforce planning. EOC managers used the reports to align rotas and shift patterns to demand.
- The core rota in EOC was based on a 10 week cycle and comprised of 12 hour shifts and an allocated period of annual leave, staff told us that this meant that they were guaranteed regular periods of leave throughout the year. There were also relief rotas to support the core rota and they were made up of 8, 10 and 12-hour shifts.
- Agency staff were not used in EOC due to the specialised nature of the roles. Generally, managers planned for staff on relief rotas to cover adhoc annual leave and long-term sickness. Overtime was offered to existing staff and there were developmental opportunities for staff to 'act-up' to a more senior position to cover staff on maternity leave and those with long term sickness.
- The trust had a Resource Escalation Action Plan (REAP) which was based on nationally agreed indicators of pressures which trigger specific measures when the trust is operating at significant and sustained levels of increased activity, including a reduction in staffing levels. The trust's REAP outlined the actions required by EOC managers to manage staffing levels when certain triggers were met, this included actions such as re-deploying staff from duties such as auditing and other support roles.
- Staff working 12-hour shifts told us that they received adequate breaks throughout their shift.
- CSD paramedics worked on both EOC sites, a core component of NHS Pathways is that a clinician trained in NHS Pathways is available at all times to support the non-clinical call-assessors. Staff told us that there was always a member of CSD available at either site to give advice; we observed this during our inspection.
- We observed effective handovers at change of shifts between staff at all levels. We saw the duty managers conducted a comprehensive verbal and written handover to their colleagues and dispatch staff and call-assessor supervisors completed verbal handovers highlighting any issues or concerns including staffing levels.

Anticipated resource and capacity risks

- Potential risks were taken into account when planning services; this included seasonal fluctuations in demand, the impact of adverse weather and disruption to staffing.
- The trust had policies and processes in place to manage foreseeable risk including REAP which incorporated specific management plans for EOC, business continuity plans and major incident plans.
- The business continuity plans provided staff with a clear process to follow in the event of loss of power or infrastructure. There were action plans and cards related to any planned or unplanned evacuation of the EOCs and covered all functions.
- The hospital liaison desk in EOC monitored the status of local emergency departments and ambulance handover times to help identify capacity risks. They used a shared NHS webpage where they were able to see the escalation status of each trust that patients were being conveyed to and utilise a practice known as 'intelligent conveyancing' to advise crews and managers where they were likely to have longer handover delays.
- When carrying out changes to the service or staff, the impact on safety was assessed and monitored. For example, we saw that the evacuation plans for both EOCs had been risk assessed in terms of safe exit and transfer of staff and there were arrangements in place with neighbouring ambulance trusts to assist with answering 999 calls and deploying resources to ensure patient safety.

Response to major incidents

- The trust had a comprehensive major incident plan and the actions for EOC were clearly defined.

Emergency operations centre

- Staff understood their roles in the event of a major incident; this included requesting and recording specific reports from attending crews, other emergency services, healthcare providers and other local authorities.
- Staff attended joint training incidents with local police and fire services and we saw that staff had access to specific training via online learning and as part of mandatory training. From April 2015 to March 2016, 99% of EOC staff had completed major incident awareness training.
- Staff within EOC had undertaken Joint Emergency Services Interoperability Programme (JESIP) training. JESIP training was based on a multi-agency approach to major incidents and provided training packages and tools that were used by ambulance trusts nationally. From April 2015 to March 2016, 95% of dispatch staff had received JESIP and major incident training and 99% of call-assessors had received major incident training. All CSD staff had also attended major incident training.
- All EOC staff had been provided with a set of major incident cards, as carried by road crews. This provided them with the same information and guidance as staff who might attend the scene and promoted familiarity and consistency when dealing with serious incidents. The trust were in the process of developing an electronic version of the cards and re-writing the major incident policy with pages formatted to be identical to the layout of the cards. This meant staff were familiar with the layout of the information and understood in time critical situations where to find guidance.

Is emergency operations centre effective?

Good

We rated effectiveness overall as good because:

- From April 2015 to March 2016 the trust was the only ambulance trust to meet all national targets for response times for the most immediately life threatening calls and answering 999 calls.
- The EOC used an evidence based triage system for 999 calls and 'Hear and Treat'.
- Technology was used to enhance performance and for long and short term planning.
- The trust was part of a national pilot designed to change the way that ambulances respond to patients.
- The trust was actively working with external providers and services to improve patient outcomes.
- The trust was a part of an operational delivery network which was developed to manage the care and treatment for patients with major trauma.
- We saw excellent examples of teams working together to deliver quality patient care.
- The design and functions of the regional co-ordination centre (RCC) within the EOC provided specialist support for the local community.
- Staff had a good understanding of the Mental Capacity Act 2005 and consent procedures.

However, we found:

- The performances for some individual patient outcomes were below the national average for ambulance trusts.
- The trust was not submitting frequent caller data nationally to allow them to be benchmarked against their peers.

Evidence-based care and treatment

- We saw care and treatment was delivered in line with national guidance for ambulance services.
- NHS Pathways was an evidence based triage system designed by NHS clinicians for 999-call triage and other services such as GP out of hours. NHS Pathways was integrated with a Directory of Services (DOS), which was a list of local health care providers, and services that allowed EOC staff to refer patients to more appropriate services.
- Managers and auditors attended regular national NHS Pathways user group meetings, where 'hot topics' such as specific triage processes and suggestions for improvement were discussed. Any areas identified as potential for improvement were assigned to a specific trust to investigate and bring back to the user group. For example, we saw this trust had provided valuable evidence to the user group to improve patient care and treatment. One example related to patients who were in labour and had a breech presentation.
- There was a robust auditing process in place to monitor compliance to NHS Pathways protocols and procedures. NHS Pathways set a level of compliance at 86%; however, the trust had set the level for themselves at

95%. We saw regular audits were carried out for all staff in line with requirements and there was a clearly defined process to manage performance and support staff if they failed to meet their targets.

- The clinical support desk (CSD) had access to a dedicated web page that provided access to relevant national guidelines such as Joint Royal Colleges Ambulance Liaison Committee (JRCALC) and National Institute for Health and Care Excellence (NICE). This meant that if ambulance staff called for any advice or guidance they were able to give the most updated guidelines.
- Call-assessors and dispatch staff contacted CSD for clinical support and advice. Policies specific to call-assessors and dispatch staff advised staff to contact CSD if they had any concerns or issues regarding a patient's care and treatment.
- The EOC used over 20 different computer software systems to enable them to deliver safe care and treatment. These included the CAD, mapping screens, tracking systems, rostering processes and mobile radio systems.
- The EOC performance cell was able to gather information from all of the computer systems to provide detailed information to assist managers with long and short term planning. We saw that senior managers were sent two hourly performance reports, 24 hours a day; these reports provided detailed performance for all areas.
- We saw that paramedics who worked in EOC were able to access live electronic patient report forms, which were used by ambulance crews on scene, which enabled them to provide instant advice.

Assessment and planning of care

- Assessment and care was planned to meet the needs of patients in a manner that took into account the needs and rights of different people.
- Equality awareness formed part of the trust's mandatory training programme and was conducted in face-to-face and e-learning sessions.
- We spoke with clinical and non-clinical staff who had a good understanding of the Mental Health Act 1983 (MHA) and code of practice. Staff were able to explain how patients detained under the MHA were being treated for their mental disorder and if they required treatment for a physical illness consent would still have to be sought in line with current legislation. There was a clear pathway within the triage system for patients who called 999 with a mental health problem.
- Call-assessors had tools to assist with delivering care and treatment; these included instructions in administering bystander cardio pulmonary resuscitation (CPR), delivering babies and basic first aid to control bleeding.
- Staff on CSD used a tool to assess pain remotely. Staff asked patients for a description of their pain based on a scale of one to five, with five being the worst pain. This information was recorded and passed to responders.
- The EOC had strict policies on which resources could be tasked to specific calls. Each specialist desk such as the air desk and incident command desk had specific protocols on which incidents required an immediate dispatch and which incidents should be monitored.
- The trust's aim was to have a paramedic on each double-crewed ambulance to ensure that appropriate care was available for every 999 call. There were also a number of alternate response models such as, community first responders (volunteers) who had specific training to respond to specific categories of calls as first responders with an ambulance crew to back them up. We saw the dispatch protocols policies, which clearly specified what types of response, could be sent to each type of call.
- Dispatch decisions were routinely audited to ensure consistency and identify best practice. We saw copies of some of these where staff received feedback and advice on decisions made.
- Two weeks before our announced inspection the trust had implemented the Ambulance Response Programme (ARP) this was an extensive project between NHS England and ambulance trusts. The main objective was to ensure higher acuity patients received a timely response and that the correct response was sent to more patients. Staff told us that they had been able to give feedback on the implementation and this had resulted in changes being made based on staff suggestions. For example, staff in dispatch told us they had been able to change the way that calls appeared on their display screens to allow them to identify specific conditions such as breathing difficulties easier.

Response times

Emergency operations centre

- All ambulance trusts were required to answer 95% of all 999 calls within five seconds. From April 2015 to April 2016, the trust answered 96% of calls within five seconds. The trust's average call answering time for this period was consistently one second which was better than the England average which ranged between one and two seconds.
- Calls were prioritised using red, amber and green to signify the seriousness of each call. Red calls were the highest priority and were split into two categories Red 1 (R1) and Red 2 (R2) also known as 'Category A' calls. R1 calls were calls such as cardiac arrest or confirmed complete airway obstructions where it was critical to get to the patient within eight minutes. R2 calls were calls such as patients who were fitting (convulsions).
- All ambulance trusts were required to respond to 75% of R1 and R2 calls within eight minutes and 95% of all R1 and R2 calls within 19 minutes. The clock started when the caller connected to the 999 service for R1 calls and up to 60 seconds after the call connected for R2 calls. The trust are a pilot for a new national programme, it is important to note that as of 16th June 2016, response times for West Midlands Ambulance NHS Foundation Trust would continue to be monitored but not reported in the same way as all other ambulance trusts due to the implementation of ARP and the differences in coding, the trust were still required to submit daily submissions of performance to NHS England.
- From April 2015 to April 2016, the trust responded to 79% of all R1 calls within 8 minutes; this was better than the England average of 73%. R2 response rate was 75%, which was better than the England average of 67%. The trust responded to 97% of all R1 and R2 (Category A) calls within 19 minutes, which was better than the England average of 92%.
- The call abandonment rate related to the percentage of 999 callers that hung up before their call was answered. From April 2015 to April 2016, the call abandonment rate was consistently in line with the England average at less than 1%.
- The re-contact rate was measured in two ways, firstly the percentage of patients who re-contacted 999 within 24 hours after receiving telephone advice. From April 2015 to April 2016 the trust re-contact rate, after telephone advice was 14% this was significantly (worse) than the England average of 6%. The second measure was for patients that re-contacted via 999 24 hours after being discharged at scene. From April 2015 to April 2016, the trusts re-contact rate after discharge at scene was 7%, this was higher (worse) than the England average of 5%. The trust had an action plan to improve the re-contact rate, which included annual clinical audits, developing an education package and assessment for discharge at scene and continuous monitoring and review in these areas to identify areas for improvement.
- Real time performance was monitored in all areas of EOC. Staff had access to performance data via the trust's intranet and dashboards were available on all monitors. In the EOCs, there were visual display screens and staff could see how the trust was performing in real time. This included a visual alert if there were 999 calls waiting to be answered, staff were instructed to use specific call shortening techniques in these instances and support staff were able to log in to the system to receive 999 calls from their workstations. If performance levels in dispatch fell, staff had specific procedures to follow which included moving resources to provide cover in areas with high utilisation rates and requesting assistance from CSD to ring back lower acuity calls, check on the welfare of patients, and upgrade calls where appropriate.

Patient outcomes

- Information about the outcomes of people's care and treatment was routinely collected and monitored by the trust. Outcomes monitored included those for patients who received telephone advice known as 'Hear and Treat' and patients who had suffered a cardiac arrest and achieved return of spontaneous circulation (ROSC) which was the return of significant respiratory effort and a palpable pulse.
- From April 2015 to April 2016, the percentage of 999 calls, which were treated through telephone advice and did not receive an ambulance response, was 5%, which was below (worse than) the England average, which was 10%. Staff told us that they felt this difference was because they would send a face to face response if they had any doubt about the patient's condition rather than wait for an update from another provider as they felt this was better for individual patients. Senior managers told us that they supported staff's clinical decisions and we saw that they were working to develop more alternative care pathways through the Directory of Services. The trust had an on-going action plan to improve performance in this area and this included additional support and feedback, auditing and training for staff.

Emergency operations centre

- The Care Quality Commission conducted a national survey related to 'Hear and Treat', which was published in 2014 and asked questions about the initial 999 contact with the call-assessor, the communication with the clinician and the outcome. This trust scored worse in three out of the ten questions relating to the initial call-assessor and similar to other trusts for the remaining seven questions. The trust scored better than other ambulance trusts for the question 'Did the ambulance service explain why an ambulance would not be sent on this occasion?'
- From April 2015 to March 2016, the percentage of patients who had achieved return of spontaneous circulation was 30%, which was better than the England average of 27 %. All staff involved in a 999 call where the patient had return of spontaneous circulation, including those in EOC and staff attending to the patient on scene, received acknowledgement of their contribution from the chief executive officer. The percentage of patients that survived cardiac arrest and were discharged from hospital after resuscitation for this trust was 8%, which was in line with the England average.
- The trust monitored outcomes for patients who had a heart attack caused by a sudden complete blockage of a heart artery known as ST-elevation myocardial infarction (STEMI). Heart attacks of that type could be treated with primary angioplasty (a balloon would be inflated in the coronary artery to unblock it) within a specified timeframe and appropriate care bundles within a specified time. From April 2015 to March 2016 the percentage of patients who had contacted 999 and received primary angioplasty within a specified time for this trust was 86%, the England average was 87%. The percentage of patients who received an appropriate STEMI care bundle after contacting 999 for this trust was 78%, the England average was 79%.
- There were two measurements monitored for patients who had dialled 999 and had potentially had a stroke (a disruption of the blood flow to the brain caused by a blockage or rupture of an artery). The first measurement was for patients who could potentially receive thrombolytic treatment (a clot busting treatment) if they arrived at a specialist centre known as a Hyper Acute Stroke Unit within 60 minutes. From April 2015 to March 2016, 54% of patients who called this service and were potentially eligible for thrombolysis arrived at the centre within 60 minutes, this was worse than the England average of 57%. The second measurement was for patients who received an appropriate care bundle after a face-to-face assessment. From April 2015 to March 2016, the trust achieved 96% for that target which was worse than the England average of 98%. Staff told us that the reconfiguration of stroke services in certain areas had been challenging with crews having to travel further to access some services. This had been highlighted in the trust's operational plan and quality report to the board in 2014.
- Patient outcomes were regularly discussed at local and board level meetings.

Competent staff

- All staff working in EOC received a comprehensive training and induction programme to provide them with the skills and knowledge they needed to perform their roles.
- All staff who used NHS Pathways received a comprehensive training package. This included a two-week initial training session and then an eight-week period of supervision using the system with a mentor. The training included the triage system and process, using the DOS, communication skills, care advice and defining trauma and non-trauma related problems, this was in line with the NHS Pathways End User License agreement. The trust also provided staff with an intermediate first aid course, senior managers told us this was so that non-clinical staff would have a greater understanding of anatomy and physiology. Paramedics who used NHS Pathways were also required to complete the course and a supervised period of handling 999 calls; we saw evidence that paramedics had completed the course and attended regular update sessions.
- Clinical staff also undertook a separate module of training which included clinical decision-making and the role of the clinician using NHS Pathways. There was on-going training for NHS Pathways, this consisted of regular version updates and training in relation to issues identified by the NHS Pathways User Group.
- Paramedics working in the control rooms were required to ensure that they re-registered with Health and Care Professional Council (HCPC) every two years. They are required to undertake continuous professional development (CPD) and receive clinical supervision and appraisals. Paramedic staff undertook mandatory training clinical update training days as part of their CPD and we saw that for 2015/16 85% of EOC paramedic staff

had completed this which was in line with the trust's target. All EOC paramedic staff had received an appraisal in 2015/16 and each person was assigned a clinical team mentor for clinical supervision.

- Staff told us that they received regular annual appraisals and adhoc one to one meetings with their immediate line managers to identify individual training needs and support their continuous development. Training needs were also identified through regular audits in call assessing and dispatch.
- Records showed that from April 2015 to April 2016, 99% of all staff in EOC received an annual appraisal; this was higher than the trust target of 95%. Staff told us that appraisals were meaningful and tailored to meet their individual needs and strengths; they did not consider it a generic 'tick box exercise'. We looked at the personal records of eight members of staff and saw that appraisals were up to date and specific to individual requirements, we also saw evidence of personal development plans which were monitored by line managers and individual training records for staff.
- All staff had received training in conflict resolution and communicating with patients with different needs; this included dealing with children who were calling for themselves or others. Call-assessor guidelines also included specific instructions on how to manage calls where child callers were unable to answer the questions, for example if they were too young.
- There were comprehensive processes in place to monitor individual performance and identify areas of improvement when appropriate. This meant that poor performance was identified and a supportive process was in place to enable improvements.
- Staff retention was good; all staff we spoke with had positive comments to make about their roles in EOC and their contribution to providing safe quality patient care. Some staff told us they would consider training as paramedics within the trust.
- Staff told us that they felt that additional optional training and development opportunities were consistent and available for all staff if they wanted to take advantage of it.

Coordination with other providers

- The EOC worked in co-ordination with other teams, emergency services and healthcare providers to deliver effective care and treatment.
- The trust was a part of the Midlands Critical Care Network, which was a co-ordination of services developed to manage the care of major trauma patients within a certain geographical area. The regional trauma desk was based in EOC and supported the delivery of care for major trauma patients by providing advice and support to crews and identifying when 999 incidents involving trauma may need specialist intervention on scene or conveyance to a specialist major trauma facility.
- The Directory of Services (DOS) was a central directory, which could be populated by any health and social care services. Services using the DOS were required to have DOS leads who liaised with local providers to identify services that patients could be referred to; this included minor injuries units, GPs and community services such as district nurses. The trust had five designated DOS leads who worked with local services and commissioners to develop profiles that could be added to the DOS and provide appropriate alternative care pathways based on strict criteria. It was the responsibility of the DOS leads to monitor the performance of the services, which were in their geographical area.
- The trust had worked with a local health care provider and the local police service to establish an alternative care pathway for patients experiencing mental health illness. This was a mental health triage car, which had a paramedic, mental health professional and a member of the police responding to specific calls in a designated area. Staff in dispatch told us that they were able to task this resource to appropriate calls.
- The trust had comprehensive reciprocal arrangements with local ambulance trusts to provide support to EOC in times of high demand. There were also robust procedures to follow for incidents, which were on the borders of neighbouring ambulance trusts. For example, when a dispatcher received R1 calls (immediately life-threatening 999 calls) for a neighbouring ambulance trust they automatically sent the nearest available responder. The dispatcher would then contact the neighbouring trust to pass the details and the resource would only be cancelled if the neighbouring trust had a closer responder on the way and did not require assistance.
- The CAD administration manager was responsible for liaising with local GPs to update patient records with specific special notes such as do not attempt cardio

pulmonary resuscitation (DNACPR) instructions. These were highlighted on the CAD system when the relevant patient details were entered. Call-assessors highlighted this information so dispatch staff was aware and the responding crew received the information on their mobile data terminals. Staff had clear protocols and guidelines to follow to manage patients with DNACPRs.

- The EOC worked with other emergency services and agencies to ensure the safety of patients and staff. The EOC had a dedicated direct line for both fire and police services and call-assessors highlighted a specific area of the records if either service had been requested or was required.
- We saw the trust had worked with the local clinical commissioning group (CCG) in Staffordshire to establish a 'Telemed' desk. This was staffed with a paramedic who was able to help crews on scene arrange specific referrals for patients in that area and arrange care at home. Staff working on the Telemed desk had access to current drugs information, community services which included the 'Hospital at home' team. We saw the Telemed paramedic was able to access the crew's live electronic patient report form, give advice on results of tests, and support for crews to help treat patients in their homes.
- Crews pre-alerted hospitals of their estimated time of arrival for certain situations where a patient may require immediate medical attention or equipment at the hospital. Staff in dispatch told us the crews would normally place these calls themselves but if they were unable to, dispatch staff would contact the hospital on a priority line and relay the relevant information.
- We saw the EOC worked with the local police service to ensure that appropriate calls were passed to each other.

Multidisciplinary working

- We observed effective communication at handovers for all areas and evidence that the different internal and external teams worked together to assess, plan and deliver care and treatment.
- We saw duty managers at both EOCs conducted comprehensive handovers between control rooms highlighting any specific areas of concern both verbally and written.
- We observed staff working effectively as a single team across both EOCs.
- We saw staff in call-assessing liaising with clinical staff for help and support.
- The CAD system allowed staff in different areas to contact each other through a messaging system; this meant that staff could deliver urgent messages to each other regardless of which EOC they were based in, about incidents without having to leave their workstations or make a phone call.
- The EOC had a Regional Co-ordination Centre (RCC) who worked with the dispatch and call-assessing teams and external providers, functions within the RCC included:

Incident Command Desk – this was to manage incidents that required multiple resources or specialist responses such as the Hazardous Area Response Team (HART); this function allowed the incident to be managed away from the dispatch desk so staff could manage the other 999 calls.

Air Desk – co-ordinated with a local air ambulance charity for provision of Helicopter Emergency Medical Services (HEMS). The desk had set criteria for dispatch of the air ambulance however; call-assessors and dispatch staff could highlight specific incidents for the desk to monitor. This could be done by staff entering a specific code on the call which highlighted it to the desk, or they could contact the desk directly.

Strategic Operations Cell – maintained an overview of the RCC and provided a clinical managerial escalation point and regular performance reports on the functions of the RCC.

Hospital Turnaround Desk – this desk monitored the status of local hospital emergency departments and liaised with the trusts Hospital Ambulance Liaison Officers (HALOs) to identify areas where ambulance handover delays may have an impact on service delivery. Crews were required to book any delays over a specified time at the hospital with the desk. Staff on this desk used a specific process, which told them when they should contact crews who were delayed at ED and had not already booked a delay. Staff told us that sometimes crews perceived this as 'harassment', however if the crew had already booked the delay there would be no reason for them to contact the crew and 'harass' them. There was also a practice of 'Intelligent conveyancing', this meant that staff on the hospital turnaround desk would advise crews of which hospitals were experiencing longer delays and re-direct them to a hospital where there were fewer capacity issues. We saw that generally, this worked well; however, a few crews told us that sometimes they

considered this process as questioning their clinical judgement. Staff on the desk told us that the re-direct was primarily a request to help manage capacity issues and ultimately it was the crew's decision where the patient was conveyed to in line with the trust's conveyancing policy. Staff sought advice from the strategic operations cell's managers who were clinically trained if there were any issues.

Regional Trauma Desk – a HEMS paramedic with specific training was available to identify specialist units such as major trauma units and burns and monitor capacity of these units and worked closely with the incident command desk and air desk to identify incidents that may require specialist treatment or interventions. They were also able to provide support and advice to crews and EOC staff. This desk also co-ordinated with other members of the Midlands Critical Care Network.

- The EOC performance cell worked with managers for all areas; during our inspection, we saw managers from different areas of the trust requesting various data reports from the performance cell to inform long and short term planning.
- We saw that there was good communications between EOCs; staff in dispatch told us that sometimes they would use resources that were controlled by a different dispatch area. They said that they would contact their colleagues regardless of which EOC they were based in to explain why they had used their resources as a matter of courtesy.
- We saw that managerial staff from EOC attended trust wide performance and governance meetings including the learning review group.

Access to information

- Staff had access to information relating to trust policies and procedures via the trust intranet and EOC managers had produced a 'Sharing Information' document that directed staff to useful internal and external links such as safeguarding leads.
- All staff in EOC had access to the CAD system and were able to see 999 calls as they were being taken, call-assessors were able to see when crews had been dispatched on the calls they were handling and all staff could see urgent messages and special notes that were linked to the 999 calls.
- The trust had taken actions to address NHS England's 2015 Patient Safety Alert: Harm from delayed updates to ambulance dispatch and satellite navigation systems. The gazetteer system (an electronic street map and location directory) used by the EOC was updated from internal and external sources on a regular basis. Staff had a clear process to identify locations that were not on the gazetteer to the CAD administrative staff so it could be updated on the system. Staff who were call assessing were able to access the internet to assist with location queries, specifically for new developments and road names, which were not on their gazetteer system yet. Staff were able to get assistance from the call-assessing supervisor during this time, by pressing an emergency button.
- Staff on CSD had a dedicated intranet page, which gave them access to relevant national clinical guidance.
- CSD staff accessed the DOS to find appropriate alternative care pathways for patients receiving 'Hear and Treat' or local relevant services for crews on scene with patients who required treatment in the community, for example, arranging district nurses to assist with patients experiencing catheter problems.
- The trust had a 'frequent callers' policy which had been in place since 2012; this was for patients who called 999 regularly for a variety of reasons including those who had complex conditions and had a special care plan in place which included referral to specialist services. Identified frequent callers were 'flagged' on the system with special notes and call-assessors and dispatch staff were able to access this information and pass it to the responding crews. We saw that staff were able to identify on the CAD system if a caller had made more than one 999 call within a specified a period of time. The policy set out the guidelines for how many calls would constitute a 'frequent caller' in line with national standards, for example, if they received five or more 999 calls from an individual or specific location within a one-month period. The trust had developed a central database that contained details of the frequent callers in all the geographical areas which CSD staff were able to access. At the time of our inspection, the trust was in the process of reviewing their frequent callers process and policy and was not submitting data nationally. The trust told us they planned to submit data when there was a new national standard agreed; we saw that this had been discussed at a national 'frequent callers' ambulance group.

Emergency operations centre

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The Mental Capacity Act 2005 (MCA) was covered in mandatory safeguarding training for all staff. Staff told us that they were aware of safeguarding and consent issues and training included Gillick competence, which was a means to establish if children aged 16 years and below had the capacity to consent to care and treatment.
- Staff described situations when they would consider a caller's mental capacity, for example, patients who threatened suicide or self-harm. Staff told us if a child under the age of 16 called they would always ask if there was a parent or other responsible adult available and if not, ensure that the child caller understood the questions they were being asked.
- Staff in call-assessing, dispatch and CSD told us that it was difficult to assess capacity remotely, however, if a patient/caller appeared acutely confused and tried to cancel an ambulance they would not accept the cancellation until a face to face assessment could be made. This was in line with the trust's policy.
- When 999 calls were made on behalf of a patient, the call-assessor would attempt to speak with the patient if it was appropriate to do so, staff told us this served as a means to ensure that the patient had consented to the call being made on their behalf.

Is emergency operations centre caring?

Good

We rated the service as good for caring because:

- Staff spoke to patients and callers in a calm and professional manner even in distressing situations.
- Staff displayed empathy towards patients and their loved ones.
- Staff took the time to ensure that patients understood their care and treatment.
- The trust completed Friends and Family Test for patients and staff.

Compassionate care

- We listened to staff treating patients with empathy, kindness and compassion.
- Staff were respectful towards callers and were mindful of a patient's dignity, especially to calls where patients were in the public gaze.
- The CQC 2014 'Hear and Treat' survey showed that the trust received a score of nine out of 10 for dignity and respect shown by the initial call-assessor and the clinician. They also scored nine out of 10, for the question relating to their understanding of the care and treatment by the call-assessor. These results were similar to other trusts.
- Staff were acutely aware of the emotional distress that some callers faced when dialling 999, especially for those close to them and they remained calm and professional even when faced with hysterical callers.
- Staff told us that they had received specific training to calm callers in the telephone environment and they tried to empathise with callers. This training was delivered in a classroom environment at the start of training and through mandatory training workshops. From April 2015 to March 2016, 98% of call-assessing staff had received training related to communicating effectively with distressed callers.
- The Friends and Family Test was conducted by the trust and was reviewed at the learning review group. It was recognised that the trust needed to explore different ways of gathering this information from patients and they had started asking patients if they could be contacted by e-mail. From April 2015 to March 2016, 85% of patients stated they would be 'extremely likely' to recommend the emergency services to a friend or family member; this was based on 255 responses.

Understanding and involvement of patients and those close to them

- For all calls, staff engaged with the patient whenever possible to do so.
- We observed staff modifying their language, tone and pace of speech to communicate with patients and their relatives to help them understand their care and treatment.
- We observed staff taking time to ensure that their callers understood the instructions and advice they were given, even when there were other 999 calls waiting to be answered.

Emotional support

Emergency operations centre

- Staff provided support and encouragement to callers who were faced with immediately life-threatening situations when delivering instructions for instances such as cardio pulmonary resuscitation CPR or child delivery.
- Staff had a good understanding of how to support patients experiencing a mental health crisis and this included staying on the line with patients who were threatening suicide.
- We heard staff being patient with elderly callers and patients who were confused or anxious.

Supporting people to manage their own health

- The trust had established pathways to refer callers to other services.
- Patients who did not require an ambulance response or hear and treat were referred to appropriate services through the Directory of Services, which was an established central database of local services.
- Crews on scene with patients could contact the EOC to speak with a clinician to arrange care at home for patients.
- The trust provided advice and guidance to the public on their website on when to dial 999 and when an alternative service such as a minor injuries unit would be more appropriate.
- The trust had a frequent caller's policy and process to support patients with complex needs.

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

Good

We rated the EOC as good overall for responsiveness because:

- Services were planned and delivered in a co-ordinated way that met the needs of the local population.
- We saw good evidence of multi-disciplinary team working to support people with complex needs.
- There was clear evidence of improvements made because of listening to complaints and concerns.
- There were systems in place to meet the needs of individual people.
- Staff received bespoke training in awareness of patients who were living with dementia and learning disabilities.

Service planning and delivery to meet the needs of local people

- The EOC (Emergency Operations Centre) control room was the central communication point for ambulance crews to liaise with emergency departments or other providers. Staff in the control room were also responsible for sending appropriate crews to patients experiencing a mental health crisis.
- Within the EOC there was clinical support desk (CSD) which could assess and triage patients that required medical help without sending an ambulance. This process was called 'see and treat' and there was an appropriate clinical escalation policy in place to support it and access to the trust doctor.
- Planning for service delivery was made in conjunction with a number of other external providers, emergency services, commissioners and local authorities to meet the needs of local people. For example, we saw that the trust had been working with local commissioners, GPs, police, alcohol and substance misuse services and mental health services to provide care to support frequent callers.
- We saw that the different geographical desks in the dispatch area had resourcing levels to meet the demands of the area.

Meeting people's individual needs

- The EOC had access to a translation service for 999 calls. Staff told us that the service was easily accessible and all staff knew how to access it.
- Staff were trained to use type talk (which was a text relay service for patients with difficulty hearing or speaking) they could also use voice over internet protocol (VOIP) to receive 999 calls.
- Staff we spoke with were aware of the diverse population they served and were aware of the needs of people with varying cultural, ethnic and religious requirements. Staff were able to describe the principles of 'protected characteristics' as defined by the Equalities Act 2010. Senior managers told us that they always tried to incorporate topical learning into the annual mandatory training programmes. For example,

all staff in EOC had attended an additional learning disability awareness training session as part of the trust's mandatory training programme. Staff had also attended dementia awareness training sessions.
- Staff in dispatch described how they arranged transport for bariatric patients with the trust's dedicated bariatric vehicles.

Access and flow

- The EOC had robust systems in place to monitor access and flow and make changes when necessary. All staff had access to live performance data and managers could monitor the status of calls and redeploy resources in line with escalation plans.
- The EOC was required to answer 95% of all 999 calls within five seconds, We saw that from March 2015 to March 2016, the average time to answer calls for EOC was one second, this was better than the England average which ranged between 1.4 to 1.6 seconds.
- From March 2015 to March 2016, the percentage of calls which 'abandoned' prior to being answered by a call-assessor was similar to the England average which fluctuated between 0.5% and 2%.
- The service had systems in place to shorten call length times for specific calls when demand increased; this included an 'early exit' procedure and the use of recorded exit messages to provide instructions to the caller, staff were required to use these procedures when instructed to by a supervisor and when appropriate to do so. For example, all staff we spoke with were aware that the recorded exit messages were not used for calls where they were required to give instructions for patients who required cardio-pulmonary resuscitation (CPR). At the time of our inspection, we observed that use of the recorded exit messages varied with some staff using it whenever there were calls waiting and without being instructed to do so. There were guidelines on when it was appropriate to use the recorded messages which not all staff were aware of; this presented a risk if the message was played to a caller with hearing problems or mild confusion. We brought this to the attention of senior managers who immediately reissued the guidance and a separate bulletin to re-emphasise the importance of using these messages appropriately.
- Calls were prioritised using the triage system and colour coded so that dispatchers were able to identify which calls needed a quicker response when they had multiple calls on their dispatch screens.
- Calls that were being held in dispatch areas due to limited resources received welfare checks and were re-assessed when appropriate. We observed that when staff rang patients back they always apologised for the delay and checked on the patient's condition.
- Health care professionals who called the service to arrange transport for their patients from the community or inter-hospital transfers used dedicated phone lines, which meant that they did not affect the 999 call answering to the public.
- Protocols specific to dispatch and call-assessing emphasised the need to ensure patients received a response in a timely manner and included instructions such as 'no patient to be kept waiting unnecessarily' and 'all patients should receive an appropriate trust response in the quickest possible time if it is deemed that a response is required'.

Learning from complaints and concerns

- There was clear guidance in place in EOC for staff to direct callers to make a complaint if they wished to do so. Staff told us that if a 999 caller wished to speak to a supervisor or manager to make a complaint they would do their best to facilitate that and if that was not possible they would provide them with contact details for the Patient Advisory Liaison Service (PALS).
- From April 2015 to April 2016, the EOC received 229 complaints. The general theme for the complaints was delayed response. Staff told us that when a complaint was received the manager responsible would conduct an investigation to identify if there were any areas for feedback and learning. We spoke with the manager responsible for managing EOC complaints and we saw that they had no complaints waiting to be investigated. The trust's policy stated that complaints would be investigated within 25 days; the average time to complete investigations in EOC was 23 days.
- Staff told us that they received feedback from complaints if they were involved in the incident and they did not routinely receive feedback about all complaints.
- We saw evidence that the trust shared learning from complaints and concerns with other ambulance trusts through the NHS Pathways national user group. For example, we saw that the trust had shared concerns with the NHS Pathways group regarding the development of a breathing assessment tool after a complaint was received regarding a delayed response to a patient.

Emergency operations centre

- The trust had a comprehensive system in place to review complaints and identify areas for learning through the learning review group and clinical governance committee. For example, we saw that EOC staff had received additional training in understanding severe breathing conditions in children because of a complaint.

Is emergency operations centre well-led?

Outstanding ☆

We rated the EOC as outstanding for well-led because:

- There was a clear vision and strategy for the department which was realistic and achievable.
- Governance and performance management arrangements were proactively reviewed and reflected best practice.
- There was a robust governance system in place to support the delivery of the strategy and provide assurances up to board level.
- Staff we spoke to spoke highly of the leaders of the department, who inspired shared purpose and motivated staff to succeed.
- Leaders were visible, approachable and provided excellent support to staff.
- There were high levels of staff satisfaction within the service and staff we spoke to were proud of being a part of the trust and their role within it.
- Staff at all levels were actively encouraged and supported to explore innovative ways of working with a common focus on improving quality of care and people's experiences.
- Staff at all levels worked to engage with the public and develop innovative ways of including the community.
- The service had developed excellent working relationships with external trusts and agencies to improve and achieve their vision.

Vision and strategy for this service

- The trust's vision was 'Delivering the right patient care, in the right place, at the right time, through a skilled and committed workforce, in partnership with local health economies'.
- The strategic plan for this service set out defined realistic objectives for the future growth and sustainability of the department. This included; continued performance against performance indicators despite increasing levels of activity, developing staff and improving outcomes for patients through developing urgent care networks with other providers and services. This was aligned to NHS England's Urgent and Emergency Care Review and the recommendations of Sir Bruce Keogh (2013).
- Staff that we spoke to at all levels were aware of the vision and strategy of the service and their role in achieving objectives. For example, staff told us about the challenges of ensuring that patients always received the right response and described how the implementation of Ambulance Response Programme (ARP) helped them to achieve objectives.

Governance, risk management and quality measurement

- There was a rigorous governance framework in place to support the delivery of the strategy and good quality care and regular meetings were held at local and senior level.
- There was a holistic understanding of performance, which integrated the needs of other areas of the trust, the wider NHS and the community whilst focussing on improving service delivery.
- The EOC had nine risks on their register, which included implementation of ARP, response to specific hospital transfers and a lack of a robust policy for end of life care. These risks were also on the trust wide register and it was clear who had responsibility for each risk and action plans were in place and being monitored.
- The risks present on the register reflected the concerns of the staff we spoke to at all levels.
- The EOC had comprehensive assurance processes in place in call assessing and dispatch areas. Poor performance was identified and managed through a supportive process of feedback and additional training when necessary.
- The EOC dashboard was used to monitor performance and was used as a basis for performance meetings.
- Staff who wanted to work outside of the service were required to inform the trust, this was to ensure that there were no conflicts of interest and that staff were not working excessive hours that could affect care and treatment. The trust had a comprehensive sickness management policy and performance management

processes which incorporated the impact that secondary working could have on staff's ability to carry out duties and line managers were required to discuss this at performance and sickness reviews.
- The EOC regularly provided feedback to the NHS Pathways group through monitoring their own performance and identifying areas for improvement within the system.
- The trust had a robust governance process in place to manage and monitor service level agreements (SLAs) with third party providers. The process included annual reviews of third party providers to gain assurances that agreed standards in regards to safety and staff competencies were being met. We saw evidence that these arrangements were discussed and reviewed at clinical governance meetings.
- Most policies we saw were in date, however, staff referred us to three copies of documents within EOC which had passed the review date. Staff recognised this and replaced them with updated versions of the policies after checking with colleagues and managers and the old policies were removed from the control room.

Leadership of service

- The EOC was led by a general manager, EOC commanders, clinical managers, and duty team managers.
- The EOC had an established and experienced leadership team who were aware of the present and future social and economic challenges related to delivering safe quality patient care whilst delivering their strategic plan.
- Some managers had taken part in the trust's internal leadership programme and 61% of all EOC managers had completed managing and leadership courses.
- We saw clear evidence of leaders in this service working closely with their team to develop their service and encouraging more junior staff to contribute to improvements. For example, the Youth Council Strategy project had been developed by a junior member of staff and they had received support and encouragement from the general manager and their own line manager to present the project to the board of governors and directors.
- All staff we spoke to said that their leaders were approachable and visible and they felt confident they would be listened to and they could voice concerns openly.
- We spoke with the leaders of this service who described a supportive and unified work environment; this was corroborated by more junior members of staff.
- Staff told us that they sometimes saw the chief executive officer and many had received correspondence to acknowledge their contribution to the service, whether for a single job or for length of service.

Culture within the service

- We found the culture of the EOC to be open and inclusive. Staff that we spoke to felt that they were valued and respected by their peers and leaders.
- All staff spoke highly of the service they worked in and were proud to be members of the trust and work in EOC.
- We saw evidence of how the service was working towards meeting the requirements related to the duty of candour and examples of where this had been carried out. Staff understood their responsibility to be open and spoke about apologising to patients and loved ones when things went wrong. Training in Duty of Candour formed a part of the mandatory training workbook.
- Staff were motivated and encouraged to report all incidents including those where there had been no harm to patients or staff to encourage learning, however, a very small number of staff were not always aware of the incidents that had triggered learning or change and a small number of staff still perceived that there was some element of 'blame' attached to incident reporting. We saw evidence that the trust was addressing this issue through policy reviews and the development of the Learning Review Group to improve understanding of the importance of learning from incidents to improve patient safety.
- Staff told us that getting the right response to patients was more important than response times and that they did not feel pressurised or required to send an inappropriate response just to meet a target.
- We saw excellent examples of managers at all levels supporting staff to achieve personal and developmental goals. We saw that senior managers had discussed careers within EOC at board level and had explored different ways of developing staff and creating opportunities to utilise the knowledge and skills of existing staff and allow them to assume more responsibilities.

Emergency operations centre

- We found that all staff were supportive of each other within their immediate teams and other teams within the trust. Some staff in EOC told us that they had received support from the chief executive officer during times of personal crisis.
- Staff were aware of the importance of their roles and staff that we spoke to felt that their service was as important as all the other departments in the trust.
- We found that in both EOCs staff, morale was high and staff saw senior managers at both sites.

Public and staff engagement

- The trust used social media, local meetings, events, listening into action groups and surveys as a means to engage with the public and staff.
- We saw that the public and staff could access social media sites that described how the service worked and gave realistic information about the nature of the work within the service and the reasons that people should call 999. Staff were actively engaged with this method of communication and the trust told us that the amount of compliments they received had increased since they had started using social media.
- The trust's public website invited patients and the public to give feedback on their experiences and also provided the public with useful information about using the service.
- We saw examples of EOC staff actively engaging in local projects to engage younger members of the community through education and involvement.
- Staff told us that they felt that when changes were made they were involved and their opinion mattered. For example, staff told us that they had been given opportunities during the implementation of ARP to provide feedback about the process and changes related to the way information was displayed on the CAD system were implemented as a result.
- Following major incidents or incidents of high media interest, comprehensive de-briefs were conducted which involved all staff who had been involved in the incident. Call-assessors and dispatchers were invited to these de-briefs. We saw how these resulted in improvements to the service. For example, following an incident at a theme park where assumptions had been made regarding attendance of other emergency services. Standard operating procedures had been changed to ensure that other emergency services were always contacted to ensure that they were aware of the incident and to ascertain what if any deployment they were making.

Innovation, improvement and sustainability

- We saw that staff at all levels in this service continuously looked for ways to improve and provide opportunities for learning and innovation.
- An EOC manager was involved with a local voluntary ambulance service and education facility to produce a vocational and academic Youth Cadet Program for young people in the community who had expressed an interest in the ambulance service. Staff involved in the project told us that one of the aims was to encourage and engage with young local people who were representative of the population that the trust served.
- During our inspection, we saw that a member of EOC staff had presented a proposal to the trust's board of executive and non-executive directors in regards to forming a Youth Council. We saw from trust board meeting minutes dated May 2016 that the proposal had already been presented and approved by the trust's Council of Governors. The Youth Council would have a number of responsibilities including representing the views of young people, involvement in decision making on issues that affected young people and involvement in engagement activities. Staff involved told us that having a Youth Council would also enable the health and social care sector to identify leaders of the future.
- The performance cell had been recognised as a centre that produced quality data reports and the trust had received a request to become the national data lead for ambulance trusts. The performance cell had also received a local excellence award for innovation in informatics in 2011 and 2012.
- The trust had implemented the Ambulance Response Programme as part of a national pilot to shape the way that ambulances responded to emergency calls.
- Leaders in EOC were liaising with local educational facilities to develop bespoke accredited courses for staff at all levels.
- The trust was an approved NHS Pathways Beta release test site. This involved receipt of any upcoming NHS Pathways version releases prior to general release. The

trust tested the updates in a test environment before being rigorously tested in a live 999 setting. Feedback was provided to the national NHS Pathways team and recommended changes adopted before general release.

- The design and development of the regional co-ordination centre and its specialised functions provided a means to support the delivery of care in the Midlands Critical Care Network. It also provided valuable data related to access and flow in relation to capacity issues at local trusts and a single point of access for escalation matters related to ambulance handovers and access to specialist units.
- Staff members at all levels in this service were always striving for ways to improve the patients experience and provision of care. For example, staff had designed quizzes relating to policies, protocols and procedures to support each other in learning. We saw that staff worked with external providers to develop alternative care pathways for frequent callers and developed profiles for services to be added to the Directory of Services, which would enable patients to receive appropriate care and treatment in the community or their home.

Resilience planning

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

Information about the service

West Midlands Ambulance Service NHS Foundation Trust (WMAS) provides NHS ambulance services in the West Midlands region of England covering the counties of Shropshire, Herefordshire, Worcestershire, Staffordshire, Warwickshire, Coventry, Birmingham and Black Country conurbations. It covers a geographical area of over 5,000 square miles. WMAS provides a service to a local population of 5.6 million people.

WMAS resilience provided services, planning and business continuity functions to deliver its statutory obligations as category one responders under the Civil Contingencies Act (2004). The Civil Contingencies Act 2004(c 36) is anActof that establishes a coherent framework for emergency planning and response ranging from local to national level. The resilience department working collaboratively with multi-agency services and held responsibility for:

- Major incident planning
- Business continuity
- Emergency preparedness, resilience and response (EPRR)
- Air ambulances and 48 critical care paramedics
- One Hazardous area response team (HART)
- Event planning
- Special operations and air operations dispatch desks.

The WMAS resilience team planned for and responded to a wide range of incidents and emergencies. These included the following Ambulance Service capabilities:

- Incident Unit Response to Hazardous Materials
- Safe Working at Height
- Confined Space
- Inland and Swift Water Rescue
- Tactical Medicine Operations
- Marauding Terrorist Firearms Attack (MTFA)
- Chemical Biological Radiological and Nuclear (CBRN) Capabilities Initial Operational Response
- Specialist Operational Response
- NHS Decontamination of Casualties
- Mass Casualty Capabilities
- Command and Control including National Mutual Aid
- Air Ambulance services in the region were provided by the Midlands Air Ambulance Charity. Paramedics and doctors on the service were paid for by the charity but were provided by WMAS. As the provision of the Air Ambulance was provided by a separate organisation, it did not form part of this inspection.
- The Chief Officer of the trust is the National Ambulance Chief Executive Lead for Emergency Preparedness, Resilience and Response, and the Chair of the Association of Ambulance Chief Executives. The HART) & Special Operations Manager is the Chair of the National HART Operations Group.
- West Midlands Ambulance Service resilience function was coordinated trust wide from its headquarters at Millennium Point Brierley Hill.

Resilience planning

- The trust also had a hazardous area response team (HART), based in Oldbury. HART provide a specialist team, which was part of the overall ambulance response to an incident involving hazardous materials, or which present hazardous environments, that had occurred because of an accident or had been caused deliberately. The HART base contained specialist equipment and a range of vehicles to support the resilience function; in addition, vehicles containing equipment for mass casualty events were based at Hubs around the region.
- During the inspection, we visited the HART base and the control rooms at Tollgate Stafford and Millennium Point. The Millennium Point control room also housed the major incident operations room.
- We inspected vehicles at HART and Stafford and a significant array of equipment including medical bags, rescue equipment, marauding terrorist firearms (MTFA) protective equipment, chemical biological radioactive and nuclear protective, decontamination equipment and breathing apparatus.
- We inspected the security and administration systems for medicines within the base and on vehicles. We spoke with a variety of staff including those working across the wider resilience function, front-line HART paramedics and both junior, middle and senior managers.
- We conducted an announced inspection Between 28 and 30 June 2016. We were unable to observe direct patient care because the opportunity to accompany a crew to a call-out did not arise.
- The trusts Medical Emergency Response Intervention Team (MERIT) and air ambulance services were managed within the resilience services although we did not directly inspect these services as part of this report, we did consider their role in relation to emergency planning and the major incident role.
- Resilience and major incident preparedness with UK Ambulance services were monitored, supported and guided by the National Ambulance Resilience Unit (NARU) and the Joint Emergency Services Interoperability Programme (JESIP).
- These organisations were set up following national review of a number of major incidents; they aim to provide a national coordinated response to major incidents, with advice and guidance on equipment, command structures and working relationships between emergency services, health agencies, civil defence organisations, charities and the military.
- Compliance with NARU and JESIP guidance was strong and reflected industry best practice.

Resilience planning

Summary of findings

Overall, we rated resilience planning within WMAS as outstanding because:

- Resilience planning and services in the trust were based on National Guidance provided in the Civil Contingencies Act, Department of Health, NHS England, the National Ambulance Resilience Unit (NARU) and the Joint Emergency Services Interoperability Programme (JESIP).
- Performance showed an excellent track record and steady improvements in safety. When an adverse incident occurs, an appropriate thorough review or investigation involved all relevant staff and people who used services.
- Lessons were learned and communicated widely to support improvement in other areas as well as services that were directly affected. Opportunities to learn from external safety events were also identified. Improvements to safety were made and the resulting changes were monitored.
- Staff had received up-to-date training in all safety systems.
- Staffing levels and skill mix were well-planned, implemented and reviewed to keep people safe at all times.
- Risks to safety from service developments, anticipated changes in demand and disruption were assessed, planned for and managed effectively. Robust plans were in place to respond to emergencies and major situations. All relevant parties understood their role and the plans were rigorously tested and reviewed.
- All staff were actively engaged in activities to monitor and improve quality and outcomes. Opportunities to participate in benchmarking, peer review, accreditation and research were proactively pursued. Credible external bodies recognised high performance.
- The continuing development of staff skills, competence and knowledge was recognised as being integral to ensuring high-quality care. Staff were proactively supported to acquire new skills and share best practice.
- The systems to manage and share the information that was needed to deliver effective care were fully integrated and provide real-time information across teams and services. People's individual needs and preferences were central to the planning and delivery of tailored services. There were innovative approaches to providing integrated person-centered pathways of care that involved other service providers, particularly for people with multiple and complex needs. The services were flexible, provided choice and ensured continuity of care.
- The involvement of other organisations and the local community was integral to how services were planned and ensured that services met people's needs. A systematic approach was taken to working with other organisations to improve care outcomes, tackle health inequalities and obtain best value for money.
- Governance and performance management arrangements were extremely well embedded proactively reviewed and reflected best practice.
- The leadership drives continuous improvement and staff were accountable for delivering change.

Resilience planning

Is resilience planning services safe?

Good

We rated safe as good because:

- We found that resilience planning and services in the trust were based on National Guidance provided in the Civil Contingencies Act, Department of Health, NHS England, the National Ambulance Resilience Unit (NARU) and the Joint Emergency Services Interoperability Programme (JESIP).
- Performance showed an excellent track record and steady improvements in safety. When an adverse incident occurred, there was an appropriate thorough review or investigation that involved all relevant staff and people who used services.
- Lessons were learned and communicated widely to support improvement in other areas as well as services that were directly affected. Opportunities to learn from external safety events were also identified. Improvements to safety were made and the resulting changes were monitored.
- Staff had received up-to-date training in all safety systems.
- Staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times.
- Risks to safety from service developments, anticipated changes in demand and disruption were assessed, planned for and managed effectively. Plans were in place to respond to emergencies and major situations. All relevant parties understand their role and the plans were tested and reviewed.
- However we also saw; HART and MERIT refrigerators which were both maintained by the trust had not been calibrated since 2014.
- Learning from internal incidents within the trust was not widely shared.

Incidents

- The trust had an electronic incident reporting system for internal incident reporting. Staff we spoke with were familiar with the reporting process and were able to describe the process for completing incident reports.
- The system escalated the incident to the relevant managers and feedback was provided to individuals who had submitted incident reports. Between November 2015 and March 2016, the HART team had reported 10 incidents. There were no serious incidents reported during the period. All the reported incidents were classified as no-harm. We saw documentation which described each incident, the management escalation and outcome where completed.
- Whilst learning was evident within resilience and HART from national and regional engagement, learning from incidents from other services within the trust was not always shared effectively. Staff we spoke with were unable to describe incidents outside their own department. Low or no-harm incidents were recorded by the trust but there was no analysis to identify trends or share them with the specialist teams.
- The trust had a very effective debrief system following external incidents and events. All staff involved in the incident including control room and support staff were involved in debriefs and we saw a number of examples of how the process had improved the service. One example followed an incident involving multiple agencies. The West Midlands Ambulance Service (WMAS) hazardous area response team (HART) were deployed to the incident and were involved in the debrief. An assumption had been made at the time of the incident that police, fire and ambulance services had been called to the incident. However, it transpired that only the police and ambulance services had been called. As a result of the debrief the standard operating procedure for control room staff was updated to include calling partner services to ensure they were aware at an early stage. The need for additional morphine was also identified which led to the new standard operating procedure for additional supplies, as described in the Medicines section of this report.
- HART, Chemical, biological, radiological and nuclear defence (CBRN) and Marauding Terrorist Firearms Attack (MTFA) planning within the trust followed national guidance from the National Ambulance Resilience Unit (NARU). NARU works nationally on behalf of each NHS Ambulance trust in England to provide a coordinated approach to emergency preparedness, resilience and response. Amongst its functions, NARU disseminates learning between ambulance trusts and external agencies. We saw examples of how information from NARU had been used to improve or enhance services. This included the guidance on type and use of equipment required for HART teams.

Resilience planning

Mandatory training

- The HART team was fully staffed and all staff had completed 100% of their mandatory training. Mandatory training included: conflict resolution, infection prevention and control and Mental Capacity Act awareness.
- HART staff had protected time for training and every seventh week of duty was designated as a training week. Regardless of core service demands staff were not taken off training to backfill shortages elsewhere in the organisation. Staff were not allowed to take leave during their training period unless exceptional circumstances arose. They were required to plan in advance of the leave being granted, when they would complete any missed training. The only exception to protected training was if the team were deployed to a major incident to support the duty team. This was another area of outstanding practice demonstrated by the trust..
- The trust had dedicated HART trainers; this ensured that national training standards were met. We were unable to meet with them during the inspection as they were delivering training in water rescue techniques out of the area. The training was a joint venture with the Fire and Rescue service that had provided a specialist trainer to work with the team. Staff confirmed that joint specialist training was a regular feature in the team.
- Recertification requirements for breathing apparatus and working at height met national requirements. All staff on the HART team held current accreditation.
- Non-specialist staff in the trust received resilience training as part of their mandatory training, which gave them an oversight into their role in any large scale or major incident. All emergency road crews had been provided with major incident action cards, which identified roles and responsibilities. Patient transport service team leaders were also issued with the major incident cards so they could brief their staff on support roles if the need arose.
- Regular fitness assessments were carried out and processes were in place to support staff if they failed their fitness test. Senior managers told us that no one had failed the test since the teams were established in 2008.
- HART staff had undergone additional training in specialist functions which included:
  - Chemical, biological radioactive or nuclear incidents (CBRN)
  - Rescue from height
  - Rescue from water
  - Rescue from enclosed spaces
  - Mass casualty incidents
  - Firearms and Terrorist incidents.
- This meant staff were able to respond to any known eventuality and do so in the safest way possible. These functions and associated training were all based on NARU interoperability standards. In healthcare, interoperability is the ability of different information technology systems and software applications to communicate, exchange data, and use the information that has been exchanged.

Safeguarding

- The trust had a safeguarding policy and safeguarding lead.
- All HART staff were trained in safeguarding adults and children to level two as part of their paramedic training and revalidation.
- Staff we spoke with had a good understanding of safeguarding issues and clear knowledge of how to respond to any concerns. There had not been any safeguarding referrals by the HART team between May 2015 and May 2016.
- The trust website had information to patients on safeguarding; how to recognise and report abuse in both adults and children. The information was available as a printable patient information booklet However, the booklet was not carried on HART vehicles, as they were responsible for rescue and hazardous environment situations. Any casualties were handed to core service staff for transportation. The core service staff would be better placed to support patients who required safeguarding advice or interventions. In the unlikely event that information was required whilst a patient was still with the HART staff, the booklet could be requested from an attending core service crew.

Cleanliness, infection control and hygiene

- During our assessment of resilience, we visited a number of locations in the trust: Millennium Point headquarters and the control centre, Tollgate control centre and Tollgate workshops, and the Oldbury HART base.

Resilience planning

- We saw buildings and vehicles at all the locations were cleaned to a high standard. All vehicles had daily checklists available in the cabs, these showed that vehicles were cleaned daily and had monthly deep cleans.
- Hand gel was available inside office complexes with notices to staff to remind them to use gel when entering or leaving. Toilets had information notices about different infection types and how to protect against them.
- Staff presented a smart, clean and highly professional image.
- The HART management team had completed an audit of infection prevention and control procedures during 2015. This identified areas where the team could improve performance, such as the segregation and bagging of waste types. We saw how an action plan for 2015/16 had been created to mitigate or remove identified issues.
- We saw how individual HART staff took responsibility for their own vehicles and we observed staff cleaning vehicles.
- Waste at the HART centre was segregated into clinical and domestic waste. Clinical waste was bagged and sealed before being deposited into yellow industrial wheelie bins. Bins were emptied as part of the trusts wider waste disposal programme.
- Chemical, biological, radioactive and nuclear (CBRN) waste procedures were in place, adhered to and followed national guidance.
- Decontamination shelters were carried on support vehicles which were based geographically around the trust. We inspected one set of support vehicles at Tollgate. Decontamination shelters are portable shelters which provide an area for casualties who have or may have been in contact with corrosive or dangerous substances to remove and dispose of clothing. Wash themselves and dress in disposable suits. This prevents or reduces any contaminated material being transferred to other areas. The shelters and support equipment were clean, bagged and sealed ready for use.
- Staff described decontamination processes and waste disposal of contaminated materials. The process was based on the Department of Environment, Food and Rural affairs (DEFRA) and National Ambulance Resilience Unit (NARU) guidance.
- Decontamination and waste disposal also featured in the business continuity plans and in local resilience forums.

Environment and equipment

- The trust had a proactive approach towards vehicle maintenance. Normal practice in ambulance services was to replace vehicles after seven years. WMAS vehicles were replaced after approximately five years of service. Managers explained this had followed a costing exercise which identified that retaining vehicles beyond five years resulted in increased servicing and breakdown costs, this combined with higher re-sale value of younger vehicles meant it was more cost effective to replace them at five rather than seven years. This was an outstanding example of reducing costs whilst improving service provision.
- Security of the HART premises was supported with the use of external lighting monitoring through a robust closed-circuit television (CCTV) system. HART staff were all aware of the security issues which we were told resulted in a high level of vigilance. We witnessed staff at the base securing the premises when vehicles had been dispatched, which prevented unauthorised persons from accessing the building. We also saw how all entry and exit points were secured with electronic entry systems. The lack of secure compound meant that the premises and both trust and private vehicles were potentially more vulnerable to attacks of vandalism or arson. Whilst the trust were unable to follow the NARU and WHO guidance, there had been no adverse incidents recorded as a result of the lower security.
- The trust HART team were based in a converted warehouse. The trust had planned to use the location on a temporary basis whilst a site for a purpose built facility was identified. Funding had been promised to the trust specifically for this purpose however; before plans had been finalised the trust were told that funding was no longer available. The warehouse therefore became the permanent site for the service.
- The location was chosen by virtue of its easy access to major road links; increasing the effectiveness of the team.
- The site was in the centre of a small industrial estate. Surrounding businesses had a constant flow of large articulated vehicles. We were told that historically the movement and parking of these vehicles had caused problems with emergency response from the site.

Resilience planning

Senior managers from the team had met with managers from the neighbouring businesses, which had resulted in roadways being kept clear. We saw innovative practices had been employed to make best use of the available space in the warehouse area. A first floor storage area had been built which enabled safe storage of emergency equipment. Below this was a storage area for team member's personal equipment lockers. The lockers consisted of large metal lockers on wheels. When staff came on duty, they wheeled their locker out to their vehicle and loaded their equipment. This meant that staff could easily find their own equipment and transfer it quickly if required. It also meant that there was no clutter, no trip hazards and no mistaking whose equipment was whose. The system also promoted personal responsibility and ownership.

- Specialist equipment used by the trust was in line with NARU specifications. NARU acted as a central procurement facility. The majority of HART equipment was purchased through this central system. This meant that all HART vehicles were similarly equipped and could be deployed to any major incident in the country under mutual aid agreements and HART staff from any team around the country would understand where to find equipment on the vehicles and how to use it.
- Breathing apparatus (BA) had a dedicated storage room. We saw that equipment was stored ready for use and logbooks were kept with each set of equipment. We reviewed entries in two logbooks and saw that regular checks of the equipment and its operation were completed. Logbooks were clipped to the apparatus and were visible through 'see through' pockets. Apparatus which had been checked and was ready for use had the front of the logbook visible with green lettering. If equipment was found to be defective or required servicing, the logbooks were reversed inside their holders which then showed red lettering and indicated that the equipment should not be used. In addition, any apparatus which was not in use was stored on the opposite side of the room to distinguish it from serviceable equipment. Equipment checks and log entries were completed in line with best practice from the Fire & Rescue Authority Operational Guidance Breathing Apparatus, 2014.
- Specialist vehicles were maintained at the trusts Tollgate Depot in Stafford. HART staff told us they would prefer to have more local facilities, but understood that this was not practical when facilities already existed in the trust.
- WMAS took delivery of a new 'Incident Command' Vehicle in December 2015. The vehicle was equipped with state of the art satellite communications systems, flat screen monitors and facilities to provide on-site or forward command provision at major incidents. It also included a briefing room with seating for up to nine people, conference table, briefing screens, laptop positions and video and phone conferencing.
- Capital and revenue depreciation and replacement scheme included provision for replacement of vehicles after five years. It also included provision for the maintenance and servicing of vehicles. We saw documentation relating to the maintenance and servicing of the trust's new Command Vehicle this showed that £130,000 per annum had been included in the scheme to cover the costs associated with that vehicle. This demonstrated how the trust met its obligations under standards 14,15,and 16 of Appendix 3 of the NHS Service Specification 2015/16; Hazardous Area Response Teams (HART).
- We saw that local managers had been creative regarding the limited space available in the HART depot. A large, wheeled locker had been provided to each member of the team. They were able to keep all personal issue equipment in their locker, pull it from the storage area to their vehicle to load or unload kit. This prevented kit bags, personal items and equipment being left around causing trips hazards and potentially getting lost. Staff knew where to find everything they needed quickly and knew that everything would be intact and ready for use.
- A large storage area had been created above the locker storage, which enabled stocks of disposable or expendable equipment to be stored ready for use.
- Hart vehicles used by teams whilst training were fully equipped and able to divert and respond to major incidents if required. They were equipped to the same standard as other vehicles in the unit.

Medicines

- The trust had a medicines policy which staff were aware of and could access on the intranet for clarification or guidance.

Resilience planning

- We examined the storage facilities for medicines within the HART base. The medicines room was a secure room shared by the MERIT Team. MERIT doctors responded to incidents using the Air Ambulance Service during daylight and had a separate base at RAF Cosford. However, at night or during periods where the helicopter service was unable to fly, MERIT worked out of the HART base using land vehicles.
- Within the medicines room, The HART drugs cabinet, refrigerator and administrative books and papers were on one side of the room and MERIT's were on the other. Staff from each team had access only to their own teams' cabinet and refrigerator.
- We checked stock in the HART cabinet against registers and checked the date and quantity of a random selection of items. We found that drugs were properly accounted for and had not exceeded their expiry date.
- Staff had a clear understanding of the procedures for receipt, administration and disposal of drugs.
- We saw drugs were kept securely whilst in transit.
- HART followed the same trust policies and procedures as the core service staff. One exception to this was the 'Mass Casualty standard operating procedure January 2016. This allowed for additional supplies of controlled drugs by paramedics on the HART team. An additional 50 ampules of morphine were stored at the HART base, for use at mass casualty situations. Strict local guidelines and standard operating procedures were in place covering the release and delivery to scene of these supplies.
- The HART base was also used as a base for two specialist ambulances funded by the Department of Health. Drugs in these vehicles were not the responsibility of the trust. Periodic deliveries were made of sealed packages which ensured drugs were in date and appropriate for use. The HART team's only function was to exchange the packages when delivered.
- The HART team paramedics did not carry temperature sensitive medication. Their refrigerator was used solely for storage of the team's personal annual flu vaccines. At the time of our inspection, the refrigerator was empty. We noted that both the HART and MERIT refrigerators which were both maintained by the trust, had not been calibrated since 2014. When this was pointed out to the managers, they accepted that it had been an oversight and stated they would arrange calibration checks to be completed as a priority.

Records

- At the time of our inspection, the trust used a combination of paper and electronic patient records, Electronic patient records systems were being rolled out across all trust response vehicles. HART vehicles were equipped with an electronic system, but not all staff had received training in the electronic system. This was a rolling programme and senior staff were confident that all HART staff would be trained in the electronic system by the end of December 2016.
- Patient records were not stored on vehicles and we did not have the opportunity to review records at any scenes.
- We reviewed records in relation to storage of medicines, maintenance of equipment and vehicles and general administration of the department. Both paper and electronic records were complete, concise and easy to interpret.
- Policies and standard operating procedures we reviewed such as the mass casualty administration of controlled drugs, and the 'Cleaning procedure for severe infections – Category Four Diseases.' These were easy for staff to follow and followed national guidelines.

Assessing and responding to patient risk

- All HART staff were qualified paramedics and followed trust policies and procedures regarding patient care, observation and escalation. In addition, the team attended specialist training in dealing with hazardous environments including chemical, biological radioactive and nuclear (CBRN) incidents, water rescues, enclosed space rescues (including using breathing apparatus) and mass casualty incident training. The training and execution of the role was based on real-time assessment of risk to patients, public, themselves and other rescue personnel.
- Staff on scene were able to escalate incidents, which required additional resources by alerting control room staff. Serious incidents were passed to the Regional Control Centre (RCC) where they could be reviewed by senior staff. Advance notification to receiving hospitals, additional resources and further escalation to senior managers was completed from the RCC.
- We were given examples of how the team planned for large public events such as the 'V' festival and for unusual or difficult rescues. We were shown photographs of staff performing rescue exercises in an

area which simulated a collapsed building. We also saw video footage of a water rescue exercise.. We were also given examples relating to live incidents where staff had needed to make real time assessments of risk, including motorway incidents and a rescue at height from a theme park. Examples of planning are outlined in the 'effective' section of this report.

- When on scene or on route to the scene, paramedics were able to seek advice from the Clinical Support Desk within the control rooms including requesting additional resources. Information could be exchanged via radio, telephone or electronically.
- The call-assessor's telephony system had the ability for call-assessors to invite supervisors to join them in a call if they needed support or felt that the incident required additional support. This function was activated by simply pressing a red button on the phone to alert the supervisor and enable them to pick up and join the call.
- The software systems, which were used across both sites, had a Regional Control Centre (RCC) button on the screen. This meant that at any time the dispatcher felt that it was required they could select the RCC button and the incident would go live in the RCC where it could be reviewed and if necessary taken over by the RCC controllers.
- The computer systems were cloud based which meant that in the unlikely event that neither of the control rooms could function, services could be re-established remotely.
- Emergency planning officers attended regional civil contingencies joint operations exercises. We were told by partner agencies that attendance was sporadic and some scenarios were written without the inclusion of ambulance services, so that other services could continue with the exercise. The Emergency Planning and Specialist Operations Director explained that WMAS did not make direct financial contribution to civil contingencies exercises in the same way that other emergency services did. He advised; there was no provision within commissioned funding to enable financial support to external exercises, WMAS' contribution was in providing staff and equipment, all of which was funded by the trust.

Staffing

- The establishment consisted of a band 8 HART and Special Operations manager, a band 7 HART Support manager, seven band 6 team leaders each with five band six members on their team. All of these staff were qualified paramedics and an administrator supported the team.
- We saw that the HART team was staffed in accordance with NARU guidelines. There were no vacancies on the team. However, temporary vacancies that did arise were covered by staff working additional hours. The team had recently been increased by seven paramedics because of HART taking on additional responsibilities for the trust in respect of their bariatric service.
- The trust resilience structure included a number of interacting and complimentary departments. The trust had six emergency planners who worked regionally within the trust but met regularly to ensure that similar issues received a standard response and to identify and share best practice. The emergency planning staff attended local resilience forums and ensured that trust policies reflected current best practice.
- The trust also had a business continuity manager, who reviewed business continuity plans from all the trusts departments to assess their robustness and ensure compatibility with trust procedures.
- Recruitment to the HART team followed the NARU recruitment guidelines. This included personal profile characteristics, occupational health screening, physical fitness and competency based interviews.
- Sickness rates had been as high as 11% earlier in the year which managers explained had been caused by a small number of long term sick. In April 2016, sickness levels dropped to 2.6% which was in line with the overall trust levels. Managers described how the majority of sickness in the unit was because of minor injuries from the hazardous environment staff worked and trained in. Whilst safety was a high priority, risk factors were higher which accounted for higher incidents.

Anticipated resource and capacity risks

- The trust undertook a large piece of work to assess the capacity of acute hospitals in the region to receive casualties following a mass casualty incident. This is expanded upon in the 'effective' section of the report and is an area of national best practice.
- Members of the resilience team attended 68 multi-agency exercises between February 2015 and June 2016. These included firearms sieges, flooding, simulated explosion and fire in a nightclub premises, readiness exercises for international sporting events,

and communications exercises. The exercises enable participants to understand how effective each service might be in certain situations, and enabled emergency planners to assess potential demand.

- We saw that emergency and resilience planning ensured the trust was able to respond to major incidents both within and external to the trust. For example, the trust operated two control rooms from Millennium Point and Tollgate. Whilst major incidents were normally escalated within the Millennium Point control room, there was provision at Tollgate to undertake those functions if Millennium point suffered a catastrophic breakdown. An annex of the Tollgate control room, which was available for training and was fully equipped with control terminals, could be utilised as a major incident room, whilst the main control room would undertake core functions for the trust. Similarly, if Tollgate was compromised then Millennium point could take over the core service functions.
- The trusts strategy met the Department of Health's statement of NHS organisations being 'individually resilient, collectively robust' in terms of emergency preparedness capabilities.

Is resilience planning services effective?

Outstanding ☆

We rated effective as outstanding because:

- All staff were actively engaged in activities to monitor and improve quality and outcomes. Opportunities to participate in benchmarking, peer review, accreditation and research were proactively pursued.
- Credible external bodies such as JESIP and National Ambulance Resilience Unit (NARU) recognised high performance.
- The continuing development of staff skills, competence and knowledge was recognised as being integral to ensuring high quality care. Staff were proactively supported to acquire new skills and share best practice. Hazardous Area Response Team staff had protected training time. One week in seven was dedicated to training.
- The systems to manage and share the information that was needed to deliver effective care were fully integrated and provide real-time information across teams and services. Trust major incident policies were being re-written to reflect narrative on major incident cards to increase familiarity for staff.
- Staff competencies were maintained and tested in accordance with NARU recommendations.
- Processes for seeking consent were understood and followed thoroughly by staff.

Evidence-based care and treatment

- The trust Resilience Strategy 2011 to 2016 'Building and Maintaining Organisational Resilience and Readiness' set out the trusts aims and provided guidance for staff to plan resilience within their own departments.
- WMAS had a trust wide business continuity officer. Senior staff in each of the trust 42 operational departments completed business continuity plans. Assistance in completing plans was available from the business continuity manager, and completed plans were reviewed for completeness and compliance before being accepted as part of the trust plan. This meant that individual departments were able to create plans relevant to their function which complemented the trust in providing an overall service.
- The trusts' business continuity plans were now being developed in line with International Standards Organisation (ISO) ISO 22301. This international guidance supersedes British Standard (BS) BS 25999. The two standards were very similar; however, ISO 22301 has a number of fundamental changes to increase organisational resilience. In order to monitor their progress in transitioning from BS to ISO standards, the trust had implemented a steering group and produced a RAG rated chart to enable them to monitor and prioritise and develop the required changes. TheRAGsystem is a risk management method of ratingfor issues or status reports, based on Red, Amber (yellow), and Green colours used in a traffic lightrating system.
- The NHS England Core Standards return for 2015/16 was rated 100%, which is an area of outstanding practice.
- WMAS had developed a set of Major Incident aide memoire cards. The cards were colour coded to assist staff in emergencies to identify the cards relevant to the type of incident. The cards contained summary guidance based on the trusts policy and standard operating procedures for each type of incident. These cards had been issued to all operational staff including

control room staff. The cards were based on national best practice from NHS England, National Ambulance Resilience Unit (NARU) and the Joint Emergency Services Interoperability Programme (JESIP). For example, the acronym METHANE is used throughout WMAS. METHANE was introduced by JESIP and established a common basis for the exchange of information between and within organisations

M-ajor incident declared

E-xact location

T-ype of incident: for example, explosion, fire in tall building, CBRN etcetera.

H-azards present and potential

A-ccess routes known to be safe

N-umber, type, severity of casualties

E-mergency services now present and those required.

- The Major incident aide memoire was being further developed by the trust. Electronic versions were in production which would enable control room staff to view information on one of their control screens and response crews to view on their data terminals. Senior staff explained that this also had the added benefit of being easily updated if national or local best practice changed. A simple electronic document edit would provide all staff with the latest guidance, whereas the card system required re-printing of the relevant section, distribution to staff who then had to remove the old cards and replace with the new version.
- The trust policies were being re-written so that the format of the pages printed or on-screen mirrored the cards. This was being done to increase familiarity. Staff at major incidents would find the layout of the cards familiar, as they would be the same as the documents they had used during training.

Assessment and planning of care

- The NARU training, equipment and procedures used by the HART staff ensured that effective procedures were in place enabling staff to provide effective care to casualties. Training and use of appropriate equipment ensured that staff remained safe and patients were treated as quickly and safely as circumstances allowed. Subsequent debriefing of actual incidents and issues identified on training exercises were used to improve services and care. This was evidenced by changes to control room practice and the purchase of additional equipment following one incident involving rescue from height.
- We were given an example of how the trust had planned in advance for known risks. Leading up to the 2015 New Year's Eve celebrations, WMAS recognised that there would be large numbers of people gathering to celebrate the festivities. They identified the potential for a mass casualty event outside, the most likely location being London. As a precaution, they identified HART resources and personnel who would be deployed if they were called to assist. This meant that if mutual aid were called for the trust could respond knowing that sufficient resources were available. The plan was shared with the London Ambulance Service, so that they understood what support they could expect from WMAS. It is not thought that any other regional service made this provision and represents an area of outstanding practice.
- Evacuation of patients from scenes to appropriate on-going care was arranged through control staff, and involved additional resources such as core service ambulance crews, Air ambulance services, or in some instances patient transport services.
- HART staff provided two single crew response vehicle each day to support core service crew's. This enabled staff to maintain their own clinical skills which enhanced the care they were able to provide.
- In addition, we saw how an extensive piece of work had been completed involving liaison with all acute hospital services in the region and neighbouring regions. This was the West Midlands Ambulance Service JRB Casualty Regulation & Capability Chart 2015 -2020. The work identified the number of level 1 2 or 3 casualties each hospital could accommodate during the first hour of any mass casualty incident. Casualty levels were set nationally and identify the acuity of patients so that everyone receives the most appropriate treatment. This forward planning meant that dispatchers could make immediate decisions about where up to 400 patients could be evacuated to in such circumstances without having to make contact with individual hospitals. This piece of work had been shared with NHS England and consideration was being given to rolling the system out across the country as it was recognised as a national improvement in resilience planning.

Resilience planning

Response time

- NHS HART Interoperability standard 8 specifies that four HART staff must be released and available to respond locally to any incident identified as potentially requiring HART capabilities within 15 minutes of the call be being accepted by the provider. We were shown computer records which showed that response times had been met in respect of all incidents classified as a HART response.
- WMAS always had a team of seven HART staff. It was common practice for two staff to be deployed in single crewed vehicles to support core service crews. These resources were not able to ferry passengers but would provide initial paramedic response or support core service paramedics. If an incident requiring HART response was called, the unit still had the capability to respond with four staff. The crews assisting core service would then be released as soon as it was safe to do so and would join the HART response if required.
- Interoperability standard 11 requires that HART staff can be on scene within 45 minutes at strategic sites of interest. The strategic sites of interest were set out in the Home Office Model Response Strategy. WMAS HART base was situated on an industrial estate with excellent trunk road and motor way links to the major built up areas of Birmingham and the Black Country. Motorway links also enabled fast access to other areas covered by the trust which were not listed in the Home Office document but enabled HART to support core service staff and be re-deployable if required.

Patient outcomes

- Patient outcomes were not directly monitored by HART managers. Hart resources responded to incidents where their additional training and equipment enabled them to reach patients and provide an initial service. Once patients had been made safe or removed from the hazardous area, core service staff transported them to hospital.
- Patient outcomes were reviewed as part of a major incident debrief and identified areas, which went well, and what could be done differently or better. For example, an incident at a theme park where HART staff used their skills in working at height to reach seriously injured patients who were trapped. The debrief identified that staff had taken the initiative to work outside their normal safety limits in order to reach patients. In reaching the patients and assisting to establish blood supply, the debrief concluded that two of the casualties would not have survived without the intervention of the staff.
- During 2015, the MERIT team were peer reviewed by the Trauma Network; and they were graded as providing recognised best practice in nine out of the ten criteria.
- The NARU national benchmarking review 2016/2017 gave the WMAS HART unit an overall score of 'Average'. The benchmarking data consisted of 27 criteria spread over three categories. The three categories were 'Workplace features' which had 12 criteria, 'Preparedness' had five criteria and 'Health and well-being' had 10 criteria.

Positive and negative responses were collated to provide a risk rating of safe, low risk, medium risk, and high risk and dangerous for each criteria and category. The results were then translated into an overall position for the trust between "Unsatisfactory", "Below average", "Average", "Good" and "Outstanding". The results for WMAS were 13 criteria were safe, 11 were low risk and one was medium risk. The medium risk factor related to unsupportive leader behaviour

Category - Workplace Features – 12 criteria – five Safe, six Low risk and one Medium risk.

Category - Preparedness – five criteria – two Safe, three Low risk.

Category - Health and Wellbeing – 10 criteria – eight Safe, two Low risk.

Competent staff

- All operational staff on the HART team were required to be qualified paramedics and to maintain their accreditation, which was in line with NARU best practice. In addition, training programmes were designed to meet the NARU national training standards and fitness levels, this included team leaders, and managers.
- We saw records and we were shown video footage of recruitment and training events. One training event involved a water rescue which was being filmed for training purposes. We saw how the exercise did not go according to plan resulting in the scenario turning into an actual rescue. We saw how staff instinctively acted in accordance with their training in responding to the situation and bringing it to a safe conclusion.

Resilience planning

- Training and fitness standards were maintained in line with NARU guidance. Fitness tests followed NARU guidance and support systems were in place to help staff improve if they failed to meet the required standard. Managers told us that in the history of the unit no one had failed the fitness test.
- The Resilience functions within the trust were extremely robust. Each manager had one junior member of staff who had received training and had the experience to act up in the higher role.
- Command structure followed nationally recognised standards of:

Gold- Strategic command

Silver- Tactical command

Bronze- Operational command.

- The command and control system of ambulance officers with 13 Bronze trained officers on duty on a 24/7 basis provided an extremely robust response capability.
- The trust had three 'on duty/on call' geographically based Silver (Tactical) command officers.
- Gold (Strategic Command) were exclusively career paramedics, which is regarded as best practice in England.
- HART staff all had current staff appraisals. Appraisals took place annually and staff had regular one to one meetings with their team leaders.
- Team meetings took place on a weekly basis; staff told us they felt supported in their role and were able to raise issues or seek guidance either through these meetings or directly with managers. HART staff had clinical supervisions each month. This involved assessors who were also paramedics double crewing with HART staff to assess their actions and competencies.

Co-ordination with other providers

- The trust were able to demonstrate incidents where they had provided mutual aid, these included airport incidents and the London bombings of 2005.
- We also saw evidence of planning mutual aid in advance of potential incidents; as demonstrated by the 2015 New Year's Eve plan.
- The emergency planning team had geographic responsibilities and when they could, they attended joint operations and exercises with other emergency service and the wider health community. We were provided with lists of events and exercises which they had attended. Senior staff also attended and often chaired meetings such as the Local Resilience meetings, which were attended by representatives of the local health community, emergency services and local authorities.
- We saw how joint training exercises took place with specialists from the fire and rescue service joining the HART trainers on water rescue training.
- HART also provided external CBRN training to the police.
- The trust also supported major public events by providing standby or field triage and treatment facilities. In the case of the nationally publicised and popular V-Festival the trust provided the equivalent of a field hospital on site.
- HART staff have attended joint exercises with the military including NATO CBRN training exercise 'Clean Care.'

Multidisciplinary working

- The trust had a Medical Emergency Response Intervention Team (MERIT), which consisted of a paramedic and a trauma doctor. The MERIT team provided day and night cover. During the day, they operated from the Air Ambulance facility at Cosford and during the hours of darkness when the air ambulance was unable to fly, they operated from the Oldbury HART base. This system had the added bonus that when on standby at night the MERIT doctor provided training to the HART team enhancing their skills and understanding.
- Control room staff; call-assessors and dispatchers at both Millennium Point and Tollgate were able to describe how they dealt with major incidents, they produced their major incident aide memoir cards and were aware of on-going developments to incorporate them into the electronic system. Major incident plans were available and systems were in place, which ensured that major incidents were escalated to the regional coordination centre (RCC). This demonstrated how control room staff, paramedics on scene, clinical supervisors in control rooms and core service crews worked together to provide a comprehensive service.
- Patient transport services were not staffed by paramedics, however did form part of the trusts overall emergency planning response. For example, following a mass casualty incident patient transport services could be used to evacuate patients with minor injuries away

from the scene. Patient Transport supervisors had all been provided with major incident aide memoire cards so they had access to information on how to respond in various major incident situations.

Access to information

- All emergency operational staff had been provided with ring bound copies of the major incident aide memoires.
- Trust policies, procedures and standard operating procedures were available on the trusts intranet site, which all staff had access to.
- Medical alerts, patient safety alerts and trust information were circulated through the intranet and staff had personal email accounts which were used to circulate team messages or for individual correspondence.

Consent and Mental Capacity Act

- Staff we spoke with in the HART team and in the control rooms understood their responsibilities regarding people's rights. Call-assessors described how they would escalate any concerns to their supervisor by inviting them into the call.
- HART staff acted in accordance with people's best interest during emergencies. This meant that the paramedics in accordance with their training often made decisions about care. In such circumstances, full details of why actions were taken were recorded on patients care records. Full consideration of patient's wishes or those of their carers were considered when the casualty and the staff had been removed from the hazardous area and were no longer at risk from factors at the scene.
- WMAS had assisted in the formulation of the Association of Ambulance Chief Executives (AACE) clinical guidelines on the Mental Capacity Act 2005 (MCA). The trust supports the universities in the region in presentation of MCA.
- The trust mandatory training schedule for 2016/2017 included a two-day course on the MCA.

Is resilience planning services caring?

We were unable to rate this area of the service as we did not observe interactions with the public due to lack of opportunity and information from other sources could not be attributed directly to resilience staff.

- HART staff attended a considerable number of incidents in support of the core service crews; however, the trust had no method to collect information from patients, which differentiated, between the incidents attended by HART crews and the larger number of incidents attended by core service crews.
- Managers told us that although they did not currently have a method of collating information in support of this domain, they were satisfied that staff treated patients with respect and dignity in all situations. They cited that all HART staff were qualified paramedics and had needed to exhibit outstanding personal behaviours as part of the selection process.
- HART staff were high profile and wore different uniforms to core service staff which meant they were easily identifiable if someone had wanted to complain or raise an issue. No such issues had been raised.
- Managers felt that any behaviour from a member of the team, which did not meet the highest standards, would be reported by other HART staff or by core service staff. That combined with regular clinical and operational supervision of staff where managers had observed staff dealing with patients gave them confidence in their teams.
- Feedback from external agencies regarding interaction with the trusts emergency planners and senior officers was all complimentary.
- Feedback from incidents on the MERIT teams twitter site included video clips of patients explaining how they were dealt with and the care and compassion which staff showed.
- Managers told us that they would look at methods to capture this information in future to ensure standards were met and also to highlight appreciation for staff.
- From a trust wide perspective, results of the 'Hear and Treat survey' between 01/12/2013 and 31/01/2014 showed that patients experience with ambulance staff was within national expectations in respect of: being able to ask questions of staff, overall experience and respect and dignity. However, the trust were below the national average in relation to treating people with kindness and understanding, but these data relate to the whole of West Midlands Ambulance Service.

Resilience planning

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

Outstanding ☆

We rated responsive as outstanding because:

- People's individual needs and preferences were central to the planning and delivery of tailored services. The services were flexible, provided choice and ensured continuity of care.
- The involvement of other organisations and the local community was integral to how services were planned and ensured that services met people's needs. There were innovative approaches to providing integrated person-centered pathways of care that involved other service providers, particularly for people with multiple and complex needs. Emergency planners attended local resilience forums.
- There was an active review of complaints within the trust and how they were managed and responded to, and improvements were made as a result across the services. People who use services were involved in the review.
- Hazardous Area Response Team had been given additional staff and equipment in order to provide the trust response to bariatric patient's needs.
- Guidance was available to control room staff to enable them to recognise when incidents required HART, Air Ambulance or other escalation.

Service planning and delivery to meet the needs of local people

- Emergency planning for the trust was based on the needs of local people at the time of severe or catastrophic disruption to normal activities in the community. Plans were formulated to provide a safe response in a timely manner with the most appropriate resources. Joint Emergency Services Interoperability Programme (JESIP) protocols were included which enabled senior staff to understand how to interact and cooperate with other emergency services, civilian and where required military personnel. The planning met the requirements of Standard 31, Appendix 3 of the NHS Service Specification 2015/16.
- Aide memoire cards colour coded for each type of incident were carried by all emergency response staff. If they were unsure of their personal role, reference to the cards would highlight what was required of them to assist the public in the current situation.
- Two single crew HART vehicles were deployed each day to support core service crew. The vehicles were fully equipped HART vehicles and intentionally did not have facilities for conveying patients. This meant that core service crew conveyed any casualties to hospital which ensured that HART staff remained easily deployable to any HART based incidents. This meant that HART staff were able to provide paramedic response to patients in support of the core service enabling WMAS to respond quickly and to more patients. The vehicles were deliberately not equipped for patient transfer which ensured the potential re-deployment of the highly trained staff and vital equipment was not delayed.
- Emergency planners and trust executive managers attended Local Resilience Forums, regional exercises and event planning meetings. Plans were put in place to meet foreseen/planned events and also to deal with unforeseen eventualities.
- We saw that planning for different scenarios had ensured HART had a comprehensive range of vehicles and equipment in line with NARU specifications. This meant they were equipped to deal with any eventuality within the NARU remit.
- We examined a variety of vehicles and their equipment at the HART base and at Tollgate where we saw the support vehicles with mass casualty equipment. We saw that the specification and maintenance of the vehicles and equipment reflected the planning. This in turn ensured that specialist equipment and vehicles were always available to support the public in major incident scenarios.

Meeting people's individual needs

- The trust had a number of specially equipped bariatric vehicles to enable core service crews meet the needs of an increasing number of bariatric patients in the region. In addition to the core service response the trust had purchased a higher specification specialist bariatric ambulance to deal with extreme cases. However, due to the availability of suitably trained staff within the core service, the ambulance was rarely used and was eventually taken out of use. The specialist ambulance had now been added to the HART team fleet and the

service would be operational by the end of August 2016 following necessary equipment checks. The vehicle is in the process of having all the equipment checked and serviced after which the HART staff will provide the trust bariatric response. In order to provide this service the team received an additional seven paramedic staff who at the time of our inspection had already been integrated into the teams. This meant that the HART team were would be able to support patients with specialist bariatric needs. We saw documentation which showed how the team had responded to a patient who required hospital care. The bariatric patient's home was not suitable for their needs and the patient was effectively trapped inside the building. HART staff used 'rescue from height' equipment to assist in the transfer of the patient from the building to a specialist ambulance.

- HART staff had all completed mandatory training which had included input on the Mental Capacity Act and how to support patients who were temporarily or permanently unable to make informed decisions. Patients finding themselves in mass casualty situations are often disorientated and confused, and in some cases unconscious. HART staff who were all trained paramedics understood the need to make to best interest decisions on behalf of patients, and to explain to conscious patients what was happening and who they (The paramedics) were.
- Mandatory training included conflict resolution training which equipped staff to deal with aggressive or potentially violent patients.
- Translation services were available through a telephone language line system.

Access and flow

- HART staff and vehicles were not used for patient transport, which meant that hospital turnaround times, or issues in the wider healthcare economy did not affect them.
- We saw computer records which showed that when dispatched to an incident within Home Office Model Response Strategy guidelines, the team had always met the required response times of 15 and 45 minutes. The Home Office Model Response Strategy identifies locations where HART response times must be met. Where the team had responded to incidents outside the West Midlands urban conurbation whilst response had been immediate arrival times could be affected by the distances involved.

Learning from complaints and concerns

- There had been no complaints about the staff or service provided by HART since it was set up.
- Managers explained that they did not have a mechanism for requesting feedback from patients about work of the HART team. Patients often received care and support from core service personnel both before and after any HART involvement this made it very difficult for patients to identify that HART staff had even been involved. The trust feedback systems did not differentiate between specialities involved. However, managers were equally confident that any investigation or debrief of a less than satisfactory incident would identify any shortcomings of the team.
- All incidents of note were comprehensively debriefed in line with the trusts constructive debriefing policy. We saw evidence of how the debriefing system was designed to involve all staff disciplines involved in the incident, and reviewed what went well and what could be improved. We saw how one incident debrief had resulted in improvements to the call taking system, where assumptions had previously been made about attendance of other emergency services, there is now a fail-safe requirement to call the other services to confirm their knowledge of the incident and determine any actual attendance. We also saw how a debrief had identified that additional safety equipment for working at height would have improved response on site. As a result, an additional two sets of equipment were purchased increasing the number from five to seven.

Is resilience planning services well-led?

Outstanding ☆

We rated well led as outstanding because:

- The strategy and supporting objectives are stretching, challenging and innovative while remaining achievable.

Resilience planning

- A robust and systematic approach was taken to working with other organisations to improve care outcomes, tackle health inequalities and obtain best value for money.
- Governance and performance management arrangements were well embedded and proactively reviewed and reflected best practice.
- There was strong collaboration and support across all functions and a common focus on improving quality of care and people's experiences.
- The leadership drives continuous improvement and staff were accountable for delivering change. Safe innovation was celebrated. There was a clear proactive approach to seeking out and embedding new and more sustainable models of care.
- Leaders had an inspiring shared purpose and strived to deliver and motivate staff to succeed.
- There were high levels of staff satisfaction across the service. Staff were proud of the organisation as a place to work and spoke highly of the culture.

Vision and strategy for this service

- The trust's vision was 'Delivering the right patient care, in the right place, at the right time, through a skilled and committed workforce, in partnership with local health economies'.
- The trust resilience planning was firmly based on the Civil Contingencies Act, National Ambulance Resilience Unit and Joint Emergency Services Interoperability Programme guidelines. Senior trust staff were heavily engaged in the development and implementation of NARU and JESIP policies and operational procedures.
- The assistant chief ambulance officer described how the service had needed to make savings to meet government targets in the same way that core service functions were required to do. The trust resilience management team had lost seven posts since 2010. He described how the service had been tailored to match geographical areas which had enabled the cutbacks to take place without impacting adversely on service levels. Additionally, they told us that there were no planned cuts for the coming year, and that there were no further reductions available within the resilience structure which would affect the service.
- HART staff and managers saw the service as "providing the future leaders of the ambulance service."
- At the time of our inspection, the Chief Executive Office of WMAS was the national ambulance Chief Executive Lead for emergency preparedness, and the trust hosted NARU on behalf of the Department of Health.

Governance, risk management and quality measurement

- Robust governance procedures were in place across the resilience services. Team meetings took place on a weekly basis which fed into monthly managerial governance meetings. We reviewed the minutes of a number of meetings across the service; we saw how information fed between meetings and how issues were communicated to and from external stakeholder meetings such as the Local Resilience Forums.
- Risk registers were maintained which related to risk the service may have to deal with such as potential major incidents, or planned large-scale public events. Registers were maintained which identified vulnerable premises and locations identifying known hazards which meant information was available to staff to help them mitigate any danger..
- Information was shared appropriately with other emergency services, both in planning for events and during response to live incidents. This was demonstrated by the review of debriefed incidents and plans for large-scale public events.
- The trust used PROCLUS, a software tool, which enabled HART staff to input live information about incidents and actions. The system enabled managers to review information and assess response. Reports were generated and used for training purposes. PROCLUS reports were used during the comprehensive debrief sessions conducted after major incidents.
- The trust worked closely with other emergency services and civilian organisations to ensure a holistic approach to public safety and individual patient care were maintained.
- Performance information was shared with NARU and commissioners on a monthly basis.
- Major incidents or those which might attract media or external scrutiny, were identified by control room staff and these were passed to the regional coordination centre (RCC) which was staffed by more experienced personnel who had received additional training.
- WMAS was an integral part of the Emergency Response Management Arrangements (ERMA) and acted as the host and regional 'GOLD' - control centre for all

Resilience planning

Healthcare providers during the first hour of any large-scale emergency incident. Gold Control plans were in place to assist in coordinating any such response. This is unique in an ambulance service and represents an area of best practice nationally. Business continuity plans were written by and were specific to individual units of the organisation and were brought together to form the trust continuity plan. Staff explained how the plans had been effective in ensuring that services were not affected when storm damage caused the temporary closure of one of the trusts ambulance hubs. However, we noted that plans for one area were not visible to managers from another area. Only the managers from the area concerned, the emergency planners and business continuity managers were able to see all plans. We were told that rationale was that not everyone needed to see all the plans. This meant that when a plan was initiated other departments might have difficulty understanding what was being done and why, which seemed at odds with the principle of continuing services with as little disruption as possible.

Leadership of service

- We found strong leadership throughout the resilience services of the trust. Staff at all levels told us they felt supported and understood their role.
- Leaders at all levels had a clear understanding of the staff, the capabilities of their department and how they contributed to the trusts values.
- Leadership progression was built into the operational structure with all managers having at least one member of their team trained and experienced enough to step up and fill the role if required.
- We were told that four of the trusts six Gold commanders had been issued with personal body armour and were available to stand down as Gold commander and go into the field as Silver Commanders in support of their staff when dealing with 'marauding terrorist or firearms incidents'.
- The 2016/2017 NARU staff review had identified unsupportive leader behaviour as a medium risk for Workplace Features. The HART staff we spoke with all described good relationships and support from their line managers and the trust as a whole. One member of staff told us "Some managers were easier to approach than others.". They all agreed that home/work life balance was difficult particularly in respect of taking leave or time off. However, they accepted that the resilience of the role required strict controls.
- Staff were clear about their role; they were keen to assist the core service to deliver an effective service and told us that they found it frustrating not being able to further assist with more core service functions. They also told us that despite standard procedures being in place, some control room staff made more use of their services than others. One comment was: "We know how busy we were going to be when we hear who the dispatcher is." We asked senior managers about this and they noted the comment and assured us that all staff should understand the role of the HART unit and should deploy them appropriately.
- The HART and special operations manager for the trust had been in post since the HART service was formed. At the time of our inspection, he was also the Chair of the HART National Operations Group. He had been supported by the trust to implement the trusts HART functions.
- The resultant is an exemplar service which follows NARU guidance and in many instances helped formulate the guidance.
- Managers were proud of the calibre and commitment of staff on the HART teams. When we spoke with managers they were clear that they believed the success of the HART team rested with the ability of staff to perform professionally in extraordinary circumstances and situations, and their role was to provide them with the facilities and training to enable them to do so.

Culture within the service

- There was a clear culture of 'can do', within the resilience services of the trust. HART staff had been selected partly due to their physical ability and their mental attitude towards the role.
- The HART, MERIT and air ambulance services were all run on strict standard procedures, which enhanced safety by creating a disciplined methodical response.. Staff who worked on the units appeared comfortable with the regime and accepted that the role required a professional and confident and efficient face to be shown to the public.

Resilience planning

- Comprehensive debriefing took place following any HART deployment to a non-core role incident. We saw reports of debrief sessions which had taken place, and we were told how these had resulted in improvements to procedures and equipment.
- The trust stress policy outlined the assistance available to staff who were affected by stress. A 24/7 Staff Advice and Liaison Service (SALS) telephone service was available to all staff. Occupational health services provided counselling for individuals and where required external professional referrals could be made for counselling.

Public and staff engagement

- Public engagement was a major function of the resilience service. Emergency planners represented the trust at local meetings.
- The HART unit had a dedicated twitter account where staff posted anonymised details of incidents, training or other events they were attending or had attended. The account had almost 5,500 followers at the time of our inspection.
- The new HART Command vehicle had been taken to all areas of the trust to show staff its capabilities and how it could be used to support them. It had also been taken to local resilience forum meetings to allow members of the forum to see the facilities available. The vehicle was also demonstrated to the public at an open day at Shrewsbury Ambulance hub.

Innovation, improvement and sustainability

- Provision of major incident action card aide memoires to all operational staff was outstanding.
- Further development of the major incident cards to develop an easily upgradable electronic version will enhance the usefulness and accessibility of the system.
- Re-writing major incident policy documents in the same format as action cards will produce enhanced usability of the system as all reference materials will have the same layout. Familiarity at times of high demand and extreme stress will improve efficiency.
- Protected training in line with National Ambulance Resilience Unit (NARU) guidelines is exemplary and should be maintained despite financial pressures.
- Large secure rolling cabinets for HART staff personal issue equipment enables the limited space available in the depot to be kept clear and means equipment is always to hand when staff need it.

Outstanding practice and areas for improvement

Outstanding practice

Emergency Operations Centre

- Use of data from the performance cell to inform long and short term planning
- The functions within the Regional Co-ordination Centre provided effective support for complex incidents within the trust's geographical region and externally through the Midlands Critical Care Network.
- Achieving response targets for red calls in 2015
- Finding innovative ways of engaging with the local population – youth Council Strategy and Youth Cadet scheme.
- Quality assurance processes in dispatch functions
- Selection for ARP

- Request for national data lead for ambulance trust.

Emergency and Urgent Care Services:

- HALOs across all divisions had developed innovative and forward thinking ideas to reduce hospital admissions and ambulance call outs which proved to be very effective.
- Online engagements with patients provided them with clear and concise tools to self-care and recognise life threatening conditions.
- Paramedic availability throughout the service, and plans to increase this further meant that highly qualified staff could provide emergency care to patients.

Resilience Planning

- All operational staff on the HART team were required to be qualified paramedics and to maintain their accreditation which was in line with NARU best practice. Not all trusts followed this guidance. The HART service was fully staffed which again reflected best practice.
- The only exception to protected training was if the team was required to deploy to a major incident to support the duty team [this is another area of best practice in the UK
- Compliance with NARU and Joint Emergency Services Interoperability Programme JESIP guidance was seen to be very strong and reflected industry best practice.

- The trust had a very proactive view of vehicle maintenance. Vehicles were replaced after approximately five years of service. This was another area of best practice.
- During 2015 the MERIT team were peer reviewed by the Trauma Network; and they were graded as providing recognised best practice in nine out of ten criteria, which is a recognition of best practice.
- The NHS England Core Standards return for 2015/16 was rated 100%, which is an area of outstanding practice.
- The sharing of the trust forward planning for New Year's Eve represented an area of outstanding practice.
- Gold (Strategic Command) were exclusively career paramedics, which is regarded as best practice in the UK.
- West Midlands Ambulance Service JRB Casualty Regulation & Capability Chart 2015 -2020. The work identified the number of level 1, 2 or 3 casualties each hospital could accommodate during the first hour of any mass casualty incident.

- The trusts responsiveness to learning following major incident debriefs meant that safety and efficiency could be improved quickly with minimal bureaucracy.
- WMAS was an integral part of the Emergency Response Management Arrangements (ERMA) and acted as the host and regional 'GOLD' - control centre for all Healthcare providers during the first hour of any large-scale emergency incident. Gold Control plans were in place to assist in coordinating any such response. This is unique in an ambulance service and represents an area of best practice nationally.

Outstanding practice and areas for improvement

- Provision and on going development of the major incident aide memoire cards, electronic versions and mirrored policy documents was an outstanding development, which would potentially increase efficiency and confidence of staff when dealing with major incidents.
- The trust commitment and adherence to NARU and JESIP best practice in relation to HART practice and procedures.
- Commitment of HART staff to improve their personal skills and provide a comprehensive service and where they feel competent and safe to do so to exceed normal working practices in support of casualties.

Areas for improvement

Action the hospital MUST take to improve

Patient Transport Services:

- The trust must ensure they continue to safety store all medication on high dependency vehicles.

Action the hospital SHOULD take to improve

Patient Transport Services:

- The trust should ensure that it continues to lock all vehicles when unattended.
- The trust should ensure that there is a record of checking all equipment on vehicles that is consistent across all PTS sites and ensure that all equipment is in date and that a sterile environment is maintained for relevant equipment.
- The trust should ensure staff have the continued support to carry out risk assessments particularly in relation to the assessment of people with mental health problems.
- The trust should ensure the use of yellow clinical waste bags on vehicles.
- The trust should consider a review of written information available for people who use the patient transport service, particularly in relation to the high ethnic minority population it serves and ensure that all staff are aware of the easy read information that is already available.
- The trust should consider ways to engage patient transport service staff in surveys to enable a greater uptake on gathering their opinions.
- The trust should consider a review of the appraisal system to ensure they are all meaningful and those areas with low completion rates are targeted.
- The trust should ensure effective review of delays at PTS Stoke.

Emergency Operations Centre

- The trust should consider ways to embed the frequent callers policy and process.
- Ensure that expired paper versions of policies are removed from the EOCs when they are updated.
- The trust should consider ways to ensure staff are aware of incidents that have led to opportunities for learning and changes to practice.

Emergency and Urgent Care Services

- Improve wider learning across EUC areas from incidents and communicate themes and patterns to all staff to improve practice.
- Ensure all staff have sufficient knowledge of duty of candour regulations and processes, to allow patients to be informed if something goes wrong.
- Ensure medicines management follows a robust process across all EUC areas.
- Ensure there are clear lines of accountability for checking vehicle equipment, including defibrillators.
- Compliance of hand hygiene is consistent across all divisions.
- Staff awareness of cultural diversity is consistent across all divisions.
- Trust wide learning occurs from incidents, not just local feedback.
- Take steps to improve response time to rural areas within some divisions.

Outstanding practice and areas for improvement

- Provide communication tools to staff who care for patients with complex needs, including learning disabilities and dementia.
- Information is available to patients on how to make a complaint about the service, and also that all local complaints are documented to allow tracking of themes and learning points.
- Improve manager availability to staff in some areas, to allow appropriate staff support.

Resilience Planning

- The provider should consider methods to ensure that HART deployment is consistent and in line with NARU and trust guidelines to enable staff to provide meaningful support to core service, maintain their own skills and improve morale.
- The provider should ensure that learning from incidents within the trust are communicated effectively.
- The provider should introduce systems which ensure calibration of refrigeration equipment for storage of temperature sensitive medication is completed on schedule.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Diagnostic and screening procedures. Transport service, triage and medical advice provided remotely. Treatment of disease, disorder or injury Regulation 12. (g) Care and treatment must be provided in a safe way for service users. (g) the proper and safe management of medicines; How the regulation was not being met; The trust did not always keep proper and safe storage of medicines across PTS services. Medicines were stored in an unlockable cupboard in an unlocked vehicle and controlled drugs were stored in the glove compartment of an unlocked vehicle