North East Ambulance Service NHS Foundation Trust

Quality Report

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

Ratings

Overall rating for this trust	Good
Are services at this trust safe?	Good
Are services at this trust effective?	Good
Are services at this trust caring?	Good
Are services at this trust responsive?	Good
Are services at this trust well-led?	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

North East Ambulance Service NHS Foundation Trust (NEAS) covers the areas of County Durham, Northumberland, and Tyne and Wear, along with the boroughs of Darlington, Hartlepool, Middlesbrough, Redcar and Cleveland and Stockton-On-Tees covering almost 3,230 square miles. The trust employsover 2,700 staff and provides 24-hour emergency and healthcare services to a population of 2.71 million people.

The trust provides an accident and emergency (A&E) service to respond to 999 calls, a 111 service for when medical help is needed fast but it is not a 999 emergency, patient transport services (PTS) and Emergency operation centres (EOC) where 999 and NHS 111 calls are received, clinical advice is provided and from where emergency vehicles are dispatched if needed. There is also a Resilience and Hazardous Area Response Team (HART).

The comprehensive inspection of the ambulance service took place from 18 to 22 April 2016 with an unannounced inspection carried out on 4 May 2016. We carried out this inspection as part of the CQC's comprehensive inspection programme.

We inspected five core services:

- Emergency Operations Centres
- Urgent and emergency Care
- Patient Transport Services
- Resilience Services including the Hazardous Area Response Team
- 111 services.

Overall, we rated all of the five key domains as good which meant the overall rating for the trust was also good.

Our key findings were as follows:

- There was generally a culture of passion and enthusiasm with a focus on the patient. However, there were differences in culture across the different geographical patches. The trust had recently undertaken a cultural survey which had identified some concerns regarding management support. Actions had been identified and were being implemented to address this; an example was the management essentials programme.
- Most staff we spoke with confirmed there had been a shift in emphasis toward patient engagement and staff wellbeing. This was reinforced by the NHS Staff Survey 2015 where it was reported trust management had shown an interest in staff health and wellbeing which was better than the England average.
- The relationship between the executive team and union representatives had improved and we were told by both sides that there was now a more open dialogue and discussion regarding meeting the needs of staff and the service.
- The emergency care clinical managers were front line leaders who supported staff and supervised operations. This recently established role was to ensure staff received appropriate clinical leadership, which was documented and evidenced via quarterly one to one meetings. However this had been implemented in the urgent and emergency care service, whereas the Patient Transport Service had Team Leaders.
- Throughout the inspection and across services we found that patients received care in a clean, hygienic and suitably maintained environment.
- Patients on the whole told us they were happy with the care they received and the attitude of staff. We observed staff engaging with patients in a caring and respectful manner.
- The trust was experiencing difficulties recruiting to paramedic vacancies and information provided by the trust before the inspection indicated there was a vacancy of 102.49 wte paramedic posts which equated to vacancy rate of 16%.
- There were concerns identified during the inspection regarding the emergency operations centre in relation to the management of clinical risks when the 'stack' of calls was increasing.
- Concerns were raised regarding the business continuity plans for the emergency operations centre in the event of a major disruption of services. There would be a delay in the setting up of the dispatch function of this service.
- Data showed that between April 2015 to March 2016 out of the eleven national ambulance trusts NEAS was the joint worst performing ambulance service in NHS

Summary of findings

with responses within the target for Red 1 performance. There was a downward trend in the proportion of Red 1 calls responded to within 8 minutes between June 2015 and March 2016.

- There had been a backlog of complaints that had resulted in delays to responding to complainants. The trust had reviewed the complaints process and had taken steps to address this problem. We saw that improvements had been achieved as a result of the changes.
- Patient Transport Services provided resilience to support the emergency and urgent care service, both operationally and within the Emergency operations centre. The trust was in the process of implementing a project to integrate PTS with emergency care to create an integrated care and transport service. This meant additional capacity would be created to support the transportation of urgent care patients.
- The trust took into account local events which increased demands on the service. Information provided by the trust highlighted that staffing demands for local events were planned in advance and staffing rotas were adjusted as required.
- There was a lack of clarity in the line management and governance arrangements for the community first responders. The responders told us that there had been many changes recently, which had left them unclear about who managed them.

We saw several areas of outstanding practice including:

- The trust had enrolled in the Mind blue light mental health programme and had encouraged staff to take on training to support colleagues with their mental health.
- The trust provided national support for a motorcycle application; this was a mobile phone application, that used smart phone technology to identify if a motorcyclist had had an accident, and sent location data to the NEAS EOC, allowing staff to contact the nearest appropriate ambulance service to arrange an emergency response. The trust had been recognised at a national level for this.
- The resilience service developed strong working relationships with the Sports Ground Safety Authority (SGSA) following innovative approaches to improving medical safety standards at stadia events such as premier league football matches and music concerts.
- The advanced paramedic programme was an area of work that would benefit patient care and improve treatment pathways for patients.
- The trust research and development team were involved in a number of trials which were underway at the time of the inspection. These included for example trailing a device that regulated intrathoracic pressure during resuscitation and the PASTA trial which was a multi-centre randomised controlled trial to determine whether a Paramedic Acute Stroke Treatment Assessment (PASTA) pathway could speed up access to stroke patients.
- The Trust had pioneered a Flight Deck methodology for the North East. This was a capacity management system intended to support improved whole system awareness of capacity, quicker and safer diverting of patients to appropriate receiving care locations, and enhanced whole system learning.
- The trust had been nominated for a national innovation award for the development and use of the electronic communication system.

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

Importantly, the trust must:

- The trust must review and ensure there are appropriate arrangements in place to provide dispatch in the event that Bernicia House was unavailable to operate as a dispatch centre.
- The trust must ensure at all times there are sufficient numbers of suitably skilled, qualified and experienced staff.
- The trust must ensure all staff have completed mandatory and role specific training relevant to their role.
- The trust must ensure all staff receive an appraisal and are supported with their professional development. This must include support to maintain the skills and knowledge required for their job role.
- The trust must continue to address the complaint and incident backlog and ensure systems and processes are put in place to prevent a re-occurrence.
- The trust must ensure that clinical records are stored securely.

In addition the trust should:

Summary of findings

- The trust should ensure all relevant staff have received appropriate major incident training.
- The trust should ensure staff within the emergency operations centres are involved in the development of the strategy and vision of the service.
- The trust should ensure staff are supported and encouraged to report incidents and feedback is provided to staff on the outcomes of the incident investigation.
- The trust should review the training requirements for operational staff for vulnerable groups such as patients living with dementia and patients experiencing mental health concerns.
- The trust should ensure there is a robust system in PTS to monitor the daily cleanliness of vehicles and ensure deep cleans are carried out to planned levels.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to North East Ambulance Service NHS Foundation Trust

North East Ambulance Service NHS Foundation Trust (NEAS) covers the areas of County Durham, Northumberland, and Tyne and Wear, along with the boroughs of Darlington, Hartlepool, Middlesbrough, Redcar and Cleveland and Stockton-On-Tees covering almost 3,230 square miles. The trust employs over 2,700 staff and provides 24-hour emergency and healthcare services to a population of 2.71 million people.

The trust provides an accident and emergency (A&E) service to respond to 999 calls, a 111 service for when medical help is needed fast but it is not a 999 emergency, patient transport services (PTS) and Emergency operation centres (EOC) where 999 and NHS 111 calls are received, clinical advice is provided and from where emergency vehicles are dispatched if needed. There is also a Resilience and Hazardous Area Response Team (HART).

NEAS responds to over 360,876 urgent and emergency incidents each year with over 502,510 emergency calls per day received by the 999 Emergency operation centres.

The front-line A&E staff included paramedics, advanced technicians and Emergency Care Support Workers (ECSW)/Emergency Care Assistants (ECA), emergency care technicians/advanced technicians, advanced practitioners and are supported by community first responders.

The Patient Transport Service (PTS) provided pre-planned non-emergency transport for patients who had a medical condition that would prevent them from travelling to a treatment centre by any other means, or who require the skills of an ambulance care assistant during the journey. In addition PTS provided unplanned same day hospital discharge requests.

During our inspection we visited both ambulance premises and hospital locations in order to speak to staff and patients about the ambulance service. We inspected the Emergency operations centre that received calls and dispatched ambulances.

Our inspection team

Our inspection team was led by:

Chair: Ellen Armistead, Deputy Chief Inspector, Care Quality Commission

Head of Hospital Inspections: Amanda Stanford, Care Quality Commission

The team of 49 people included CQC inspectors, inspection managers, national professional advisor, pharmacy inspectors, inspection planners and a variety of specialists. The team of specialists comprised of

Paramedics, Emergency Medical Technicians, operational managers, Patient Transport Service Managers, Emergency Operation Centre managers, operations directors and safeguarding managers.

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?

Summary of findings

The inspection team inspected the following:

- Emergency Operations Centres
- Urgent and Emergency Care
- Patient Transport Services
- Resilience Team including the Hazardous Area Response Team
- 111 service

Prior to the announced inspection, we reviewed a range of information that we held and asked other organisations to share what they knew about the ambulance service. These included the clinical commissioning Groups (CCG's), NHS Improvement, NHS England, and the local Healthwatch organisations. We held focus groups and drop-in sessions with a range of staff in the service and spoke with staff individually as requested. We talked with patients and staff from a range of acute services who used the service provided by the ambulance trust. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' personal care and treatment records.

We carried out the announced inspection visit from 18-22 April 2016 and undertook unannounced

Inspection on 4 May 2016.

What people who use the trust's services say

The CQC Ambulance survey looked at the experiences of over 2,900 people who called an ambulance service in December 2013 or January 2014.Responses were received from 333 patients at North East Ambulance Service NHS Foundation Trust. The trust scored about the same as other trusts in all of the outcome measures.

We reviewed the most recently available Friends and Family Test (FFT) results for the 111 service and found that in February 2016:

- 87% of respondents said they were likely or extremely likely to recommend the service to friends and family. Comments referred to the service as first class prompt, friendly, reassuring and professional. On average the results for the FFT were in the three top performers of NHS 111.
- urgent and emergency care Friends and Family Test showed that 100% of respondents said they would recommend the service to friends and family.

The hear and treat survey showed that the trust scored 9.2 out of 10 for call handlers showing dignity and respect to patients. 'Hear and Treat' survey results showed that the trust was mostly in line with others trusts results. The trust performed better for understandable instructions from the call handler, waiting for a call back from a clinical advisor and it being possible to follow the advice given. All others results were in line with other ambulance trusts. 333 patients responded to the survey.

The 'Hear and Treat' survey showed that the trust scored 7 out of 10 for patients who called and had fears or anxieties and had the opportunity to discuss these with a clinical advisor.

The patient experience annual report 2015 reported 98% of patients said PTS crews showed kindness and consideration towards them and the attitude of the ambulance staff was good.

Facts and data about this trust

North East Ambulance Service NHS Foundation Trust (NEAS) covers the areas of County Durham, Northumberland, and Tyne and Wear, along with the boroughs of Darlington, Hartlepool, Middlesbrough, Redcar and Cleveland and Stockton-On-Tees covering almost 3,230 square miles. The trust employs over 2,700 staff and provides 24-hour emergency and healthcare services to a population of 2.71 million people.

NEAS responds to over 360,000 urgent and emergency incidents per year with over 1,000 emergency calls per day received by the 999 Emergency operations centres.

Summary of findings

The trust provides an accident and emergency (A&E) service to respond to 999 calls, a 111 service for when medical help is needed fast but it is not a 999 emergency, patient transport services (PTS) and Emergency operation centres (EOC) where 999 and NHS 111 calls are received, clinical advice is provided and from where emergency vehicles are dispatched if needed. There is also a Resilience and Hazardous Area Response Team (HART).

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? We rated safe as good because: • The trust was aware of its obligations in relation to the Duty of Candour requirements. The trust's policies detailed the requirements to ensure the duty of candour regulation was met. • Across services patients received care in a clean, hygienic and suitably maintained environment. • Staff were made aware of any changes in policy or practice as a result of incidents by email and through bulletins and safety alerts which were displayed at each station. However: • There were concerns identified during the inspection regarding the clinical risks when the 'stack' of calls was increasing within the EOC. We were told that there was a clear escalation plan in place and staff were able to articulate what actions they would take. The stack was reviewed regularly to ensure any clinical risks were identified. Patients were advised that if their condition worsened then they should call back which would result in them potentially being re-prioritised. • There were high levels of compliance with safeguarding training at levels one and two however not all relevant staff had been trained at level three. • During our inspection within EOC there were 117 open incidents over the trust response time targets of 28 days or 14 days depending on the severity of the incident. These incident reports were in progress but over the trust timescales for completion. • The trust was experiencing difficulties recruiting to paramedic vacancies and information provided by the trust before the inspection indicated there was a vacancy of 102.49 wte paramedic posts which equated to a vacancy rate of 16%. However across emergency care operations (front line staff) had an establishment of 1111.28 and 1034.34 staff were in post (93%). • There were concerns regarding the resilience of dispatch at the trust. Dispatch was located at Bernicia house only and in the event of system failure to dispatch or Bernicia house not being able to facilitate dispatch services, staff told us they would	Good 

move the dispatch team to Russell House. This would take around 20 minutes and dispatch would use radios from the car park during that 20 minutes to manually dispatch ambulance crews.

Duty of Candour

- 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) ofcertain 'notifiable safety incidents'andprovide reasonable support to that person. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.
- The trust was aware of its obligations in relation to the Duty of Candour requirements. Information regarding duty of candour was contained within the trust's serious incident policy.
- As soon as an incident had been classified as moderate harm or above on the trusts incident reporting system an alert from the system was sent to the appropriate manager to identify that a formal duty of candour process was required.
- If the incident was classified as moderate or above or a serious incident the trust would appoint a dedicated family liaison officer (FLO) who would act as a single point of contact for the family.
- We reviewed six serious incident investigations and saw that duty of candour had been complied with.
- Throughout the trust staff we spoke with understood the Duty of Candour requirements and were able to describe candour, openness and being honest.

Safeguarding

- The Director of Clinical Care and Patient Safety was the executive lead on the board for safeguardingand there is also a non-executive director for safeguarding.
- There was a team of safeguarding staff within the trust whose role it was to ensure the trust's safeguarding practices met current regulations and to provide support and training to staff. These included a named professional for safeguarding adults and a named professional for safeguarding children. The Team were supported by a band 4 safeguarding officer and a band 3 administrator.Staff raised concerns about the capacity within the safeguarding team due to the volume of workload and the size of the team.

Summary of findings

- There were comprehensive policies for safeguarding children, young people and vulnerable adults. Staff demonstrated a thorough knowledge of safeguarding procedures for both children and adults.
- Monthly safeguarding steering groups were held. We reviewed minutes from two of these meetings and saw the group discussed policy updates, safeguarding action plans, serious case reviews and safeguarding referrals process/ procedures.
- Safeguarding training (levels one and two combined) was included in the Essential Annual Training programme, and consisted of a 30-minute presentation, incorporating both children and adults. Data showed the compliance rates for level one and two was 86%-97% compliance.
- The intercollegiate document for safeguarding children and young people: roles and competences for health care staff (2014) states that "All clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns" should have level three safeguarding training this included paramedics.
- Level three safeguarding children and adult training commenced in December 2015, initially for Emergency clinical care managers (ECCM's) and operational managers. Data showed that 83% of those had attended the training by 10th March 2016, with the rest due to attend by 31 March 2016. Level three adults and children safeguarding training was to be rolled out to paramedics from April 2016.
- There was a dedicated logistics desk in the emergency operations centre responsible for reporting safeguarding concerns. The logistics desk was open 24 hours a day, 365 days a year.
- If the Safeguarding Team were notified of any child/adult with a protection plan in place, the Safeguarding Officer would send an email to the Emergency Operations Centre (EOC) to inform them that a 'flag' needed to be placed on the address of the individual. When a call was then received into EOC it would highlight the detail and staff would receive an update via Terrafix of the flag to make them aware of any issues. However NEAS could only 'flag' on address and not the name of the individual which meant of an individual moved addresses the information would not follow the person.

- Within the 111 service staff discussed any safeguarding concerns with team leaders, who collated and forwarded the referral details via their logistics team. Staff demonstrated their understanding of their responsibilities in relation to identifying, documenting and reporting any safeguarding concerns.
- All 111 service staff were trained to safeguarding level one on induction. Call handlers were trained to level two and team leaders and clinicians received level three safeguarding training for both children and vulnerable adults. In the call handling service a safeguarding champion had been appointed to pilot and implement the new training and web form that would refer patients to Social Services.

Incidents

- The Trust used a web-based Risk Management incident reporting system (Ulysses Safeguard) to facilitate the incident reporting. All of the incidents were reported electronically and outcomes of investigations were documented on the manager's form in the system.
- The trust utilised the NPSA risk matrix, the incidents were initially graded using this matrix at the time of reporting by the reporter and the investigating officer/responsible manager reported on the actual harm at the time the investigation concluded.
- Where a serious incident was identified, a root cause analysis (RCA) was carried out to establish the causes of the incident and to allow staff to identify risks and make appropriate changes to prevent similar incidents from occurring.
- Once the incident was closed an email response went back to the reporter on the outcome of the investigation and any actions taken.
- The Board of Directors were advised of all serious incidents as they were reported, high risk frequency and high impact incidents were reported via the relevant groups, committees or Executive Management Team.
- Within the EOC between April 2015 and the inspection in April 2016 there were 8 serious incidents reported. There had also been 164 incidents in 999 triage and 1510 incidents reported in dispatch. Patient safety incidents, G2 response delays and 999 triage were the main causes of incidents.
- Staff told us there had been a backlog of open incident investigation reports being completed in EOC. During our inspection there were 117 open incidents over the trust response time targets of 28 days or 14 days depending on the severity of the incident. These incident reports were in progress but over the trust timescales for completion.

Summary of findings

- Between 31 January 2015 and 31 January 2016, the urgent and emergency care service received 2296 reported incidents. These incidents included violence and aggression (425), road traffic collisions (303), manual handling (245), and NHS 111 issues (226). The impact of patient safety incidents reported was 25 that met the services criteria for catastrophic, eight major, 26 moderate, 273 minor, 1442 relating to no harm and 176 near misses. There were seven Serious Incidents (SI's) reported in the 12 months prior to our inspection. Delayed ambulance responses and issues with triage were the most commonly reported SI's.
- Staff reported 204 incidents relating to PTS between August 2015 and January 2016. Central and South Divisions had a higher number of incidents reported (75 and 71 respectively) compared with the North Division (58). Overall, 68% of incidents resulted in no harm or low harm.
- There had been one serious incident (SI) reported in 2015 in PTS services. A root cause analysis (RCA) highlighted the inexperience of staff members who did not initially report or escalate the incident. The RCA also identified current PTS procedure did not stipulate the need for the crew member to walk in front of a wheelchair when transporting patients through a narrow space. This would have potentially prevented the incident from occurring. The service amended its procedures to include new guidance and recommended further training about the reporting of incidents.
- Between July 2015 to December 2015, 40 incidents were attributed to the resilience service. Of these, the inspection team were able to identify 11 related to patient incidents, five related to equipment, nine related to staff and 15 were other incidents for example, vehicle related issues and broken drug vials. Whilst there were no particular themes, it was noted that four of the 11 patient related incidents (no harm) involved bariatric patients and three of the five equipment issues related to breathing apparatus issues during a training exercise. With the exception of one, all incident investigations had been completed.
- From January to April 2016, the service recorded 18 incidents. Three related to patient incidents (no harm), three related to equipment, four related to staff and there were eight 'others' relating to drug vial breakage and vehicle incidents. There were no particular themes identified.

- One serious incident (SI) was reported in February 2016 relating to controlled drugs. In accordance with local and national guidance, the trust had appointed a lead officer and an investigation team. The investigation was on going at the time of our inspection.
- Staff were made aware of any changes in policy or practice as a result of incidents by email and through bulletins and safety alerts which were displayed at each station. The information displayed was consistent at each ambulance station. Staff were able to give examples of changes in practice as a result of incidents for example, the type of needles used to reduce the amount of needle stick injuries.
- Within the 111 service the service carried out detailed analysis of significant events and incidents. We saw documentary evidence to support this. We saw detailed changes to practice when incidents had occurred were there had been an adverse impact on patient's health and wellbeing. This included a team leader being appointed as a family liaison support; they did not investigate but worked in a supportive role with the family.

Assessing and Responding to Patient Risk

- During a visit to the emergency operations centre we observed the management of the 'stack' which is the list of calls received and awaiting a response, we raised concerns regarding the clinical risks when the 'stack' was increasing. We were told that there was a clear escalation plan in place and staff were able to articulate what actions they would take. The stack was reviewed regularly to ensure any clinical risks were identified. Patients were advised that if their condition worsened then they should call back, this would result in them potentially being re-prioritised.

Staffing

- The trust was experiencing difficulties recruiting to paramedic vacancies and information provided by the trust before the inspection indicated that the planned establishment for paramedics was 642.40 wte. This included staff in management roles and within the urgent and emergency care and resilience core services. The actual number of staff in post was 539.91wte which meant there was a vacancy of 102.49 wte.
- The trust had dual crew ambulances staffed by an emergency care assistant (ECA) and Paramedic, urgent care ambulances staffed by two ECA's or an emergency care technician

(ECT)/Advanced Technician and ECA, rapid response paramedics who respond in cars and advanced practitioners who respond in cars for those patients with long term conditions.

- Emergency care operations (front line staff) had an establishment of 1111.28 and 1034.34 staff were in post (93%).
- In the EOC Clinical advisor staffing levels were described as a challenge by staff. Staff told us there were not always enough clinical advisors for support. There were 24 clinical advisors and management told us they were currently recruiting with the aim of fulfilling a staff level of 34 clinical advisors. This would enhance the ratio of clinicians to non-clinicians to 1 to 7. Staffing records showed several occasions over the three months prior to inspection where only one clinician was available across both the emergency operation centres, however, there was at least one at all times.
- Data from February 2016 showed that theEmergency operations centre had 75.02 whole time equivalent posts for 999 call handlers against a budgeted establishment of 72.08 whole time equivalents. Dispatch services in theEmergency operations centre had a whole time equivalent of 104.5 against a budgeted establishment of 102 whole time equivalents. The clinical hub had 19.78 whole time equivalents against a budgeted establishment of 24 whole time equivalents.
- The number of substantive Patient Transport Services staff in post in April 2016 was 441 whole time equivalent posts. The overall vacancy rate was 5% and the turnover rate, across the North, Central, and South divisions, was 8%. Managers and staff did not report any problems in relation to staffing levels and the trust also employed a bank workforce on zero hour contracts.
- The resilience service planned for a minimum of six Hazardous Area Response Team (HART) staff on duty at all times, in excess of the minimum requirement of five, in accordance with National Ambulance Resilience Unit (NARU) national requirements for HART interoperability. There were currently no vacancies within the HART service and staff turnover was low (one whole time equivalent equating to 2.8% in 2015).
- Within the 111 service clinical advisors were employed by another provider and were deployed to NEAS to provide support to call handlers both on-site and remotely via telephone 24 hours a day, seven days a week. There was an agreed minimum ratio of one clinical advisor to four non clinical call handlers. There was at least one clinical advisor at each call centre and up to five available remotely depending on staffing levels based on predictive modelling of call volumes. There were 67 whole time equivalent (wte) clinical advisors

contracted to NHS 111 services. The other provider provided GP out of hours services to the region and was responsible for the recruitment, training and development of clinical staff providing support to the NHS111 service.

- There were a total of 67 clinical advisors contracted from the other provider to the 111 service, most working on a part time basis. We saw evidence that at peak times (weekends and Bank Holidays) there could be 20 clinical advisors available, either at the call centre or remotely.

Major Incident and Business Continuity

- During the inspection we raised concerns with the executive team regarding the resilience of dispatch at the trust. Dispatch was located at Bernicia house only and in the event of system failure to dispatch or Bernicia house not being able to facilitate dispatch services, staff told us they would move the dispatch team to Russell House. This would take around 20 minutes and dispatch would use radios from the car park during that 20 minutes to manually dispatch ambulance crews. A draft procedure was in place, however staff had not received training in dispatch resilience procedures and this could potentially lead to a delay in being able to dispatch ambulances to patients.

Are services at this trust effective?

Good

We rated effective as good because:

- Care and treatment was delivered based on National Institute of Health and Care (NICE) Guidance, Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines and the Resuscitation Council UK (RCUK) guidelines.
- The median showed that the trust was performing better for time taken to answer calls when compared to the average of all ambulance trusts.
- Between January 2015 and December 2015 the proportion of patients receiving primary angioplasty (unblocking of a coronary artery) within 150 minutes was above the national average other than in March 2015, when they were below, ,this ranged from 82% of patients to 95% of patients.
- Following a heart attack the 79% to 96% of patients received the correct treatment in line with ambulance guidelines. This includes certain drugs being given and observations being taken and recorded was above the national average between January 2015 and December 2015. This was above the national average of between 76% and 84%.

However:

- Data showed that between April 2015 to March 2016 out of theelevennational ambulance trusts NEAS was the joint worst performing ambulance service in NHS with responses within the targetfor Red 1 performance. There was a downward trend in the proportion of Red 1 calls responded to within 8 minutes between June 2015 and March 2016.
- The trust was failing to meet the national standard of responding to 75% of Red 2 calls. Data showed that from April 2015 to March 2016 the trust was fifth of theelevenambulance services in the NHS with responses at 68.6%.
- A19 calls national standard is that 95% of Category A calls should be responded to within 19 minutes with appropriate transport to convey the person to hospital. There was a downward trend in the proportion of category A calls responded to within 19 minutes since August 2015 to March 2016. Data showed from April 2015 to March 2016 the trust was seventh of theelevenambulance services in the NHS with responses at 92%.

Evidence based care and treatment

- Staff had access to policies and procedures and other evidence-based guidance via the trust's document management online system.
- Throughout frontline services staff followed Joint Royal Colleges Ambulance Liaison Committee (JRCALC guidelines) which provided evidence based clinical advice to ambulance services. The service also followed a number of national recommendations from NARU and The National Institute for Health and Care Excellence (NICE guidelines).
- The electronic system used within EOC to triage and carry out risk assessments on 999 calls was evidence based and took into account National Institute of Care and Clinical Excellence guidelines.
- The triage system used prompts on the screen with questions that were asked to the caller to establish the appropriate response. At the end of the triage and risk assessment, the system highlighted the most appropriate response.
- The trust followed the National Institute for Health and Care Excellence (NICE) guidance in relation to patients who received renal dialysis treatment in South Tyneside and the trust gave patients with other specific medical conditions, such as cancer, priority to use the service.
- The trust also used the Department of Health's assessment criteria to determine whether a patient was eligible for patient transport. PTS control centre staff and hospital staff assessed a patient's eligibility through a series of specific questions about

mobility, disability, and access to other forms of transport. If a patient was deemed non-eligible for patient transport, the trust had an appeals process and the Patient Advice and Liaison Service (PALS) provided assistance with other transport options.
- Clinical practice updates were cascaded throughout the organisation from relevant departments.
- A number of HART operatives were specialists in particular core competencies such as Urban search and rescue (USAR) and provided care and treatment updates to colleagues.
- HART operatives followed training and competencies to inform evidence based care. Every five weeks each HART team completed evidence based training covering clinical practice and procedures, skills and current practices.

Patient outcomes

- The trust routinely collected and monitored information about patient care and treatment. Ambulance clinical quality indicators measured the overall quality of care and end-results for patients following care and treatment.
- The percentage of emergency calls resolved by telephone advice was lower than the England average between July 2014 and December 2015. The percentage of emergency calls resolved by telephone advice was 7.4% in December 2015. The England average was 9.1%.
- The trust participated in the 'Hear and Treat' survey. Results showed the trust were mostly in line with other trusts and better in some areas.
- Following a cardiac arrest, the Return of Spontaneous Circulation (ROSC) which included signs of breathing, coughing, or movement and a palpable pulse or a measurable blood pressure, was a main objective for all out-of-hospital cardiac arrests, and can be achieved through immediate effective treatment at the scene. The ROSC is calculated in two patient groups. The overall rate measures the overall effectiveness of the urgent and emergency care system in managing care for all out-of-hospital cardiac arrests. The rate for the 'Ustein 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.
- The overall return of spontaneous circulation rate for NEAS was worse than the England average for 8 months between January 2015 and December 2015, ranging from 19% to 28% compared

with national average 25% to 31%. However, using the Ustein comparator group, the trust performed better than the England average for 8 months out of the 12 months between January 2015 and December 2015.

- Heart attack or ST segment elevation myocardial infarction (STEMI) is caused by a prolonged period of blocked blood supply within the coronary arteries. Reductions in STEMI mortality and morbidity is influenced by those patients who received the appropriate care bundle, those who have timely delivery to the cardiac catheter laboratory for intervention, and those who have timely thrombolysis (clot busting medicines). Between January 2015 and December 2015 the proportion of patients receiving primary angioplasty (unblocking of a coronary artery) within 150 minutes was above the national average other than in March 2015, when they were below, ,this ranged from 82% of patients to 95% of patients.
- Following a heart attack the 79% to 96% of patients received the correct treatment in line with ambulance guidelines. This includes certain drugs being given and observations being taken and recorded was above the national average between January 2015 and December 2015. This was above the national average of between 76% and 84%.
- Local commissioners had agreed set performance targets for PTS, which covered planned journeys made during the core hours of each day. Targets for arriving at hospital 'on time' (between 45 minutes early and 15 minutes late) and collection following treatment (within 60 minutes) were 80% and 85% respectively. The latest performance figures provided by the trust showed 76% of patients arrived at hospital within the commissioned target and 86% were collected within 60 minutes.
- The trust exceeded the 90% target relating to the time patients spent on a vehicle. Patients were not expected to be on a vehicle for more than an hour and the latest figures showed the trust had achieved 92%. The trust reported this figure was improving each month.
- PTS operated to a different set of quality standards when transporting renal dialysis patients in the South of Tyne area. The service was required to drop off patients no more than 30 minutes early and not late for their appointment, and collect them again no more than 30 minutes after the scheduled end of their appointment. The target for both measures was 95%.
- Data published in February 2016 showed 85% of patients attending renal dialysis appointments were collected from their residence on time and 76% of patients were collected again from hospital within the required period. Overall, 6% of patients

were late for their appointment, which was worse than the target of 2%. The percentage of patients who spent less than 60 minutes on the vehicle, for both inward and outward journeys, was 99%. Although the trust had not met the contracted renal dialysis standards, the commissioners were reportedly happy with the current performance of PTS and had extended the contracted for an additional year.

- NEAS NHS111 Service monitored their performance against the National Minimum Data Set (MDS) and Key Performance Indicators (KPIs), some of which were locally agreed. Performance was monitored by their Quality Governance Group as well as by the national NHS 111 service governance via the Regional NHS 111 Governance Committee who included senior CCG managers for safety and GP clinical leads.
- Patient outcomes were closely monitored. In response to higher than national average referrals to A&E or an ambulance being dispatched, the Quality and Performance team reviewed these calls on a monthly basis. This was to monitor the appropriateness of this disposition. Where shortfalls were identified the member of staff in question would receive additional coaching or training to improve their confidence in completing the NHS Pathways assessment. NEAS NHS 111 had already piloted different ways of supporting call handlers to help reduce the emergency department and ambulance final dispositions.
- The trust had recently started a mortality review process to review patient deaths and identify learning from these.

Response times

- NEAS response times were measured and reported nationally following the agreed national response standards for Red 1, Red 2, and Category A19 calls. The national target for immediately life threatening Red 1 calls was that 75% of calls (the most time critical, where patients were not breathing, do not had a pulse or peri- arrest) were to be responded to within 8 minutes.
- Data showed that between April 2015 to March 2016 out of the eleven national ambulance trusts NEAS was the joint worst performing ambulance service in NHS with responses within the targetfor Red 1 performance. There was a downward trend in the proportion of Red 1 calls responded to within 8 minutes between June 2015 and March 2016.
- Red 2 calls national standard was that 75% of Red 2 calls (still serious, but less immediately time critical, like strokes or fits)

were to be responded to within 8 minutes. For Red 2 calls, the trust failed to reach the national target of 75%. Data showed from April 2015 to March 2016 the trust was fifth of the ten ambulance services in the NHS with responses at 68.6%.

- A19 calls national standard is that 95% of Category A calls should be responded to within 19 minutes with appropriate transport to convey the person to hospital. There was a downward trend in the proportion of category A calls responded to within 19 minutes since August 2015 to March 2016. Data showed from April 2015 to March 2016 the trust was seventh of the eleven ambulance services in the NHS with responses at 92%.
- Green calls were divided into four categories (G1 to G4). A green 1 call should be responded to in 20 minutes and a green 2 within 30 minutes. Green 3 and 4 calls require a 60-minute response for non-blue light emergency calls. For conditions that were not life threatening there were no requirements to report on these standards nationally.
- For patients requiring admission to hospital (classed as “Urgent”), NEAS had four hour, two hour and one hour transport times for GP and health care professional’s referrals. These response times were reported live in the control room and available for review on system performance dashboards. This live data was shared across the service through shift summaries, in daily conferences calls and a report was generated every 24 hours to show how quickly the service was responding to patients.
- The EOC was required to answer 95% of calls within 5 seconds. Information provided by the trust showed that this rate varied between January 2015 and February 2016. Between June 2015 and November 2015, 999 call performances were between 89% and 95%. In December 2015, 999 call performance was 96.5%.
- The median shows that the trust was performing better for time taken to answer calls when compared to the average of all ambulance trusts.
- Data showed from April 2015 to March 2016 the number of calls abandoned before being answered was 0.8% compared to an England average of 0.6%.
- The proportion of patients who re-contacted the service following discharge of care by telephone within 24 hours data showed between April 2015 and March 2016 was 14.2% compared to an England average of 6.3%.

Summary of findings

- From January to April 2016, the inspection team found response times varied from two to 12 minutes achieving policy compliance with NHS HART Interoperability Standards 8-11. These standards required HART staff to be on scene within 15 minutes of a call.
- The location of the HART base facilitated access to major road networks in the region. This allowed the requisite number of HART operatives to be present at the majority of strategic sites of interest as defined by Home Office Model Response Strategy within 45 minutes.
- In the event of a 'notice to move' for mutual aid to support adjacent ambulance services, it was acknowledged by staff due to the size of the trust area, it would not always be possible to meet the 30 minute target. To mitigate this, the service stationed a number of HART and resilience vehicles at stations in the north and south regions. Mutual aid requests within the trust area were more likely to meet this standard.
- However the data to support HART compliance with national response times was not collated automatically but via a manual process. The collation of patient outcomes specific to the resilience service and HART functions was not routinely recorded.
- For week ending 10/04/2016, for a number of indicators, NEAS 111 service performance was:
  - 97.6% Calls answered within 60 seconds, against a local contract target of 95% and a national average of 86.3%
  - 17.5% Triaged Calls resulting in referral to 999, against a national average of 11.9%
  - 10.2% Triaged Calls resulting in referral to Emergency Department against a national average of 8.5%
  - 28% Triaged Calls resulting in transfer to Clinical Advisor against a national average of 21.4%
  - 1.1% calls abandoned against a national average of 2.9%
  - 14.7% call backs offered against a national average of 12.2%

Multidisciplinary working

- We observed the handover of patients between ambulance crews and staff in hospital emergency departments. The handovers we observed were well structured and comprehensive.
- Ambulance crews pre-alerted hospitals where necessary so that hospital staff were aware when a critically ill patient was due to arrive at the emergency department.

- IT systems in the EOC allowed the automatic transfer of information and referral between call handlers, clinical advisors and dispatch. Flags on the system to highlight important information to ambulance crews were automatically transferred to the crew during dispatch.
- Clinical advisors told us that referring patients to mental health professionals or district nursing was challenging as they were not able to refer patients that were not known to the service, patients who were intoxicated or patients with any possible physical health needs. Clinicians often felt the need to send patients to emergency departments as other services were not accessible to them.
- There was evidence of multidisciplinary working between PTS staff and other care providers, such as hospitals, GP surgeries, and care homes. During our visit, we observed cooperation between hospital staff, third party PTS booking providers, the control centre and PTS crews.
- The resilience service worked with various agencies to assess, plan and deliver resilience function and care for people at multiple locations in an assortment of scenarios.
- There was documented evidence in the resilience service of Joint Emergency Services Interoperability Programmes (JESIP) and working with Local Resilience Forums (LRFs) across the region which detailed the joint working relationships and shared agenda in the case of specific incidents.
- Within the 111 service call handlers and clinicians were able to make appointments directly with the GP out of hours services (OOH) when required.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- Consent was carried out in accordance with the trust capacity to consent to examination or treatment policy and was supported by a range of specific patient consent forms. We saw examples were appropriately completed in the paper and electronic records.
- The trust provided mental health act and capacity act training as part of the annual mandatory training programme and information provided to us by the trust stated a clinician was on call every day to support staff with any queries.
- For patients on their own and who were unconscious, staff acted in the patients' best interest. There was a trust policy in place regarding the use of CCTV. Staff told us that patients were informed of the CCTV in operation on all vehicles. Patients were informed by a recorded audible message from the vehicle and by signage displayed. Normally low level footage was recorded.

- We observed the 'assessment of capacity' form used by the trust including HART operatives. This form captured key and relevant questions to support staff in determining whether or not a patient had capacity to consent to care and treatment.
- However, we spoke with ambulance care assistants in PTS services who were unsure about their responsibilities in relation to restraining patients and did not have a clear understanding about mental capacity or deprivation of liberty safeguards.
- We listened to several calls in the 111 service. Throughout the telephone clinical triage assessment process the call handlers checked the patient's understanding of what was being asked of them. Patients were also involved in the final disposition (outcome) identified by the NHS Pathways and their wishes were respected.
- At the end of each call the patient was asked to consent to their information being transferred to their own GP.

Are services at this trust caring?

Good

We rated caring as good because:

- As part of our inspections, we observed care delivered directly to patients and we observed staff speaking to patients and relatives on the telephone. In order to gain an understanding of people's experiences of care, we talked to patients and their relatives who used services across the trust.
- Patients on the whole told us they were happy with the care they received and the attitude of staff. We observed staff engaging with patients in a caring and respectful manner.
- Throughout our visit we observed patients being involved in decisions about their care and treatment. Clear explanations of treatments and procedures were given to the patients prior to them being administered.

Compassionate care

- During our observation of care delivery by front-line staff in urgent and emergency care, we saw compassionate care of patients in ambulances, patient's homes and in the hospital emergency departments we visited. We saw staff were polite and courteous with patients and their relatives or carers.
- We spoke with 36 patients and 16 relatives. All patients and relatives spoke very highly of the crews regarding the care and treatment they had received.
- In the EOC we listened to 59 calls during the inspection. Staff spoke with patients and carers in a caring and professional manner.

Summary of findings

- 'Hear and Treat' is the telephone advice that callers who do not have serious or life threatening conditions receive from an ambulance service after calling 999. The trust participated in the 'Hear and Treat' survey.
- The hear and treat survey showed that the trust scored 9.2 out of 10 for call handlers showing dignity and respect to patients. 'Hear and Treat' survey results showed that the trust was mostly in line with others trusts results. The trust performed better for understandable instructions from the call handler, waiting for a call back from a clinical advisor and it being possible to follow the advice given. All others results were in line with other ambulance trusts. 333 patients responded to the survey.
- Feedback from patients was unanimously positive about the care they received from PTS crews. One patient described the service as 'excellent' and another as 'very good'.
- Three dialysis patients reported receiving excellent care from ambulance care assistants (ACAs) who they felt went the extra mile to ensure they were comfortable. Examples included staff escorting patients back into their home and making a hot drink, turning the television on and finding blankets for them before leaving, carrying their own personal umbrellas so patients didn't get wet and changing a light bulb in the house for a patient who was at risk of falls.
- Throughout our inspection, we observed ambulance care assistants treat patients with courtesy, dignity, and respect. We saw crews gently supporting patients in to and out of the vehicle, and securing them appropriately in their seats. The patient experience annual report 2015 reported 98% of patients said PTS crews showed kindness and consideration towards them and the attitude of the ambulance staff was good.
- We reviewed the most recently available Friends and Family Test (FFT) results for the 111 service and found that in February 2016:
  - 87% of respondents said they were likely or extremely likely to recommend the service to friends and family. Comments referred to the service as first class prompt, friendly, reassuring and professional. On average the results for the FFT were in the three top performers of NHS 111.

Understanding and involvement of patients and those close to them

- Throughout our visit we observed patients being involved in decisions about their care and treatment. Clear explanations of treatments and procedures were given to the patients prior to them being administered.

- The trust had a Patient's Charter to help patients understand what to expect when using PTS, particularly those who used the service regularly. The Patient's Charter was available on the trust website and we saw copies in hospital departments and on PTS vehicles. Patients had the opportunity to provide feedback about PTS by completing 'Tell us what you think' leaflets, which were also available on vehicles.
- Patients said they felt informed about their care and treatment. We observed staff asking patients about their personal capability and mobility choices, ensuring patients were involved in the decision making process.

Emotional support

- Throughout the inspection we observed staff reassuring patients and providing emotional support.
- The 'Hear and Treat' survey showed that the trust scored 7 out of 10 for patients who called and had fears or anxieties and had the opportunity to discuss these with a clinical advisor.
- Staff told us that they would support relatives as much as they could during or after a death of a patient. Literature to assist relatives immediately following the death of a loved one was provided. This contained information as to what happens next, in the subsequent hours and days.
- Managers told us the importance of applying the "6 Cs" had been communicated to all staff and continues to remain at the core of behaviours. Staff we spoke with could explain what these were. The 6Cs were developed by NHS England and stated goals that staff should strive towards when providing care. These included care, compassion, courage, communication, commitment and competence.
- We observed and spoke with PTS crews who showed a respectful understanding of the impact a patient's care, treatment or condition had on their wellbeing and on those close to them. Staff were sensitive towards patients attending regular chemotherapy appointments and the effect treatment and any relapse had on them.
- The inspection team observed staff from the HART team provide emotional support to colleagues from other emergency services following an extremely traumatic multi-agency call.
- Within the 111 service we observed call handlers speaking calmly and reassuringly to patients. We also saw that call handlers repeatedly checked that the patient understood what was being asked of them and that they understood the final disposition (outcome) following the clinical assessment.

Summary of findings

Are services at this trust responsive?

Good

We rated responsive as good because:

- PTS provided resilience to support the emergency and urgent care service, both operationally and within theEmergency operationscentre. The trust was in the process of implementing a project to integrate PTS with emergency care to create an integrated care and transport service. This meant additional capacity would be created to support the transportation of urgent care patients.
- Within the EOC the trust had dual trained many call handlers in 999 and 111 services which allowed them to be flexible in times of peak demand on the 999 service.
- The trust took into account local events which increased demands on the service. Information provided by the trust highlighted that staffing demands for local events were planned in advance and staffing rotas were adjusted as required.
- The service reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Groups (CCGs) to secure improvements to 111 services where these were identified.
- Within the 111 service systems were in place to electronically record additional information for vulnerable patients via the 'special notes' system.
- Alternative pathways of care were used including 'see and treat,' leaving patients at home if appropriate following assessment, alleviating inappropriate admissions at hospitals.
- In response to the introduction of major trauma centres and midwifery led services in hospitals, NEAS implemented guidelines for staff to bypass departments based on the needs of their patients

However:

- Staff told us they had not received specific training about equality and diversity including mental health awareness, dementia or learning disability training other than a brief overview during their induction and annual refresher training. Their awareness of how to meet patients' needs came from their own experiences and knowledge rather than from training by the trust.
- There was a comprehensive and current complaints policy which covered the complaints management process for the trust. There had been a backlog of responding to complaints across the trust and as a result the patient experience team now coordinated responses to improve the timeliness and quality of the responses.

Summary of findings

Service planning and delivery to meet the needs of local people

- To facilitate a better service for local people, the urgent and emergency care service participated in the north east urgent care network (NEUCN) vanguard programme to support delivery of the urgent and emergency care review. This pilot programme aimed to provide additional resources to help ensure a timely response to patients and offer a wider range of treatment options for patients including treating patients and discharging them or referring them to other services, avoiding unnecessary attendances at emergency departments. We saw evidence of this in the south division.
- PTS provided resilience to support the emergency and urgent care service, both operationally and within theEmergency operationscentre. The trust was in the process of implementing a project to integrate PTS with emergency care to create an integrated care and transport service. This meant additional capacity would be created to support the transportation of urgent care patients.
- PTS primarily operated Monday to Friday, 8.00am to 6.00pm. However, the service also operated outside of those hours in specific localities and clinical services such as hospital discharge, renal dialysis, and urgent care.
- PTS provided an urgent care transport service in Durham as a specific contract. The service operated in the evenings, Monday to Friday, and 24 hours a day at the weekend. A similar but smaller service operated in Gateshead whilst the main contract also included an element of urgent care, out of hours transport in Northumberland.
- The service used Auto Plan, an automated software planning system, to schedule patient journeys and the system planned approximately 80% of all activity. PTS transported patients based on the time of their appointment and Auto Plan scheduled journeys to ensure patients were collected and delivered within an arrival window of 45 minutes early and 15 minutes late.
- Within the EOC the trust had dual trained many call handlers in 999 and 111 services which allowed them to be flexible in times of peak demand on the 999 service.
- The trust took into account local events which increased demands on the service. Information provided by the trust highlighted that staffing demands for local events were planned in advance and staffing rotas were adjusted as required.

- The trust was developing plans to progress work on enhancing mental health provision in the EOCs. Management told us commissioners had been involved in the work around mental health provision.
- During changes in demand and seasonal weather challenges, hospital ambulance liaison officers (HALO) would communicate information between the hospitals they were at and the ambulance service.
- The resilience facilities were purpose-built and located strategically for optimum geographical coverage, ease of access to those areas of greatest populous and highest risk.
- The resilience service took the lead in assessing, planning and resourcing for events that had the potential to affect the 'normal' running of the service. NEAS resilience and HART response was available 24 hours a day, seven days a week to meet the needs of the local population.
- Day-to-day resource planning followed a structured approach using the NARU and Association of Ambulance Chief Executive national decision model known as REAP (Resource Escalation Action Plan). The trust adopted REAP into local policy to inform escalation procedures due to surge and disruptive challenges. REAP was implemented to protect staff, patients and the organisation when difficult situations arose.
- The service reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Groups (CCGs) to secure improvements to 111 services where these were identified. For example, it had been identified that there was a high demand and limited access for unscheduled dental care within the region. As a result the CCGs were in the process of developing access to 'Dental Hubs' across the region, which would allow NHS 111 call handlers to book appointments directly with these services for their patients.

Meeting people's individual needs

- Translation services were available for patients requiring this assistance with communication. Some, but not all, PTS crews we spoke with were aware they could arrange an interpreter for patients for whom English was not their first language.
- Staff in the EOC had access to a text relay service for hearing impaired patients who contacted the EOC.
- The trust had developed a document to support staff called "an introduction to dementia". The document contained information on dementia/ delirium, pain and distress and communication.

- The trust had signed up to the Alzheimer's society's dementia friend's programme over the next 12 months the trust planned to train its entire workforce to become dementia friends.
- Staff told us they had not received specific training about equality and diversity including mental health awareness, dementia or learning disability training other than a brief overview during their induction and annual refresher training. Their awareness of how to meet patients' needs came from their own experiences and knowledge rather than from training by the trust. Within EOC they had developed a vulnerable adult's document which included a section on dementia for staff to work through.
- The resilience service had worked with other blue light services to help remove some barriers faced by those individuals with hearing difficulties by providing staff with basic sign charts for reference and use by patients at a scene.
- The control centre team planned and delivered PTS journeys to take into account the needs of different patients. For example, a two-person crew always transported patients living with dementia for safety reasons.
- The service had two ambulances specifically equipped for bariatric patients. These included a hoist. These ambulances were used for non-emergency work, so could be requested by the crews. Crews commented there was a wait at times for these vehicles to become free. All newer ambulances had stretchers that were appropriate for bariatric weight and had an adjustable width. For situations where crews needed additional support for example lifting patients they would contact the HART team and / or the fire service for further support.
- Systems were in place to electronically record additional information for vulnerable patients via the 'Special Patient Notes' (SPN) system. The information was available to call handlers and clinicians at the time the patient or their carer contacted the NHS111 service. This assisted the call handler to safely manage the needs of these patients.
- All call handlers had additional training to help them to identify and support confused or vulnerable callers, and calls could be transferred to a clinical advisor for further assessment.

Access and flow

- Alternative pathways of care were used including 'see and treat,' leaving patients at home if appropriate following assessment, alleviating inappropriate admissions at hospitals.
- In response to the introduction of major trauma centres and midwifery led services in hospitals, NEAS implemented guidelines for staff to bypass departments based on the needs

of their patients. There were a number of local referral pathways for specialist services in place for stroke provision, primary percutaneous coronary angioplasty (PPCI), and trauma bypass.

- Twice daily conference calls with directorate managers and on call managers were used to identify pressure areas, hospital delays and staff shortages. Any flow issues relating to hospital delays were then escalated via executives so that hospital diverts or other measures could be arranged to assist with patient flow.
- The region also had a divert policy in place that was managed as part of its escalation plan.
- During winter pressure months, there were daily conference calls with NHS England to discuss the north east escalation plan (NEEP) levels at hospitals and also conference calls with commissioners to assist with flow.
- Calls into the emergency operations centres were monitored in real time. The EOCs had display screens located around the centre which showed information such as the number of calls waiting to be answered, the number of calls in progress and how many staff were available to answer calls. Staff told us the 999 escalation plan was implemented if calls started to stack.
- The urgent and emergency care service worked in partnership with commissioners and local police to provide a Newcastle city centre triage unit on Friday and Saturday evenings. The triage unit provided an assessment and triage facility and a place of safety for vulnerable people who had excess alcohol. The service aimed to reduce the number of patients attending the emergency department. During bank holidays, this service was also provided in Middlesbrough city centre.
- Within the resilience service there were no breaches of NARU response time interoperability standards based on the data provided.
- The NEAS NHS111 telephone number was a free 24 hours a day 365 days a year telephone number for people in the County Durham, Sunderland, Northumberland, Tyne and Wear, Darlington, Hartlepool, Middlesbrough, Redcar and Cleveland and Stockton on Tees, North Tyneside, South Tyneside, Gateshead and Newcastle areas. Calls were answered at either of the two call centres based in Newburn, Newcastle upon Tyne or Hebburn, Tyne and Wear/South Tyneside. Those patients who were not registered with a GP or who were seeking asylum were not restricted from using the service.
- We saw evidence that the call abandonment rate was lower than the national average, and that average times for calls being answered were better than the national average.

- The service prioritised people with the most urgent needs at time of high demand. Capacity and demand was monitored constantly, and conference calls were held three times each day between section managers andEmergency operationscentre managers to review call handling data. This helped to ensure staff shortages or peaks in demand were responded to quickly and adequately.

Learning from complaints and concerns

- There was a comprehensive and current complaints policy which covered the complaints management process for the trust.
- The policy detailed that the response time was determined by the nature of the complaint, but current Trust timescales for a written response were 25 working days and verbal responses were 10 working days.
- Between 10 December 2015 and 12 February 2016 the trust had undertaken a survey about complaints and had received nine responses. Of the nine respondents six people felt the complaints process had been clearly explained. However three out of nine respondents indicated the complaint had not or had been partially responded to within the timescale.
- There had been a backlog of responding to complaints across the trust and as a result the patient experience team now co-ordinated responses to improve the timeliness and quality of the responses. This also ensured that the complainant had a key person to contact and who would keep them up to date on the progress of their complaint.
- Between April 2015 and March 2016 the urgent and emergency care service received 561 complaints, compared with 632 in 2014, which showed a decreased of 11.2%. There were 100% of all complaints acknowledged within policy timescale of 3 days, 63.4% of complaints responded to within policy timescale of 25 days, and 36.6% of complaints responded to outside of policy timescales of 25 days year to date. The top themes for complaints were related to the action of the crew, the care provided and staff attitude due to comments made.
- Between February 2015 and February 2016 there were 357 complaints about the emergency operations centres, 81% of the complaints made to the emergency operations centre were related to waiting for resource. Staff told us there had been challenges with dealing with complaints and there was a backlog.
- Management had responded to this by seconding staff from the EOC to assist and help manage complaint handling and

response. Staff told us there was still a backlog of complaints, although this was reducing with the staff secondments. Information provided by the trust highlighted that there were 54 outstanding complaints.

- From February 2015 to February 2016, there were 101 complaints about PTS and the most common theme related to the timeliness of transport. The trust had made some changes to improve the service. For example, rather than show the patient's appointment time on Terrafix, the system now showed what time to collect the patient.
- The 111 service had received 81complaints, comments, concerns and incidents in the period between April 2015 and March 2016. This represented 0.012% of all calls handled by NEAS NHS111 during that period. Records indicated that all complaints received were investigated and responded to within a short time frame. Investigations included reviewing the call made to the service to assess the quality of the call and the responses provided to the patient. Where the complaint investigation identified shortfalls in a call handler's performance, this was discussed with the individual concerned, and additional support, such as coaching or training was provided. In some instances call handlers were removed from the call lines to allow for further training.

Are services at this trust well-led?

Good

We rated well-led as good because:

- The trust had an overall five year strategy for 2015-2020 which included a mission statement, a vision which was underpinned by values. The trust's mission was safe, effective and responsive care for all and the vision was to deliver unmatched quality of care, every time we touch lives.
- The trust was re-configuring their resource base which currently included the EOC (and dispatch function), Patient Transport Services (PTS) and Emergency Care (EC), this formed part of the Integrated Care and Transport strategy. PTS and EC currently operated as two relatively discrete services however the trust had identified a need to change the operating systems to facilitate access to a single service model with no access barriers to any type of resource, responding appropriately to both scheduled and unscheduled care 7 days a week.
- The trust had governance framework that supported delivery of safe and high quality care from 'the frontline services to board'.

There were a number of assurance groups including a quality committee and audit committee. The assurance committees were chaired by Non-Executive Directors who provided challenge and scrutiny.
- The trust made significant improvements on its Equality Index Stonewall assessment moving from 222 to 46 place in January 2016.

However:

- During the inspection we raised concerns with the executive team regarding the resilience of dispatch at the trust. Dispatch was located at Bernicia house only and in the event of system failure to dispatch or Bernicia house not being able to facilitate dispatch services, there would be a delay in the trusts ability to dispatch ambulance crews to patients.
- Staff in some locations knew who the executive team were and understood some senior managers had visited ambulance stations and hospital departments; however, some staff reported they had not seen the executive team during their work.
- There was a lack of clarity within the trust regarding the line management, clinical oversight and governance of the community first responders we raised this as a concern with the executive team during our inspection.
- The medical director post was only part time however the trust were looking to appoint an associate medical director to strengthen clinical leadership and to further support the transformation programme.
- There were concerns regarding the current service structure in the HART team, managers described the service as running at capacity and concerns had been highlighted regarding the sustainability of the resilience function with current pressures in the long term.
- The trust were addressing the culture of the service and had carried out a culture survey to assist in addressing the challenges, results from the survey were mixed.

Vision and strategy

- The trust had an overall five year strategy for 2015-2020 which included a mission statement, a vision which was underpinned by values. The trust's mission was safe, effective and responsive care for all and the vision was to deliver unmatched quality of care, every time we touch lives.

- The trust vision was supported by values which included respect, take responsibility and be accountable, compassion, pride, strive for excellence and innovation and make a difference day in day out.
- The trust was re-configuring their resource base which currently included the EOC (and dispatch function), Patient Transport Services (PTS) and Emergency Care (EC), this formed part of the Integrated Care and Transport strategy. PTS and EC currently operated as two relatively discrete services however the trust had identified a need to change the operating systems to facilitate access to a single service model with no access barriers to any type of resource, responding appropriately to both scheduled and unscheduled care 7 days a week. This development would enhance the trust's responsiveness through more effectively matching patient demand in terms of acuity and need, with a more targeted clinical skill-set and a wider range of vehicle resource type.
- The trust had recently developed its strategy and the key themes were to be progressed through four project groups. These groups were culture, integration and collaboration, new ways of working and education and training. Information provided by the trust highlighted that further engagement with staff around the strategy and implementation was required.
- The trust had developed one year operational plans to support the delivery of the strategy.
- The Sign up to Safety campaign is a national initiative to help the NHS improve the safety of patient care. Collectively and cumulatively these initiatives aim to reduce avoidable harm and support the ambition to save lives. The trust formally launched their sign up to safety campaign in February 2016 and developed a safety improvement plan.
- The Quality Strategy 2014-2017 highlighted that the trust aimed to provide high quality care which was safe, prevented all avoidable harm and risks to individual's safety; and to have systems in place to protect patients by:
  - Preventing people from dying prematurely, including those with mental illness
  - Reduce deaths attributable to problems in healthcare
  - Reduce severe harm attributable to healthcare
  - Reduce avoidable harm

Governance, risk management and quality measurement

- The trust had governance framework that supported delivery of safe and high quality care from 'the frontline services to board'.There were a number of assurance groups including a quality committee and audit committee. The assurance

committees were chaired by Non-Executive Directors who provided challenge and scrutiny. The quality committee were aware of a number of concerns and monitoring issues including the governance around community first responders and backlog of incidents.

- At a service level across services there were processes in place for teams to review incidents and ensure shared learning.
- A Board Assurance Framework and Corporate Risk Register identified strategic and operational risks. We reviewed the corporate risk register, which documented actual risk, control measures and residual risk ratings. The Board Assurance Framework was under regular review and was presented three monthly to the Trust Board.
- Risks on the corporate risk register included Future Operational (and hence staffing requirements) Model is untested and skill mix requires development and Inappropriate behaviours underpin a culture that impacts negatively on the trust's ability to deliver high quality safe healthcare.
- We reviewed a sample of reports that formed part of the board papers, there were no concerns raised from this review.
- There was an ECLIPS group that reviewed patient experience, complaints, litigations and PALS group that reviewed all information and reported into the Quality Governance Group which in turn reported in to the Quality Committee. We reviewed a sample of ECLIPS reports which showed discussion of themes and trends from each of the above areas and escalated these up through the governance framework. Patient stories were identified for presenting at trust board.
- Both Executive Directors and Non-Executive Directors complete quality walkarounds and test out learning through discussing with staff incidents and how learning has been disseminated.
- The trust had a Deloitte LLPled governance review in January 2015 which identified areas of strength and areas for improvement.In addition the trust had a Governance Review under the new well-led framework carried out by Deloitte LLP and this concluded in January 2016. The follow-up review concluded that good progress had been made in a number of areas, with the work on the mission, vision and values being particularly praised, alongside the refinement of the committee structures and quality governance framework.
- The trust had a business continuity policy. This described the roles, responsibilities, and processes to ensure continuity of services, protection of patients and staff and the reputation of the organisation.
- During the inspection we raised concerns with the executive team regarding the resilience of dispatch at the trust. Dispatch

was located at Bernicia house only and in the event of system failure to dispatch or Bernicia house not being able to facilitate dispatch services, staff told us they would move the dispatch team to Russell House. This would take around 20 minutes and dispatch would use radios from the car park during that 20 minutes to manually dispatch ambulance crews. A draft procedure was in place, however staff had not received training in dispatch resilience procedures and this could potentially lead to a delay in being able to dispatch ambulances to patients.

- The resilience service reported excellent outcomes in the NARU EPRR Quality Assurance Framework Core Standards Compliance Report in October 2015. Governance, duty to assess risk, command and control, duty to communicate with public, information sharing, co-operation and training and exercising all recorded 100% compliance with duty to maintain plans for emergency and business continuity recorded at 86%. Overall scoring was recorded at 97%.
- The service met governance obligations set in accordance with NARU/NHS HART Service Specification Interoperability Administrative Standards (26-28 and 30). Governance and performance was reported on the national PROCLUS system. Governance compliance against the HART standards was 90% or above for all core functions.
- A monthly NHS 111 Clinical Governance Report was produced by the NEAS Quality Regional Group to summarise the ongoing work across the region and included statistical data relating to call activities, audits and trends.This gave an overview and assurance of the service. Monthly contract monitoring review meetings were held with the lead commissioners and the North of England Commissioning Support Unit. Actions to address any performance issues were highlighted and monitored.A copy of this report was also sent to the National NHS 111 Advisor for discussion at the National NHS 111 Clinical Governance meetings.
- The trust had a transformation board in place and there were eight transformation projects in progress looking at areas that included workforce, productivity, medicines management, integrated care and transport and estates. There was a project management office that provided assurance around the transformation programme. Risks identified fromongoing projects were recorded on the project or directorate risk registers unless they are rated as 15 or above, when they will then be recorded on the corporate risk register. The Board received regular updates with regard to the progress of the transformation plans.

- The trust had a cost improvement programme in place and there was a process in place for identifying impact of schemes on quality and patient care.
- The trust had previously identified concerns in relation to DBS checks. The process had been reviewed and there was weekly monitoring via a report to ensure compliance with this.

Leadership of the trust

- Chief executive roadshows, team briefings and quality walk arounds by senior managers took place. Senior managers listened to the views of staff and shared information with staff about the challenges the trust was facing and the ongoing work which was taking place to address the challenges.
- Staff knew who the executive team were and understood some senior managers had visited ambulance stations and hospital departments; however, some staff reported they had not seen the executive team during their work.
- As part of the inspection process we held a focus group, which was attended by community first responders. They expressed to us that they felt their role was not being developed as much as it could be, and that they were not being used to the best of their ability. Additionally, they were unsure of their management structure and told us that there had been many changes recently, which had left them unclear about who managed them. When we checked with senior managers we were told different information regarding who managed the community first responders. We raised this with the trust at the time of inspection.
- The ECCM's were front line leaders who supported staff and supervised operations. This recently established role was to ensure staff received appropriate clinical leadership, which was documented and evidenced via quarterly one to one meetings. ECCM's will eventually be full time managerial roles with completion of at least 2 operational shifts per month with a view to maintaining their clinical skills and professional registrations and not to work as a crew member although this was difficult due to current vacancies.
- The medical director post was only part time however the trust were looking to appoint an associate medical director to strengthen clinical leadership and to further support the transformation programme.
- There were concerns regarding the current service structure in the HART team, managers described the service as running at capacity and concerns had been highlighted regarding the sustainability of the resilience function with current pressures in the long term.

- In PTS some staff did not feel engaged with the senior management team. A PTS forum took place bi-monthly, chaired by a member of the senior management team, however, representatives from this group told us the same topics were discussed and senior managers did not appear to act on ideas or information provided by staff. However, one example raised at the focus group led to an improvement in the information available on Terrafix about patient appointment times.
- Team leaders and section managers were visible in the 111 call centre.All the staff we spoke with told us they found their immediate manager supportive and approachable.They told us they could approach any team leader with any concerns. Staff told us that senior managers were less visible, but described how they received feedback from them via their team leader when something had gone well.

Culture within the trust

- We were told that the culture was one of passion and enthusiasm however there was an awareness of differences in culture across the different geographical patches. The trust had recently undertaken a cultural survey which had identified some concerns regarding management support. Actions had been identified to address this through the management essentials programme.
- Results from the survey were mixed. The survey of the culture of the trust carried out in 2015 found that 76% of people felt pride in working for the trust; however the survey also showed that 54% of staff rarely felt cared for by the trust. 73% of respondents felt neutral or not encouraged by their manager to put forward ideas for improving the service they work in. Feedback regarding how often staff felt supported by their line manager was positive with 40% of staff stating often and 37% stating always.
- Most staff confirmed there had been a real shift in emphasis toward patient engagement and staff wellbeing. This was reinforced by the NHS Staff Survey 2015 where it was reported trust management had a real interest in staff health and wellbeing (better than national average, 3.34 against 3.15). Trust had re-launched the sickness absence policy and we were told that sickness rates had recently started to reduce although at the time of inspection the sickness rates in all services were above the trust target of 5%.
- Morale amongst staff varied in the different regions in PTS services and within EOC. Some staff in the South division, for

example, felt separated from and undervalued by managers and the wider organisation while crews from the Central division felt there was less of a divide between managers and staff.

- The relationship between the executive team and union representatives had improved and we were told by both sides that there was now a more open dialogue and discussion regarding meeting the needs of staff and the service. There were monthly meetings in place with the Chief Executive Officer and we were told that there was an increasing willingness to find solutions to issues.
- The Workforce race equality standard (WRES) aims to ensure employees from black and ethnic minority (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. The trust had benchmarked itself against the standard and indicators.

Fit and Proper Persons

- The trust was prepared to meet the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensures that directors of NHS providers are fit and proper to carry out this important role.
- We reviewed files of executive and non-executive directors and found they were compliant with the requirements.

Public and staff engagement

- The trust participated in the annual NHS Staff Survey. The survey results had shown some improvements in the way staff felt. For the 2015 NHS staff survey 36.9% (888 staff) responded. Of the 60 questions asked, the trust was significantly better than the national average for 27 of these, significantly worse for one and showed no significant difference for the remaining 32 questions. The service developed an action plan to demonstrate to staff that they had been listened to and the trust had acted on their feedback. These results were trust wide.
- Within the survey staff highlighted that they had had a performance review, that they had seen positive action taken on health and well-being. They were getting better support from managers, felt more motivated and that the quality of non-mandatory training, learning and development had improved.

- There was a reduction in the number of staff who said they had suffered from work-related stress in the last 12 months and more staff said they would recommend NEAS as a place to work or receive treatment.
- We were told that the trust had started to use 'survey monkey' technology to obtain feedback from staff who were leaving the organisation. However we did not review any results and we were informed that currently numbers of responses were low.
- PTS consistently received a high response rate in relation to the Friends and Family Test. The trust had implemented a number of new initiatives to improve the response rate further, which included volunteer porters conducting surveys at one of the large acute hospitals and volunteer car drivers supporting patients to complete the online survey using their electronic PDA device.
- The customer care team met with a patient representative from the South of Tyne renal service every two weeks to discuss any issues or concerns. The team also engaged with patients through patient experience surveys that were undertaken each month, and had been shortlisted for the Friends and Family Test champions of the year award for their work with the renal service. However, when we spoke with patients who attended regular dialysis appointments, they told us they had never had any communication with the trust.
- Resilience staff received professional students on-site to see the services provided across the department.
- Resilience staff attended school events with and without professional colleagues to educate and promote key themes such as road traffic safety.
- The website for NEAS included a link which enabled the public to make a complaint or provide a compliment on the service they had received. The provider received feedback from the public via the Friends and Family Test (FFT) and monitored the responses on a monthly basis. The results were shared with 111 staff via the LAMP.

Innovation, improvement and sustainability

- The trust provided national support for a motorcycle application; this was a mobile phone application, that used smart phone technology to identify if a motorcyclist had had an accident, and sent location data to the NEAS EOC, allowing staff to contact the nearest appropriate ambulance service to arrange an emergency response. The trust had been recognised at a national level for this.

Summary of findings

- The resilience service developed strong working relationships with the Sports Ground Safety Authority (SGSA) following innovative approaches to improving medical safety standards at stadia events such as premier league football matches and music concerts.
- The resilience managers have been asked to contribute to the 'First Aid and Medical Provision' section of the Green Guide to Safety at Sports Grounds publication.
- The advanced paramedic programme was an area of work that would benefit patient care and improve treatment pathways for patients. This role was still relatively new in the organisation. The team of advanced paramedics met with their counterparts across the service to discuss strategy and the future of the role within NEAS.
- The trust research and development team were involved in a number of trials which were underway at the time of the inspection. These included for example trailing a device that regulated intrathoracic pressure during resuscitation and the PASTA trial which was a multi-centre randomised controlled trial to determine whether a Paramedic Acute Stroke Treatment Assessment (PASTA) pathway could speed up access to stroke patients.
- The Trust had pioneered a Flight Deck methodology for the North East. This was a capacity management system intended to support improved whole system awareness of capacity, quicker and safer diverting of patients to appropriate receiving care locations, and enhanced whole system learning.
- The trust had recently worked in partnership with Newcastle County Council to allow PTS vehicles to use bus lanes in the city. The use of bus lanes meant fewer delays caused by traffic, and fuel savings. The ambulance care assistant who initiated the project was in the process of contacting other local authorities in the region.
- As part of the continuous drive to improve the timeliness of transport, the trust planned to introduce a 'traffic light system' where a sensor was fixed on a vehicle which could change a traffic light from red to green on busy stretches of roads across the region.
- The trust made significant improvements on its Equality Index Stonewall assessment moving from 222 to 46 place in January 2016.

Overview of ratings

Our ratings for North East Ambulance service

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	Good	Requires improvement	Good	Good	Good	Good
Patient transport services (PTS)	Good	Good	Good	Good	Good	Good
Emergency operations centre (EOC)	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Resilience	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Our ratings for North East Ambulance Service NHS Foundation Trust

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

Outstanding practice and areas for improvement

Outstanding practice

- The trust had enrolled in the Mind blue light mental health programme and had encouraged staff to take on training to support colleagues with their mental health.
- The trust provided national support for a motorcycle application; this was a mobile phone application, that used smart phone technology to identify if a motorcyclist had had an accident, and sent location data to the NEAS EOC, allowing staff to contact the nearest appropriate ambulance service to arrange an emergency response. The trust had been recognised at a national level for this.
- The resilience service developed strong working relationships with the Sports Ground Safety Authority (SGSA) following innovative approaches to improving medical safety standards at stadia events such as premier league football matches and music concerts.
- The advanced paramedic programme was an area of work that would benefit patient care and improve treatment pathways for patients.
- The trust research and development team were involved in a number of trials which were underway at the time of the inspection. These included for example trailing a device that regulated intrathoracic pressure during resuscitation and the PASTA trial which was a multi-centre randomised controlled trial to determine whether a Paramedic Acute Stroke Treatment Assessment (PASTA) pathway could speed up access to stroke patients.
- The Trust had pioneered a Flight Deck methodology for the North East. This was a capacity management system intended to support improved whole system awareness of capacity, quicker and safer diverting of patients to appropriate receiving care locations, and enhanced whole system learning.
- The trust had been nominated for a national innovation award for the development and use of the electronic communication system.
- The trust had received national awards for the Lamp electronic communication system.

Areas for improvement

Action the trust MUST take to improve

Action the trust MUST take to improve

- The trust must review and ensure there are appropriate arrangements in place to provide dispatch in the event that Bernicia House was unavailable to operate as a dispatch centre.
- The trust must ensure at all times there are sufficient numbers of suitably skilled, qualified and experienced staff.
- The trust must ensure all staff have completed mandatory and role specific training relevant to their role.
- The trust must ensure all staff receive an appraisal and are supported with their professional development. This must include support to maintain the skills and knowledge required for their job role.
- The trust must continue to address the complaint and incident backlog and ensure systems and processes are put in place to prevent a re-occurrence.
- The trust must ensure that clinical records are stored securely.

Action the location SHOULD take to improve

- The trust should ensure all relevant staff have received appropriate major incident training.
- The trust should ensure staff within the emergency operations centres are involved in the development of the strategy and vision of the service.
- The trust should ensure staff are supported and encouraged to report incidents and feedback is provided to staff on the outcomes of the incident investigation.
- The trust should review the training requirements for operational staff for vulnerable groups such as patients living with dementia and patients experiencing mental health concerns.
- The trust should ensure there is a robust system in PTS to monitor the daily cleanliness of vehicles and ensure deep cleans are carried out to planned levels.

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
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 (1) Systems and processes must be established and operated effectively to: (2) (a) assess, monitor and improve the quality and safety of services; (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users; (c) Maintain securely and accurate, complete and contemporaneous record of care; (e) seek and act on feedback from relevant persons and other persons on the services provided for the purpose of continually evaluating and improving such services. How the regulation was not being met: There were concerns about the resilience of dispatch at the trust. Dispatch was located at Bernicia house only and in the event of system failure to dispatch or Bernicia house not being able to facilitate dispatch services, there would be a delay in the trusts ability to dispatch ambulance crews to patients. There was a lack of clarity within the trust regarding the line management, clinical oversight and governance of the community first responders we raised this as a concern with the executive team during our inspection. There were occasions where paper records were not always stored securely. Learning from incidents, complaints and audit was not always consistently shared across staff groups. There were concerns identified during the inspection regarding the regarding the emergency operations centre in relation to the management of clinical risks when the 'stack' of calls was increasing

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Reg. 18 (1) There must be sufficient numbers of suitably qualified, competent, skilled and experienced staff on duty.

How the regulation was not being met:

There were 24 clinical advisors against a planned establishment of 34 clinical advisors.

The planned establishment for paramedics was 642.40 wte. The actual number of staff in post was 539.91wte which meant there was a vacancy of 102.49 wte.

Reg. 18 (2) (a) Persons employed by the service provider in the provision of the regulated activity must receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out duties they are employed to perform.

How the regulation was not being met:

Mandatory training across services did not always meet the trust targets.

Appraisal rates between staff groups across the trust did not always meet the trust targets.