

South Central Ambulance Service NHS FT

South Central Ambulance Service (Bucks & Oxon Divisional HQ)

Quality Report

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

Summary of findings

Letter from the Chief Inspector of Hospitals

South Central Ambulance Service NHS Foundation Trust (SCAS) was formed on 1 July 2006, after the merger of the Royal Berkshire Ambulance Service NHS Trust, the Hampshire Ambulance Service NHS Trust, the Oxfordshire Ambulance Service NHS Trust and part of the Two Shires Ambulance Service NHS Trust. It provides NHS ambulance services in Berkshire, Buckinghamshire, Hampshire and Oxfordshire in the South Central region. This area covers approximately 3,554 square miles with a residential population of over 4 million. On 1 March 2012, the trust achieved foundation trust status.

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 logistics and commercial services. There is also a Hazardous Area Response Team (HART) based in Hampshire. Services are delivered from the trust's main headquarters in Bicester, Oxfordshire, and a regional office in Otterbourne, Hampshire. Each of these sites includes an emergency operations centre (EOC) where 999 and NHS 111 calls are received, clinical advice is provided and from where emergency vehicles are dispatched if needed. There was a PTS contact centre at each EOC.

Our inspection took place on 10 and 11 September 2014 with unannounced visits on 30 September and 1 October. We inspected the trust as part of our first wave of comprehensive ambulance inspections. We looked at three core services: access via emergency operations centres, patient transport services and emergency and urgent care. The 111 service provided by the trust was not inspected on this occasion. The logistical and commercial training services were also not inspected as these do not form part of the trust's registration with the Care Quality Commission (CQC).

The team of 48 included CQC inspectors and inspection managers, an analyst and inspection planners and a variety of specialists: The team of specialist was comprised of a consultant physician in intensive care, two nurses working in accident and emergency departments, four paramedic staff, one emergency care practitioner, a paramedic clinical supervisor and development manager, three managers with an operations role, a head of governance, a director of service delivery, two chief executives, a pharmacist, a safe guarding lead, two people with a role in an operations centres and three experts by experience

We did not provide ratings for this trust because this inspection was part of our first wave of ambulance inspections to apply our methodology and develop our understanding of inspecting in this sector.

Key findings

Across the core services:

- Staff were caring and compassionate, and treated patients with dignity and respect.
- Staff were positive about the quality of care they provided for patients and were proud to work for the trust. There was low morale in places and the pressures faced by the trust were recognised. Staff however "lived" the values of the organisation: "Towards excellence – Saving lives and enabling you to get the care you need".
- Patients told us their experiences of care and treatment was good. They were positive about emergency ambulance response times but there were concerns about the punctuality of patient transport services.
- Incident reporting was increasing on the newly introduced electronic reporting system. The trust was taking action following incidents, but there needed to be earlier and quicker investigation for some incidents. Learning was shared via clinical bulletins, the trust intranet, noticeboards and email. The trust had introduced SCAScade to improve organisational learning from when things go wrong. This included anonymous cases and reflective tools for staff to use on the trust intranet. However, staff in the EOC and PTS needed to be encouraged to use and take responsibility for reporting incidents and also required feedback and shared learning in their areas.
- Staff in the emergency and urgent care service had good knowledge of the Mental Capacity Act 2005, but staff in EOC and PTS needed to have better knowledge to ensure the best interest of patients.

Summary of findings

- Safeguarded procedures were being used but needed to improve and the safeguarding lead had a limited capacity to deliver the safeguarding agenda across the organisation. Safeguarding champions in geographical areas were to be developed but this needed to be prioritised.
- Staff had good training opportunities and specialist training on dementia care, learning disabilities and mental health was being improved. Staff were supported with funding for further qualifications and professional development. However, some staff did not always have access to computer facilities to undertake training or the dedicated time to complete it, and attendance at mandatory and statutory training was low.
- Most complaints were responded to within the trust's target time of 25 days and action was being taken to improve services as a result. Complaints were analysed to identify themes and the trust aimed to share learning, for example, through teams and noticeboards. There was evidence of actions taken as a result of complaints in all services. However, staff told us they did not always get feedback on complaints or concerns raised.
- The trust understood its duties under the Civil Contingencies Act 2004 and all staff were aware of what to do in the event of a major incident. Staff had appropriate training, there was joint working with partner organisations (such as the fire service, police and military), and rehearsals were undertaken as part of preparation and planning exercises.
- The trust had worked with partner organisations including fire and rescue, police, and the environmental agency during the floods in the Thames Valley area in early 2013. The Hazardous Area Response Team (HART) had worked throughout the region and specifically in Wraysbury, Berkshire, 24 hours a day over 4 days, to assist with the rescue and support operation.

Emergency Operation centres (EOC)

- Emergency 999 calls were triaged through NHS Pathways (which is a software system of clinical assessment for triaging telephone calls from the public based on the symptoms they report when they call). There was good compliance to prioritise and categorise calls for ambulance dispatch according to the clinical needs of patients. However, staff knowledge of appropriate dispatch times for mental health patients in crises under a Mental Health Act Section 136 and needing a place of safety, needed to improve.
- There were dedicated triage lines for GPs and healthcare professionals, and for patients who were critically unwell and needed the air ambulance (the Helicopter Emergency Medical Services, [HEMS]) or other specialist services, such as the Hazardous Area Response Team (HART).
- Some safety processes needed to improve, such as incident reporting and raising safeguarding concerns, and some staff needed a better understanding of the Mental Capacity Act 2005.
- Staffing levels were a concern and staff worked long hours, sometimes without breaks. Action was being taken to manage peaks in demand but staff were not meeting target times to answer emergency calls.
- Overall, the trust had referral rates of 8% from NHS 111 to 999 services, and these were better than the service level agreement performance of 10% and one of the lowest in the country. Staff identified the need for further action on managing the demand created by the NHS 111 service, and the trust's long-term planning against the rising increase in demand for services was ongoing.
- The staff were supportive to patients who called in distress. They listened carefully, explained their actions and involved patients in their decisions.
- Clinical advisors were available to help staff and to support patients to manage their own health when appropriate. The clinical adviser also undertook welfare checks over the phone to ensure a patient's condition was not deteriorating while they were waiting for an ambulance. The trust was below the national average for 'hear and treat', which is the proportion of calls that are dealt with based on provision of telephone advice only. The re-contact rate within 24 hours of 'hear and treat' was higher than the national average in 2013-14 but had decreased this year and was below the national average in (April to July 2014).
- Engagement between the trust and the public and patients was being developed further.

Summary of findings

- The trust had a clear strategy for the EOC to provide clinical coordination of care across a range of health and social care settings. However, most staff were not aware of this strategy in relation to their service. Governance arrangements needed to improve to support staff to share learning, raise concerns, manage risk and act on performance information. Staff worked well in their teams but some wanted better support from managers, particularly in the northern EOC.

Emergency and Urgent Care

- Front-line 999 services provided an emergency response to people with life threatening emergency or urgent conditions. Overall, during 2013/14, the trust was meeting national emergency response targets for 75% of calls to be responded to within 8 minutes. The national categories are for Red 1 calls (for patients who have suffered cardiac arrest or stopped breathing) and for Red 2 calls (for all other life threatening emergencies). Red 1 and Red 2 calls added together and are referred to as Category A calls. The category A target is to have a vehicle that could convey a patient to hospital arrive at the scene within 19 minutes for 95% of cases. This target was also met.
- The trust had the highest percentage of 'see and treat' in the country (that is, managing patients at the scene without the need for ambulance transfer to hospital). The re-contact rate within 24 hours of this treatment was higher than the national average in 2013-14 but was decreasing.
- The trust used a Resource Escalation Action Plan (REAP) as a way of forecasting performance and service delivery. There was moderate to high pressure on the service during our inspection and the trust was communicating effectively with hospitals to align conveyancing decisions against waiting times and the capacity to receive patients. This included having hospital ambulance liaison officers (HALOs) to support the timely handover and safety of patients in A&E departments and to monitor and respond to situations, particularly at times of increased demand for services. There was effective planning and preparation for major incidents and the trust had worked effectively with partner organisations.
- The trust was monitoring long waiting times and had introduced measures to ensure that people were monitored while waiting and that high-priority calls took precedence. There was an impact however on people who may be in a healthcare setting but awaiting transfer to another hospital for acute care and for people at a distance from an ambulance station. The trust was taking action to reduce these waiting times.
- The service followed safety procedures overall, but needed to improve infection control practice and the management of medicines. Staff had a good understanding of the Mental Capacity Act 2005 and of safeguarding procedures although the timeliness of reporting concerns and referrals needed to improve. The performance of the external contractor to 'make ready' ambulances (that is, to prepare ambulances, for example, in terms of cleanliness and appropriate equipment) was monitored but the quality of their work required better supervision and monitoring. Ambulance crews had allocated time to check vehicles but told us they spent more time rechecking vehicles to ensure they were ready for use.
- The trust was affected by the national shortage of paramedics and there were a high number of vacancies. The allocation and skill mix of staff were appropriate but staff worked long hours and some reported stress and fatigue. There was a rising demand for services that was above predicted levels. The trust had introduced shift changes to help manage resources to meet demand in emergency services and new rotas were being introduced to further improve the work life balance of staff. The trust used private providers to ensure service cover and these providers were appropriately monitored. Staff spoke positively about the level of communication on issues and they understood the need to match resources and demand, and requested further ongoing dialogue around these issues.
- National evidence-based guidelines were used to assess and treat patients. Patients experiencing a heart attack did receive pain relief although this was not always the pain relief that was nationally recommended. Patients experiencing a heart attack were transported quickly to hospital. Patients that had had a stroke had appropriate care but there could be delays in their transport to hospital. Some hospital staff identified the need for better pain relief for children in certain circumstances.

Summary of findings

- The coordination of emergency care with hospitals and GPs was good overall, but needed to improve for heart and stroke care in Buckinghamshire and for mental health patients in crisis across the four counties. The trust was working with its partners and had action plans to improve care in these areas.
- The trust was ranked the best in the country for patients who had had a cardiac arrest and stopped breathing, who then after resuscitation, had a pulse/ heartbeat on arrival to hospital. This is called return of spontaneous circulation (ROSC). The trust had improved its effectiveness of action taken when staff witnessed a cardiac arrest and was fourth best in the country this year (April to August 2014) a change from eighth best in 2013-14.
- The trust was ranked the best in the country for patients who had had a cardiac arrest and survived to be discharged from hospital.
- Staff explained treatment options to patients in a way that they, or their relatives, could understand. Patients, and relatives or carers, received good emotional support if they were in distress. There was support for vulnerable patients, such as those with a learning disability, bariatric patients and people whose first language was not English.
- Engagement between the trust and the public and patients was well developed through a variety of channels, such as social media, surveys, newsletters and liaison work.
- The trust had a clear vision and strategy for the service to provide mobile healthcare and to coordinate care in hospital, the community and people's homes. Staff were supportive of the strategy and worked well together in teams and with their managers. There were good governance arrangements to monitor performance and quality and to manage risks although more action was needed on ongoing risks.

Patient Transport Services

- Patient transport services (PTS) provided non-emergency transport for patients who attend, for example, outpatient clinics or day hospitals, or were discharged from hospital. Commissioners had identified eligibility criteria for the service and the trust was working with 12 clinical commissioning groups to monitor performance and compliance.
- Staff followed the eligibility criteria designed by commissioners and were also working to improve the signposting of people to other services if they did not meet the criteria.
- Procedures to ensure the safety of services needed to improve, specifically around incident reporting, equipment checks and safeguarding procedures. Most vehicles were visibly clean. 'Do not attempt cardio-pulmonary resuscitation' (DNA CPR) orders were understood and used appropriately, but staff had limited awareness of the Mental Capacity Act 2005.
- There were staffing vacancies and staff felt stretched, particularly in the dispatch team where this had an impact on the planning and scheduling of transport. The trust was using volunteers and private providers to cover driving shifts. There needed to be better governance arrangements for private providers and for driving and employment checks for volunteers.
- The trust had made significant changes to the IT system in the PTS on the day of our inspection. Anticipated resource and capacity risks needed to be better managed, for example, problems with the new IT system had caused a serious disruption to transport arrangements for many patients during our inspection.
- Dispatch staff did not always have appropriate assessment information, from hospitals or patients or from their own records. Patients sometimes did not have an appropriate vehicle or equipment, and transport sometimes had to be reorganised. The system to plan journeys was manual and often reactive based on a lack of timely and coordinated information and this had caused delays to patient transport.
- The trust was not meeting performance targets and this was having an impact on patients' care and treatment. Patients were experiencing delayed and missed appointments for outpatient consultations and diagnostic scans, and renal dialysis, and some were choosing to curtail their treatment in order not to risk missing their transport home for fears of excessive delay. Some hospitals had reorganised clinics, for example, to finish early to accommodate the vagaries of the PTS. There were good examples of multi-disciplinary working with GPs and health professionals in hospitals. The trust had been working with other providers to improve the coordination of care and some progress had been made.

Summary of findings

- Patient surveys were regularly undertaken; these were positive about the service but identified delays. Patients we spoke with were positive about the care and compassion of staff. However, they were concerned that the service was not effective and that they were not given enough information about delays, missed appointments and the eligibility criteria.
- Many patients told us they had been distressed and anxious waiting for transport, but did not know whom to contact within the service. Call handlers were overwhelmed with calls about service delays and only half of all calls were answered.
- There was good support for vulnerable patients (for example, those with dementia or a learning disability), and carers and escorts could travel in the ambulances too. A policy for the transport of children needed to be developed.
- The trust had a clear strategy for the development of PTS to support safe non-emergency travel between people's homes and healthcare settings, but most staff were unaware of this strategy. Governance arrangements needed to improve in order to assess and manage risks. Although staff worked effectively in teams, many wanted the management and leadership of the service to improve and for the trust to prioritise PTS services alongside the emergency 999 service.

We saw several areas of outstanding practice:

- We observed many examples where staff demonstrated outstanding care and compassion to patients despite sometimes working in very difficult and pressured environments. Staff “lived” the values of the trust “Towards excellence – Saving lives and enabling you to get the care you need”.
- Representatives of the trust attended local youth organisation meetings, village fetes and school assemblies. The trust had developed a child-friendly first-aid book printed specially for schools and the wider local community.
- The trust provided an innovative learning resource to their frontline staff using the educational resource centre and film centre at Bracknell. The staff were involved in making films which supported learning around new guidelines from the Joint Royal Colleges Ambulance Liaison Committee (JRCALC).
- The trust had introduced a lifesaving automatic external defibrillator (AED) locator mobile phone application. By using GPS, this app locates the nearest AED in the event of a cardiac arrest. In total, the app identified over 800 AEDs across four counties.
- A new initiative was the introduction of a ‘Simulance’: a large command vehicle fully equipped with simulation learning activities. It was an innovative virtual classroom facility in that it gave ambulance staff the opportunity to experience realistic medical situations inside an ambulance saloon.
- Operation centres had direct access to electronic information held by community services, including GPs. This meant that the staff could access up-to-date information about patients (for example, details of their current medication).
- Trauma risk management (TRiM) was in place to provide confidential support to staff who may have been affected by traumatic incidents or conditions. Staff were assessed 3 days after a traumatic event and again after 28 days. Thirty-two TRiM practitioners gave peer support and advice, and there was also an external counselling service. The early intervention had both reduced sickness absence and improved the welfare of staff.
- The Helicopter Emergency Medical Services (HEMS) showed innovative practices and learning taken from combat zones. The team now had the equipment and skills to give blood transfusions and perform ultrasound and blood gas tests. In some circumstances, this bypassed or reduced the time a patient had to spend in the accident and emergency (A&E) department, and meant they could receive treatment immediately on arrival at the hospital. HEMS was also planning to introduce a night service, so it would operate 24 hours every day.
- The introduction of a midwife to the clinical support desk (CSD) in the Southern House emergency operation centre had improved the outcomes for expectant mothers and their new babies. The 24-hour labour line started as a pilot in May 2014. It gave women in labour access to advice and support, whereas the ‘professional’s line’ enabled medical professionals to speak to a midwife 24/7 during a woman’s labour and birth. The service had over 1,600 calls in the first eight weeks.

Summary of findings

- The trust provided a service on Friday and Saturday nights in the city centres of Portsmouth (Safe Place) and Southampton (ICE Bus) to provide support, first aid and transfer to hospital if required for the public enjoying a night out. This had been set up in partnership with other organisations such as the Hampshire Police, the local council, volunteers and the local street pastors
- The trust had a clinical lead in mental health and learning disability. This role was unique among ambulance trusts. The lead had established a national mental health group for ambulance trusts, and worked with partner agencies such as the Royal College of Psychiatrists and the College of Policing. The introduction of mental health practitioners into the EOC was supporting operational practice and care to mental health patients.
- The trust had worked in partnership with Oxford Brookes University to provide staff with extra opportunities to develop their careers by becoming a paramedic, and to counter the national shortage of paramedics. A foundation degree course was to start in January 2015. The training covered an 18-month period and included in-hours training. The trust's investment had been significant in terms of the time taken to negotiate the resources and facilities for the programme and the release of staff from work duties.

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

Importantly, the trust must ensure that:

- Staff uptake of statutory and mandatory training meets trust targets
- Staff in EOC and PTS understand the Mental Capacity Act 2005
- All EOC and PTS staff receive safeguarding training to the required level so that they are able to recognise signs of abuse and ensure there are robust arrangements in place for staff to report concerns within the agreed timescale.
- Emergency call takers answer calls, and the emergency medical dispatchers dispatch an ambulance within target times

In addition the trust should ensure that:

- Procedures for incident reporting continue to improve and staff in EOC and PTS have appropriate training and are able to report incidents directly. There must be timely investigation of incidents, staff must receive feedback and learning must be shared.
- The risks around IT vulnerability in the EOC and PTS are appropriately managed.
- Infection control practices are followed and ambulance stations (resource centres) and vehicles are effectively cleaned and deep cleaned.
- There are suitable arrangements to ensure that equipment regularly checked and fit for purpose.
- Staff are aware of the appropriate steps to take to reduce the risks to patients left unattended in PTS ambulances because of staff working alone.
- Appropriate equipment is available in all areas for the transport of children in PTS and this continues to be rolled out for emergency transport.
- Volunteer drivers in PTS have the appropriate safety and employment checks before working within the service.
- The trust to continue to work with partners and ensure the planning and scheduling of PTS improve to prevent delays and missed appointments, and to reduce the impact on the clinical care, treatment and welfare of patients.
- The governance and security arrangements for the management of controlled drugs need to be improved in Hampshire.
- Recruitment of staff in all areas continues and there are specific staff retention plans in response to identified reasons as to why staff leave.
- Staff in PTS receive appropriate training on dementia care, learning disabilities and all staff continue to receive training in mental health conditions.
- Anticipated resource and capacity risks in PTS continue to be appropriately identified, assessed and managed.
- Pain relief continues to be appropriately administered for patients with ST segment elevation myocardial infarction (STEMI) and pain relief for children is effectively monitored.

Summary of findings

- Continue to work with acute trusts to review protocols for the non- critical transfer of hospital patients.
- There is better coordination of care between providers, in particular for cardiac and stroke services in Buckinghamshire and mental health services.
- Complaints are responded to within the trust's target of 25 days. All staff in EOC and PTS receive feedback from complaints and learning is shared.
- Operations staff in PTS are appropriately resourced to be able to answer telephone calls.
- Patients (or people acting on their behalf) using the PTS are made aware of how to complain or send compliments about the service.
- Staff in PTS have regular supervision and the trust should raise awareness amongst staff about the professional and career development opportunities within the trust.
- The formal structure of team meetings is in place for all staff groups and staff are given the opportunity to attend, share information and raise issues or concerns.
- Staff have a better understanding of the trust's vision and strategy as it applies to their service in EOC and PTS and staff communication continues around service changes and development.
- Leadership in the northern EOC and PTS supports staff and action is taken to improve staff morale where this is low.
- Staff in PTS receive feedback from the completed patient satisfaction surveys.
- There are better governance arrangements within EOC and PTS to share information with staff, so that staff can raise concerns and risks are appropriately identified, assessed and managed.
- There are better governance arrangements for private providers of PTS and make ready services.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Access to the service (Emergency operations centres)

Rating Why have we given this rating?

Emergency 999 calls were triaged through NHS Pathways (which is a software system of clinical assessment for triaging telephone calls from the public based on the symptoms they report when they call). There was good compliance to prioritise and categorise calls for ambulance dispatch according to the clinical needs of patients. However, staff knowledge of appropriate dispatch times for mental health patients in crises under a Mental Health Act Section 136 and needing a place of safety needed to improve. There were dedicated triage lines for GPs and healthcare professionals, and for patients who were critically unwell and needed the air ambulance or other specialist services. Some safety processes needed to improve, such as incident reporting and raising safeguarding concerns, and some staff needed a better understanding of the Mental Capacity Act 2005. Staffing levels were a concern and staff worked long hours, sometimes without breaks. Action was being taken to manage peaks in demand but staff were not meeting target times to answer emergency calls. Long-term planning against the rising increase in demand for services was ongoing. Staff had identified the need for more effective communication with the NHS 111 service to better manage demand. The trust however, did have some of the lowest referral rates from NHS 111 to 999 services and was continuing plans to reduce these further.

The staff were supportive to patients who called in distress. They listened carefully, explained their actions and involved patients in their decisions. Clinical advisors were available to help staff and to support patients to manage their own health when appropriate. They also undertook welfare checks over the phone to ensure a patient's condition was not deteriorating while they were waiting for an ambulance. A new 24-hour labour line run by midwives had proved successful in supporting women in labour. However, the trust was below the national average for 'hear and treat', which is the proportion of calls that are dealt with based on provision of telephone advice only. The re contact rate within 24 hours of 'hear and treat' was higher than the national average in 2013-14 but had decreased this year

Summary of findings

and was below the national average in (April to July 2014). Staff had access to training but dedicated time to complete this had only recently been introduced and the uptake of some training, such as mandatory and statutory training, was low. The trust had a clear strategy for this service to provide clinical coordination of care across a range of health and social care settings, but most staff were not aware of this strategy. Governance arrangements needed to improve to support staff to share learning, raise concerns, manage risk and act on performance information. Staff worked well in their teams but some wanted better support from managers, particularly in the northern EOC. Public engagement activity was being developed further.

Emergency and urgent care

Front-line 999 services provided an emergency response to people with life threatening emergency or urgent conditions. Overall, the trust was meeting national emergency response times to respond within 8 minutes to 75% of patients who had had a cardiac arrest, had stopped breathing or had other life threatening emergencies, and to have a vehicle that could convey the patient to hospital arrive at the scene within 19 minutes. The trust had the highest percentage of for 'see and treat' in the country (that is, managing patients at the scene without the need for ambulance transfer to hospital). The re-contact rate within 24 hours of this treatment was higher than the national average in 2013-14 but was decreasing.

The trust used a Resource Escalation Action Plan (REAP) as a way of forecasting performance and service delivery. There was moderate to high pressure on the service during our inspection and the trust was communicating effectively with hospitals to align conveyancing decisions against waiting times and the capacity to receive patients. This included having hospital ambulance liaison officers (HALOs) to support the timely handover and safety of patients in A&E departments, and to monitor and respond to situations, particularly at times of increased demand for services. The trust was monitoring long waiting times and had introduced measures to ensure that people were monitored while waiting and that high-priority calls took precedence. There was an impact however on people who may be in a healthcare setting but awaiting transfer to another hospital for acute care and for people at a

Summary of findings

distance from a resource centre. The trust was taking action to reduce long waiting times and projects were planned in different areas. There was effective planning and preparation for major incidents and the trust had worked effectively with partner organisations.

The service followed safety procedures overall, but needed to improve infection control practice and the management of medicines. Staff had a good understanding of the Mental Capacity Act 2005 and of safeguarding procedures although the timeliness of reporting concerns and referrals needed to improve. The performance of the external contractor to 'make ready' ambulances was monitored but the quality of their work required better supervision and monitoring. Ambulance crews had allocated time to check vehicles but told us they spent more time rechecking vehicles to ensure they were ready for use. The trust was affected by the national shortage of paramedics and there were a high number of vacancies. The allocation and skill mix of staff were appropriate but staff worked long hours and some reported stress and fatigue.

The trust was affected by the national shortage of paramedics and there were a high number of vacancies. The allocation and skill mix of staff were appropriate but staff worked long hours and some reported stress and fatigue. There was a rising demand for services that was above predicted levels. The trust had introduced shift changes to help manage resources to meet demand in emergency services and new rotas were being introduced to further improve the work life balance of staff. The trust used private providers to ensure service cover and these providers were appropriately monitored. Staff spoke positively about the quality of care they provided for patients and said they were proud to work for the trust. There had been a good level of communication on issues and they understood the need to match resources and demand and requested further ongoing dialogue around these issues.

National evidence-based guidelines were used to assess and treat patients. Patients experiencing a heart attack did receive pain relief although this was not always the pain relief that was nationally recommended. Patients experiencing a heart attack were transported quickly to hospital. Patients that had had a stroke had appropriate care but there could be delays in their transport to

Summary of findings

hospital. Some hospital staff identified the need for better pain relief for children in certain circumstances. The coordination of emergency care with hospitals and GPs was good overall, but needed to improve for heart and stroke care in Buckinghamshire and for mental health patients in crisis across the four counties. The trust was working with its partners and had action plans to improve care in these areas. The trust had good outcomes overall for the survival of patients who had had a cardiac arrest. The trust had improved the effectiveness of action taken when staff witnessed a cardiac arrest and was fourth best in the country this year (April to August 2014) a change from eighth best in 2013-14.

Staff were caring and compassionate. They explained treatment options to patients in a way that they, or their relatives, could understand. Patients, and relatives or carers, received good emotional support if they were in distress. There was support for vulnerable patients (such as those with a learning disability), bariatric patients and people whose first language was not English.

The trust had a clear vision and strategy for the service to provide mobile healthcare and to coordinate care in hospital, the community and people's homes. Staff were supportive of the strategy and told us they worked well together in teams and with their managers. There were good governance arrangements to monitor performance and quality and to manage risks although more action was needed on ongoing risks. The performance of the external contractor to 'make ready' ambulances was monitored but the quality of their work required better supervision and monitoring. Patient engagement was well developed through a variety of channels, such as social media, surveys, newsletters and liaison work. There were many examples of innovation and improvement.

Patient transport services

Patient transport services (PTS) provided non-emergency transport for patients who, for example, attended hospital outpatient clinics or day hospitals, or were discharged from hospital. Commissioners had identified eligibility criteria for the service and the trust was working with 12 clinical commissioning groups to monitor performance and compliance. Staff followed the eligibility criteria and were also working to improve

Summary of findings

the signposting of people to other services if they did not meet the criteria. Procedures to ensure the safety of services needed to improve, specifically around incident reporting, equipment checks and safeguarding procedures. 'Do not attempt cardio-pulmonary resuscitation' (DNA CPR) orders were understood and used appropriately, but staff had limited awareness of the Mental Capacity Act 2005. Most vehicles were visibly clean. There were staffing vacancies and staff felt stretched, particularly in the dispatch team where this had an impact on the planning and scheduling of transport. The trust was using volunteers and private providers to cover driving shifts. There needed to be better governance arrangements for private providers and driving and employment checks for volunteers. Anticipated resource and capacity risks needed to be better managed. For example, problems with the new IT system had caused a serious disruption to the transport arrangements for patients during our inspection.

Dispatch staff did not always have appropriate assessment information, from hospitals or patients or from their own records. As a result patients sometimes did not have an appropriate vehicle or equipment, and transport sometimes had to be reorganised. The system to plan journeys was manual and often reactive based on a lack of timely and coordinated information and this had caused delays to patient transport. Computer aided dispatch was being developed.

The trust was not meeting performance targets and this was having an impact on patients' care and treatment. Patients were experiencing delayed and missed appointments for outpatient consultations and diagnostic scans, and renal dialysis, and some were choosing to curtail their treatment in order not to risk missing their transport home for fears of excessive delay. There were good examples of multi-disciplinary working with GPs and health professionals in hospitals. Trust had been working with other providers to improve the coordination of care and some progress had been made.

The staff were caring, compassionate and dedicated to improving the service. Training was available but many staff had not undertaken this training to support them in undertaking their roles. Patient surveys were regularly undertaken; these were positive but identified delays. Patients we spoke with were similarly positive about the

Summary of findings

staff. However, they were concerned that the service was not effective and that they were not given enough information about delays, missed appointments and the eligibility criteria. Call handlers were overwhelmed with calls about service delays and only half of all calls were answered.

Many patients told us they had been distressed and anxious waiting for transport, but did not know whom to contact within the service. There was good support for vulnerable patients (for example, those with dementia or a learning disability), and carers and escorts could travel in the ambulances too. A policy for the transport of children was under development. The trust had a clear strategy for the development of PTS to support safe non-emergency travel between people's homes and healthcare settings, but most staff were unaware of this strategy. Governance arrangements needed to improve in order to assess and manage risks. Although staff worked effectively in teams, many wanted the management and leadership of the service to improve and for the trust to prioritise PTS alongside the emergency 999 service. Patient feedback was gained through regular surveys and there were good examples of changes to improve the service as a result, but staff did not always receive the feedback from the surveys. There had been a number of innovation and improvement projects within the service.

South Central Ambulance Service (Bucks & Oxon Divisional HQ)

Detailed findings

Services we looked at

Access to the service (Emergency operations centres); Emergency and urgent care; Patient transport services

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Detailed findings

Background to South Central Ambulance Service (Bucks & Oxon Divisional HQ)

South Central Ambulance Service NHS Foundation Trust (SCAS) was formed on 1 July 2006, after the merger of the Royal Berkshire Ambulance Service NHS Trust, the Hampshire Ambulance Service NHS Trust, the Oxfordshire Ambulance Service NHS Trust and part of the Two Shires Ambulance Service NHS Trust. It provides NHS ambulance services in Berkshire, Buckinghamshire, Hampshire and Oxfordshire in the South Central region. This area covers approximately 3,554 square miles with a residential population of over 4 million. On 1 March 2012, the trust achieved foundation trust status.

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 logistics and commercial services. There is also a Hazardous Area Response Team (HART) based in Hampshire. Services are delivered from the trust's main headquarters in Bicester, Oxfordshire, and a regional office in Otterbourne, Hampshire. Each of these sites includes an emergency operations centre (EOC) where 999 and NHS 111 calls are received, clinical advice is provided and from where emergency vehicles are dispatched if needed.

The trust currently owns or leases 27 ambulance stations (resource centres), two HQ/operation centres plus additional standby points, aerial sites and support buildings, as well as 312 front-line ambulances spread across Berkshire (Berkshire consists of the following unitary authorities: West Berkshire, Reading, Wokingham, Bracknell Forest, Windsor and Maidenhead, and Slough), Buckinghamshire, Hampshire and Oxfordshire. South Central Ambulance Service NHS Foundation Trust operates a fleet of front-line emergency ambulances, a fleet of rapid response vehicles and supports the operation of two air ambulance helicopters.

The inspection included the emergency service and PTS. The 111 service provided by the trust was not inspected on this occasion. The logistical and commercial training services were also not inspected as these do not form part of the trust's registration with the Care Quality Commission (CQC).

Our inspection team

Our inspection team was led by:

Chair: Leslie Hamilton, Consultant Cardiac Surgeon, The Newcastle upon Tyne Hospitals NHS Foundation Trust

Head of Hospital Inspections: Joyce Frederick, Care Quality Commission

The team of 48 included CQC inspectors and inspection managers, an analyst and inspection planners and a variety of specialists: The team of specialist was

comprised of a consultant physician in intensive care, two nurses working in accident and emergency departments, four paramedic staff, one emergency care practitioner, a paramedic clinical supervisor and development manager, three managers with an operations role, a head of governance, a director of service delivery, two chief executives, a pharmacist, a safe guarding lead, two people with a role in an operations centre and three experts by experience

Detailed findings

How we carried out this inspection

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

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

The inspection took place on 10 and 11 September 2014 with unannounced visits on 30 September and 1 October.

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about the South Central Ambulance Service. These included local clinical commissioning groups (CCGs); local quality surveillance groups; the health regulator, Monitor; NHS England; Health Education England (HEE); College of Emergency Medicine; General Dental Council; General Medical Council; Health & Safety Executive; Health and Care Professions Council; Nursing and Midwifery Council; National Peer Review Programme; NHS Litigation Authority; Parliamentary and Health Service Ombudsman; Public Health England; the medical royal colleges; local authorities, local NHS Complaints Advocacy Service; local Healthwatch groups; and local health overview and scrutiny committees. We also reviewed information collected by Speak Out who hosted a listening event.

During our inspection, we spoke with a range of staff in the organisation including call handlers, dispatchers, paramedics, ambulance technicians, emergency care assistants, emergency care practitioners, community first responders, patient transport services (PTS) staff, the lead pharmacist, the safeguarding lead, the infection prevention and control lead, the mental health lead, operational managers, emergency operation centre managers, resilience staff and staff at director level.

We visited 10 ambulance stations, the northern and southern EOC (where we listened in to calls and observed dispatchers for the emergency service and PTS). We also visited 10 acute hospitals and one community hospital:

John Radcliffe, Oxford; Churchill, Oxford; Wexham Park, Slough; Bicester Community, Bicester; Stoke Mandeville, Aylesbury; Wycombe; Royal Berkshire, Reading; Milton Keynes; Southampton General; Basingstoke and North Hampshire, Basingstoke; Queen Alexandra, Portsmouth. At these hospitals, we observed the interaction between ambulance staff and hospital staff in the accident and emergency (A&E) areas, direct admission wards, outpatient areas and discharge lounges. We noted how people were being cared for and spoke with patients using the emergency ambulance service and PTS. We spoke with staff from the hospitals we visited about the ambulance service. We rode and observed on three emergency ambulances and two patient transport vehicles.

We would like to thank all staff, patients and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment provided by the South Central Ambulance Service.

South Central Ambulance Service NHS Foundation Trust: Key facts and data

1. Context

- Service covers - Berkshire, Buckinghamshire, Hampshire, Oxfordshire and Milton Keynes and the resident population approximately £4million (Significant rural areas).
- Health Summary: Health of population generally better than England average; Deprivation is lower than average; life expectancy is higher than the England average.
- The services has 40 sites; 27 ambulance stations; 489 vehicles of which 312 are frontline ambulances; and supports the operation of two Air Ambulance helicopters.
- The services covers 10 acute hospital sites, 2 Major Trauma Centres, 7 specialist site, 5 mental health trusts.
- Staff: 3,000.
- Community First Responders: 946
- Co-responders: 359
- The total income for the service was £162,4million in 2013/14 (£118m spent on emergency services)
- Cost improvement challenge £6.2m (2013/14): Trust achieved this target.

Detailed findings

2. Activity

- Calls to 999: 416,000 (2013/14)
- Calls to 111: 873,000 (2013/14)
- Patient Transport service Journeys: 678,000 (2013/14)

3. Safe

- **National Reporting and Learning System (NRLS reporting):** Between April 2013 and March 2014, 15 serious incidents were reported by the trust. No Never Events. Summer 2013 had significantly more incidents reported to NRLS than any other four month period.
- **Staff survey:** Worse than average for three questions relating to % of staff witnessing potentially harmful errors, reporting of errors and near misses and availability of hand washing materials.
- **Staff survey:** Better than average for % of staff felt satisfied with the quality of work and patient care they are able to deliver
- **Central Alert System:** Worse than expected for acknowledging with 2 days; similar to expected for completion according to deadline.

4. Effective

DH ambulance quality indicators

- **Better than expected:** proportion of suspected Stroke patients who receive an appropriate care bundle.
- **Similar to expected:**
 - STEMI patients being transferred to centre capable of delivering PPCI and receive angioplasty within 150 minutes of the call.
 - Ambulance calls closed with advice (where clinical appropriate)
 - Ambulance calls managed without transport to A&E (where clinically appropriate)
- **Tending towards worse than expected:**
 - Re-contact rate <24 hours following discharge of care by telephone
 - Re-contact rate <24 hours following discharge of care at the scene
- **Much worse than expected:**
- Proportion of STEMI patients receiving appropriate care bundles.

Ambulance clinical performance indicators (comparison between trusts) 2013/14*

- ROSC at time of arrival at hospital (Overall) (%) : **Rank 1 (best of all 11 ambulance trusts)**
- ROSC at time of arrival at hospital (Utstein Comparator Group *) (%) **Rank 8.**
- Cardiac - survival to discharge - overall survival rate (%): **Rank 1**
- Cardiac - survival to discharge –(Utstein comparator group *) survival rate (%): **Rank 1**
- % of patients suffering a STEMI who are directly transferred to a centre capable of delivering PPCI and receive angioplasty within 150 minutes of call. **Rank 6**
- % of patients suffering a STEMI who receive an appropriate care bundle. **Rank 11 (worse)**
- % of FAST positive stroke patients who arrive at a stroke unit within 60 minutes of call. **Rank 11**
- % of suspected stroke patients who receive an appropriate care bundle. **Rank 3**

Category Red calls (2103/14; April to June 2014)

- **Emergency response**
- Red 1: 75% of calls within 8 minutes - Target met overall
- Red 2: 75% of calls within 8 minutes - Target met overall
- **Vehicle capable of transporting a patient at the scene**

Category A calls (Red 1 and Red 2) - 95% in 19 minutes - Target met overall.

5. Caring

Hear and Treat survey 2013/14 national NHS survey programme.

25 questions on call handling, clinical advice, outcome and overall service.

- 23 questions - same as average
- 1 question - Best trust in explaining why an ambulance would not be sent
- 1 question - Worst trust in not mentioning the caller would receive a call back

6. Responsive

- **Conveyancing:** Above England average for emergency calls – proportion of incidents managed without the need for transport to A&E
- **Telephone Advice:** Below the England average for emergency calls dealt with by telephone advice only.

7. Well led

Detailed findings

- **NHSLA Risk Management Standard.** Level 1 achieved October 2012 (worse than expected)
- **Department of Health, Information Governance Toolkit** - attained either levels 2 (similar to expected) or level 3 (better than expected) on the indicators when compared to other trusts. .
- **Complaints:** 86% of complaints are being resolved within 25 days against a target of 95%.
- **NHS Staff Survey (2013).** The trust scored significantly better than average on 63 out of 91 questions; the trust was similar to average for 25 questions; the trust was rated as worse than average on 3 of the 91 questions.

8. CQC inspection history

- Four inspections had taken place at the trust since its registration in April 2010.
- Compliant at last inspection in October 2013.

Access to the service (Emergency operations centres)

Information about the service

The trust had two emergency operations centres (EOCs): one in the northern part of the South Central area based in Bicester, Oxfordshire, and the other in the southern part based in Otterbourne, Hampshire. In 2013/14, the trust received a total of 416,000 emergency 999 calls; 349,440 (84%) of calls resulted in a patient service that was either listening and treating the patient ('hear and treat'), seeing and treating the patient ('see and treat'), referring the patient to their GP, or treating the patient at the scene and taking them to hospital. Most calls, 289,766 (68%), were in the northern region.

The EOC was formed of three core sections: emergency call takers (ECTs), emergency medical dispatchers (EMDs) and a clinical support desk (CSD). There was also an air ambulance dispatch team and a special incident desk. Approximate 267 staff worked in the EOCs.

The ECTs were responsible for answering and triaging calls in accordance with clinical need. The service was using the NHS Pathways triage system. This had started in June 2014 and the roll-out was completed by 30 September 2014. NHS Pathways was replacing the Advanced Medical Priority Dispatch System (AMPDS) triage system, which was being phased out at the time of inspection.

The dispatch team was responsible for allocating calls to vehicles in accordance with clinical priority and location of vehicles. The CSD was staffed by clinicians, including specialists such as a midwife, paramedics and emergency care practitioners. It had responsibility for supporting ECTs with advice for more complex calls, ensuring welfare checks were made (particularly if there had been a delay in a vehicle arriving on scene) and providing advice to emergency responders.

During our inspection, we visited the northern EOC in Bicester and the southern EOC in Otterbourne. We spoke with 51 members of staff, including ECTs and EMDs (including emergency response assistants and emergency response coordinators), clinical advisors, paramedics, support crews, an education lead, a professional development manager, a shift controller, duty control room managers and an HR manager. We listened to 65 calls. We reviewed patient records.

Summary of findings

Emergency 999 calls were triaged through NHS Pathways (which is a software system of clinical assessment for triaging telephone calls from the public based on the symptoms they report when they call). There was good compliance to prioritise and categorise calls for ambulance dispatch according to the clinical needs of patients. However, staff knowledge of appropriate dispatch times for mental health patients in crises under a Mental Health Act Section 136 and needing a place of safety needed to improve. There were dedicated triage lines for GPs and healthcare professionals, and for patients who were critically unwell and needed the air ambulance or other specialist services. Some safety processes needed to improve, such as incident reporting and raising safeguarding concerns, and some staff needed a better understanding of the Mental Capacity Act 2005. Staffing levels were a concern and staff worked long hours, sometimes without breaks. Action was being taken to manage peaks in demand but staff were not meeting target times to answer emergency calls. Long-term planning against the rising increase in demand for services was ongoing. Staff had identified the need for more effective communication with the NHS 111 service to better manage demand. The trust however, did have some of the lowest referral rates from NHS 111 to 999 services and was continuing plans to reduce these further.

The staff were supportive to patients who called in distress. They listened carefully, explained their actions and involved patients in their decisions. Clinical advisors were available to help staff and to support patients to manage their own health when appropriate. They also undertook welfare checks over the phone to ensure a patient's condition was not deteriorating while they were waiting for an ambulance. A new 24-hour labour line run by midwives had proved successful in supporting women in labour. However, the trust was below the national average for 'hear and treat', which is the proportion of calls that are dealt with based on provision of telephone advice only. The re-contact rate within 24 hours of 'hear and treat' was higher than the national average in 2013-14 had decreased this year and

Access to the service (Emergency operations centres)

was below the national average in (April to July 2014). Staff had access to training but dedicated time to complete this had only recently been introduced and the uptake of some training, such as mandatory and statutory training, was low. The trust had a clear strategy for this service to provide clinical coordination of care across a range of health and social care settings, but most staff were not aware of this strategy. Governance arrangements needed to improve to support staff to share learning, raise concerns, manage risk and act on performance information. Staff worked well in their teams but some wanted better support from managers, particularly in the northern EOC. Public engagement activity was being developed further.

Is access to the service safe?

All 999 calls were triaged through the NHS Pathways (which is a software system of clinical assessment for triaging telephone calls from the public based on the symptoms they report when they call). There was compliance with the procedure to prioritise calls based on the emergency and urgent care people needed. Clinical staff in the operation centres gave advice to the emergency call takers, emergency medical dispatchers and ambulance crews, and escalated or downgraded calls appropriately. Welfare checks were undertaken for calls where there would be delays in the arrival of ambulance crews. Incident reporting needed to improve; staff needed to take more responsibility for the process and to receive feedback. Two serious incidents had occurred; these had not been reported internally, despite being known about, until information from external sources had been received. Learning from incidents needed to be shared with staff. They were aware of how to report safeguarding concerns, although safeguarding concerns were not always reported. The uptake of mandatory and statutory training was low.

The emergency operation centres had a high number of staff vacancies and staffing levels were, at times, not adequate to meet demand. The staff worked long hours, sometimes without breaks, to deliver the service. Minimum staffing levels had not been identified to escalate concerns. However, the service did have an escalation plan for when calls exceeded capacity and action was taken to shorten calls if safe to do so or divert calls to other operation centres. There had been an unexpected increase in overall demand for the service and specific arrangements were needed to manage the risk that this posed.

Incidents

- The Department of Health NHS Staff Survey 2013 indicated that 78% of staff reported errors, near misses or incidents witnessed in the past month; this was worse than the average when compared with other trusts.
- The trust had introduced a new electronic incident reporting system in April 2014. There was an incident reporting form that was accessible to all staff on the intranet and, since its introduction, staff reporting of incidents had increased. However, most of the staff we spoke with still did not feel supported or encouraged to

Access to the service (Emergency operations centres)

report incidents; instead of reporting incidents directly, they escalated them to their line managers to report. They therefore did not take ownership or responsibility themselves.

- There were 654 incidents reported by the trust to the National Reporting and Learning System (NRLS) between April 2013 and March 2014. These included 15 serious incidents. Two of these were in the emergency operation centre; one involved the failure of the IT call system for 70 minutes, and the other the dispatch of an emergency ambulance to an incorrect address.
- Most of the serious incidents reported by the EOC in 2013/14 were not reported as incidents at the time they occurred, and then were reported after a considerable delay. For example, two serious incidents were identified from an external source rather than by staff recognising them as incidents that should be reported. One serious incident had taken 17 days to be reported; the other, 57 days. However, preliminary information indicated that the centre was aware of the incidents immediately after they had occurred.
- Staff told us that they did not receive feedback from incidents in the EOC and that learning was not shared.
- The trust had recently introduced 'SCAScade' to improve organisational learning from adverse incidents, errors and near misses. The series focused on anonymised cases when mistakes had happened and the learning was shared with staff via the trust's intranet. SCAScade topics included patients with panic attacks; patients with central chest pain discharged at scene; patients with anaphylaxis; and intoxicated patients with head injuries. SCAScade included a reflective tool for learning from incidents. All staff were encouraged to complete the reflective activity as part of their ongoing learning. There were mixed views from staff about their awareness and the effectiveness of this process.

Cleanliness, infection control and hygiene

- There was an infection prevention and control lead who was responsible for delivering the trust's main infection control aim: 'To reduce the variability of station cleanliness'. Infection prevention and control policies and procedures were available and accessible to staff on the trust's intranet.
- The Department of Health NHS Staff Survey 2013 indicated that the trust was worse than average, when compared with other trusts, for the percentage of staff who reported that hand-washing materials were always

available. We observed that anti-bacterial hand gel was available outside the entrance to the EOC and other office spaces. There were also posters encouraging staff to use it before entering the call centre.

- Only 35% of staff were up to date with their infection prevention and control training, which was part of the trust's mandatory and statutory training programme. This was below the trust's target level of 80%.

Environment and equipment

- The buildings were secure and all areas needed ID access.
- The buildings provided a good working environment. Both the northern and southern EOCs were modern, clean and tidy environments. The offices had air conditioning to maintain a constant temperature.

Records

- The service used a computer-aided dispatch (iCAD) system to record details about patients who called. Records were initiated at the beginning of a 999 call. The emergency call takers (ECTs) took the caller through the NHS Pathways triage system by asking set questions to prioritise calls. All callers were advised of their reference number if they needed to call back.
- Records were colour-coded purple, red, orange or green to indicate priority and response. All records were visible to clinical support desk (CSD) clinicians and dispatch staff, and they were able to update them as more information became available. We reviewed a sample of 10 records and found that all patient records had been completed.
- The trust used 'special notes' about patients to share with ambulance crews. These detailed clinical information for patients with complex needs or risk information if there was a safety concern. The notes were recorded against a patient's name or address and could be cross-referenced with NHS records. The trust had undertaken a recent review to ensure that 'special notes' were up to date, relevant and accurate. We observed, for example, a 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) decision recorded against a patient's name. Information regarding a patient's DNACPR was provided by their GP.
- Computer pathway updates and version updates were communicated to senior managers and local operation

Access to the service (Emergency operations centres)

managers. The information was also sent to training and education departments to ensure that the staff were given appropriate training when changes occurred. Staff told us they were kept up to date with system changes.

Safeguarding

- There was a named executive director with responsibility for safeguarding, and a named safeguarding lead. The safeguarding team was small with one lead and three other members of staff. The trust was developing safeguarding champions to develop the agenda across the organisation, however, we did not identify any safeguarding champions in the EOC.
- In 2013, the government published statutory inter-agency guidance called Working Together to Safeguard Children. This guidance identified that, if there was a risk to the life of a child or the likelihood of serious immediate harm, then local authority social workers, the police or staff from the National Society for the Prevention of Cruelty to Children (NSPCC) should use their statutory child protection powers to act immediately to secure the safety of the child. The ambulance staff in the EOC may be the first people to become aware of a child or vulnerable adult at immediate risk.
- Staff in the EOCs had a good understanding of what safeguarding concerns might be for children and vulnerable adults, and they gave us examples of when they had made a referral. However, all the staff we spoke with reported that they had not completed safeguarding training since their induction. For some, this had been within the past year; for others, it had been more than 2 years ago. All staff were required to complete the level 1 safeguarding training as part of the trust's mandatory and statutory training programme. In 2013/14, only 41% of EOC staff had completed level 1 training against a trust target of 80%. However, the trust had rolled out level 2 safeguarding training in 2013/14 to all front-line and EOC staff, and 85% of staff were reported to have completed this.
- We noted one serious safeguarding incident alerted to the trust via a local authority safeguarding team. A patient who was the victim of domestic abuse and substance misuse had been found after taking an overdose. The incident had not been raised as a safeguarding referral by the EOC team.

- There was a standard safeguarding referral form to report safeguarding concerns. This was completed and faxed (using a secure fax number) to a secure server where it would be reviewed by a member of the trust's safeguarding team. The hard copy was then sent to the safeguarding lead through the internal post. However, because staff did not have a direct referral route to local authority safeguarding teams, there could be a delay in a local authority receiving safeguarding referrals, particularly out of hours and at weekends.

Mandatory training

- The staff we spoke with all told us that there was no dedicated time to complete mandatory or statutory training unless the training was face to face. However, changes to staff rotas and shift patterns had released some time for training for some staff. Most of the staff we spoke with said that, since induction, they had completed training in information governance but not training that related to the Mental Capacity Act 2005, incident reporting using the electronic system, or safeguarding. They also told us that, although callers could become aggressive at times, they had not received training in conflict resolution. The trust identified that staff had received training in managing difficult callers as part of the NHS Pathways training which all EOC staff had completed.
- The trust reported low levels of completion of mandatory training. From April to September 2014, 75% of staff had completed training in fire safety, 75% in resuscitation, 32% in equality and diversity, 52% in health and safety, and 9% in conflict resolution. Staff said that extra ad hoc training was well organised and helpful in their role for example, all staff had recently received face-to-face training in using the new NHS Pathways triage system.

Assessing and responding to patient risk

- The trust had introduced the NHS Pathways triage system in June 2014 to assess the clinical risk to patients and appropriately triage calls. A small percentage of staff continued to use the previous Advanced Medical Priority Dispatch System (AMPDS) while they completed their training.
- NHS Pathways enables a specially designed clinical assessment to be carried out by a trained person answering the call. Once the clinical assessment has been completed, a clinical skill set and a defined

Access to the service (Emergency operations centres)

timescale will be identified for the patient. Call handlers told us that it may take longer to triage patients with NHS Pathways, but it was more accurate and overall outcomes for patients were better. Call handlers were able to get advice from the senior call takers and clinicians in the CSD. All the calls we witnessed were triaged and categorised appropriately according to the patient's clinical need and priority.

- The emergency care practitioner clinical lead told us that NHS Pathways triage system elicited more Red calls (needing an emergency response) than the AMPDS, but they had the ability to upgrade or downgrade a call. The CSD clinicians listened to 999 calls and could interject and advise the ECT to hand over a call. They would downgrade a Red call to green if it was clinically safe to do so and offer the patient an alternative route to help (for example, telephone advice). We reviewed a sample of 10 calls that had been downgraded and the change in the clinical assessment of the patient was appropriate.
- EMDs were aware of the skills mix of the crews (for example, whether the vehicles had paramedics or technicians on board). This helped with selection and speed in sending crews to incidents. The nearest rapid response vehicle (RRV) was dispatched and ambulances were dispatched to provide appropriate conveyance for Red (emergency) calls. There were concerns that RRVs were not always supported by an ambulance response. The trust was participating in a pilot scheme within the M27 catchment area to prioritise ambulance response to an RRV already on the scene.
- The CSD clinicians would undertake a welfare check on a patient if there was a delay in responding to them in accordance with the assigned category. This also led to a call being upgraded or downgraded depending on whether there had been an improvement or deterioration in the patient's symptoms. We saw examples in the 'late response' report of calls being upgraded because the patient's condition had deteriorated. We observed CSD clinicians make follow-up calls to patients for welfare checks, to assess them while they were waiting for an ambulance or following up on the advice given.

Staffing

Staffing levels

- In July 2014, the trust reported 45 (17%) vacancies against a planned target of 24. The sickness rate (April to July 2014) was 6% against a target of 5.4%, and 8.8% of employees were leaving against a target of 4.9%.
- ECTs and EMDs worked 12-hour shifts in the northern EOC and had a 45-minute break period. ECTs in the southern EOC worked variable shifts for 8 hours, 10 hours or 12 hours over a 30-week rota pattern. Most staff felt that the 12-hour shift, which the trust was working towards, was too long. Supervisors and team leaders covered shifts over a 24-hour period. A duty manager worked office hours but could be contacted outside office hours.
- There were a small number of bank staff who could be called on at short notice but this was a limited resource because of the specialist nature of the roles within EOCs. Staff would be sent a text asking if they wanted to work an extra shift in an attempt to boost staffing numbers on a given shift.
- Trust data showed that there was regular use of bank staff but this did not cover all shifts. The trust provided some figures for July and August 2014 in Northern EOC. Over a 42 day period an average of 8.30 wte staff per hour out of 21.56 wte staff per hour were on duty (this was on average during a 24 hour period).
- Staff in the northern EOC told us they were "very busy" but, when they were fully staffed, a typical shift was manageable. However, they said that the emergency operations team, and particularly staff in dispatch, often worked with less than the required number of staff and the vacancy rate for dispatch assistants was high. Staff told us that the dispatch desks, particularly those in the busiest area in the east and south did not have a full complement of staff and action was not always taken to resolve this.
- Call handlers in the southern EOC told us that, since the introduction of NHS Pathways, the numbers of 999 call handlers per team had reduced from 12 to 5. Staff expressed concerns about calls taking longer to triage and the EOC being under-resourced.
- The staff we spoke with told us that it was stressful when they were short of staff on a shift, and there was an increased risk of mistakes due to human error. Calls also took longer to answer and would 'stack' in a queue.
- The trust recorded staffing levels on a shift summary report, and shifts that were short-staffed for a significant length of time were reported as incidents. We saw examples in shift summary logs of staff sickness which

Access to the service (Emergency operations centres)

on occasions had affected the performance of the EOC. There were some instances when a department was severely short-staffed. The shift report did not give the number of staff who should be working on a given shift; therefore, it was not possible for managers to accurately consider the severity of the staff shortage. Sickness absence was mentioned, but it was not clear to what extent the staff shortage was due to vacancies or sickness absences.

- The trust's operations directorate escalation policy was for an increase in activity but this did not cover staffing levels, which could also have a significant impact on the ability to meet demand. There was no minimum staffing level to trigger action and managers told us that, "We have a fair idea of how we would do things." Action was being taken to respond to demand. If the northern centre was under pressure, calls would be diverted to the southern EOC and vice versa. The trust also had a 'buddy' site in the Bedfordshire and Hertfordshire region to which calls could be diverted.

Recruitment and retention

- There was a high vacancy and staff leaving rate in the northern EOC, and in particular among the EMDs. Staff we spoke with told us that this was because of the pressure they were under and the lack of support from management. However, managers informed us that the staff were leaving because they were taking up different posts within the service, usually a promotion.
- We reviewed the recorded reasons for people leaving the EOCs over a six-month period. We found that 84% of staff had not stated their reason for leaving, while 5% reported that they had left because of work/life balance; the rest had left due to retirement, the end of a fixed-term contract, or for further education or training. None reported leaving for relocation, internal transfer or promotion. The staff we spoke with in the northern EOC reported that other staff had left because of stress and work/life balance.
- The trust's risk register identified the 'inability to retain staff' as a risk. The trust's action was recorded as 'Review of progression opportunities for all grades of staff through the workforce board'. The action did not include responses to stress, work/life balance or support from managers.
- Staff issues were reviewed by the department. Minutes of the EOC senior staff meeting for May and July 2014

included discussions about recruitment. It was recognised that recruitment for the northern EOC was an issue and that advice from external organisations should be sought.

- The trust had changed its recruitment process. Previous recruitment drives had taken place every three months but this had recently changed to monthly to improve the vacancy rate. It was too early to evaluate the impact of this change.

Anticipated resource and capacity risks

- The trust had planned for a 3.2% increase in demand in 2014/15 but the actual increase was significantly higher at 8.3% in July 2014. The trust's monthly performance report stated that "demand remains higher than planned which has adversely affected response times". Managers were unaware as to why demand was much higher than predicted.
- During periods when there was a high volume of calls, the trust had a set procedure called 'urgent disconnect' to ensure that another call could be taken as soon as possible. This procedure was only to be initiated after an instruction from an EOC supervising officer or the duty manager, and it was only for immediate call delays and not an extended period. The process meant that a call could be ended if it was safe to do so and advice could be given via a recorded message.
- Staffing rotas were aligned to peak periods and there were plans to move staff from Southern House to Northern House in the event of an emergency.
- The northern EOC had introduced the NHS Pathways triage system in June 2014, after the successful implementation of a pilot in the southern centre. Managers reported that the roll-out of the system was planned as a staged process over a four-month period. The staff we spoke with told us the implementation process had worked well. Patient safety incidents and complaints had not increased during the period. During our unannounced visit we identified that the roll out had been completed and staff were using NHS Pathways.
- The staff we spoke with also told us that the computer-aided dispatch system regularly 'froze' and they had to log out every 4 hours to prevent this from happening, although this did not seem to make any difference. Also, this did not affect all terminals at the same time. Some staff said this happened regularly, often up to four or five times a shift, and could last up to

Access to the service (Emergency operations centres)

15 minutes; we witnessed an example of this. Other staff said it did happen but less often: perhaps once or twice every four to five shifts, the system only froze for an average of 30 seconds. The trust IT department was working to resolve the problem but it had been ongoing for several months.

- Staff told us that there had been no instances of IT failure having had a significant or long-term impact on the service. Downtime was usually temporary and in these circumstances paper documentation was available to record information. Calls and dispatch arrangements for the trust could be temporarily managed by either the northern or southern EOC if one area was affected.
- The trust had a winter/summer pressure procedure to deal with seasonal risks.

Response to emergencies and major incidents

- Details of the duty control room manager and lead managers on duty for a shift were on display in the EOC offices. Also on display were the names and pictures of staff at different levels of seniority – bronze, silver and gold (the most senior) – in the organisation who would be responsible for dealing with major incidents.
- The trust used the Resource Escalation Action Plan (REAP) as a way of forecasting performance and service delivery over the next week. This was influenced by key influencing factors, such as increases in demand, seasonal or weather changes, or disruption to staffing levels. Six REAP levels were identified nationally with level 1 being considered as functioning as normal and level 6 classified as potential services failure. Mitigating actions were made depending on the REAP score. At the time of our inspection, the trust was operating REAP level 3, indicating moderate to high pressure on the service. The team leader communicated this daily to the emergency operations team. The CSD clinicians showed good understanding of the Resource Escalation Action Plan (REAP) for periods of high demand and were aware of the level at the current time, which was level 3.
- Severe weather and specific IT issues were recorded as potential risks on the operations directorate's risk register. There were plans to respond to such instances. In 2013, the area had experienced heavy flooding in the Thames Valley and staff reported that the floods had been managed well.

Is access to the service effective?

Since the NHS Pathways system had been introduced in the trust, calls were triaged appropriately and response times were allocated based on the clinical needs of patients. However, staff did not have knowledge of appropriate response times for mental health patients who needed a place of safety (Section 136 of the Mental Health Act 1983). Rapid response vehicles (RRVs) or ambulance crews were also dispatched in accordance with clinical need and priority. The performance target for answering calls within 5 seconds was not being met and the average length of time was 40 seconds in the northern emergency operation centre (EOC). The service took over 1 minute to deploy an ambulance or a rapid response vehicle (RRV) to an emergency call. This was above the trust's targets for 30 and 60 seconds, respectively. The trust was below the England average when compared with other trusts for 'hear and treat', which is the proportion of calls that are dealt with based on provision of telephone advice only.

Multidisciplinary working arrangements worked well and the trust had good links with external organisations. The staff training was being supported, although this training happened during quiet times; dedicated training time had recently been introduced. Staff had been appropriately trained on the new NHS Pathways system. Staff could apply for funding to support their continuous professional development and career aspirations, and specialist training was available (for example, on learning disabilities, dementia care, end of life care, infection control and mental health awareness). There was little awareness of the Mental Capacity Act 2005 or Deprivation of Liberty Safeguards (DoLS).

Evidence-based care and treatment

- The EOC used the NHS Pathways triage software system to manage 999 calls and ensure that patients received the appropriate care in accordance with clinical need. The Advanced Medical Priority Dispatch System (AMPDS) was being phased out by September 2014. There were slight differences in clinical outcomes between the two systems; NHS Pathways aimed to increase accuracy and prevent the dispatch of emergency vehicle when they were not needed.
- Staff were using the triage systems appropriately to triage patients. Emergency call takers (ECTs) used the

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question prompts that were displayed on the screen and asked the questions in order to progress the call and reach the appropriate clinical outcome. They would continue with the questioning until the triage system advised of the best clinical response. The system could be overridden by a supervisor or clinician working on the clinical support desk (CSD) if necessary.

- If initial questions indicated that an emergency vehicle was required, arrangements were made by the dispatch team. The dispatch team managed the allocation and prioritisation of vehicles in accordance with clinical need, and instructed vehicles to attend the scene. The dispatch operators had an overview of where ambulances were, and which call each crew was responding to. They allocated and reallocated calls as needed, in accordance with clinical priority.
- All policies and procedures were accessible to staff via the trust's intranet, and had been updated in line with national guidelines. Staff told us that changes in policies and procedures were passed on to them via email or the 'Staff Matters' newsletter.
- The shift control officer said that they monitored and reported on performance against national targets on a 4-hourly basis.

Assessment and planning of care

- All 999 calls were triaged through the NHS Pathways or the AMPDS triage system.
- The CSD was staffed by clinicians, including specialists such as a midwife, paramedics and emergency care practitioners. The clinicians could interject into calls and downgrade or escalate as necessary to ensure that appropriate assessment took place.
- Call handlers told us that they would follow the mental health pathway for patients under Section 136 of the Mental Health Act 1983 and would hand patients over to clinicians in the CSD for assessment and advice.
- The trust had introduced mental health practitioners into both the EOC's to better support patients.
- The trust had identified the need for more mental health advice and support to the CSD and was in discussions with the local mental health trust.

Care delivery

- ECTs allocated response times to attend patients in terms of clinical need as well as a patient's individual circumstances. We observed, for example, a call about

an older patient who had fallen in the garden and needed assistance to get up. This was assessed as needing a 20-minute response time because of the person being outside.

- A survey of EOC emergency medical dispatchers in the north in May 2014 confirmed that the Section 136 protocol response time of 30 minutes was operational. ECTs however, did not always identify or allocate the correct response times for mental health patients. For example, call-handler staff in Southern House told us that the response time for Section 136 patients was under an hour and that the 30-minutes time had not come into operation.

Response times

- In April to June 2014, the trust was responding within the target time of 5 seconds in 87% of cases, against a trust target of 95%. During the inspection (September 2014), the trust was taking an average of 40 seconds to answer a call. Managers in the northern EOC told us that this was because of staff shortages within the department. The average call length was 6 minutes and 24 seconds.
- There had been an increase in calls taking more than two minutes to be answered; in the northern EOC, for example, the number of these calls was 69 in April 2014, rising to 184 in July 2014 with a slight decrease to 132 in August 2014. The staff told us that, when calls were 'stacking', the manager could advise them to follow the 'urgent disconnect' procedure.
- The trust was better than the England average for the proportion of calls that were abandoned before being answered in 2013/14. The trust had abandoned 0.6% of calls compared with the England average of 1.2%. The figure remained low at 0.7% in April to June 2014.
- The trust had a target to ensure that vehicles were dispatched within 30 or 60 seconds for Red 1 and 2 calls, respectively, if a trigger word was mentioned by the caller (for example, chest pain). Data for June and July 2014 identified that average times for Red 1 dispatch was 1 minute 20 seconds, and for Red 2 it was 1 minute 33 seconds. We could not find data on the average times for an ambulance to follow up an RRV.

Patient outcomes

- The proportion of calls dealt with based on telephone advice ('hear and treat') was 4.5% in 2013/14, against the England average of 5.9%. The trust was below the

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England average for 2013/14 and in the first 3 months of 2014/15 for the proportion of calls dealt with by giving telephone advice only. However, the trust's integrated performance report showed that it was performing better than expected (April to July 2014) against its own target, with a rate of 5.1% compared with the trust target of 4.6%.

- The trust was tending towards worse than expected when compared with other trusts for the re-contact rate within 24 hours after discharge of care by telephone. The measure was only used as an indicator because it was based on the same patient address but could be a different person or a different condition. In 2013/14, the re-contact rate for the trust was 19.2% compared with the England average of 9.6%.
- The trust had changed how the re-contact rate was measured and was now more precise about address and gender of caller. For April to August 2014, the re-contact rate had improved and was 6.5% compared with the England average of 8.10%.
- The staff in the northern centre told us that regular audits of calls were undertaken.
- The CSD midwife gave advice and support to paramedics. They told us that, since their introduction to the team, there had been a decrease in the number of babies born before arrival at hospital. They also told us that they gave telephone support to crews working in the north of the trust area.

Competent staff

- The staff we spoke with told us the induction process was a positive experience and they were well supported through this period. Induction included face-to-face training sessions covering elements of mandatory requirements as well as training specific to the person's role. Time was spent listening to 'live' calls and undertaking role-play exercises. Staff were trained in using the computer systems relevant to their role. After the induction process, new employees were given a period of mentorship, which meant they were supported by a mentor for more than 20 shifts. All staff had their competencies assessed before working unsupported.
- Most staff training was provided online and staff reported that they completed training during quiet

periods. Managers told us that the trust had recently included training time in staff shift rotas to enable staff to undertake training. We asked for evidence of this but did not receive any documentation.

- Staff said that extra ad hoc training was well organised and helpful in their role, for example, all staff had recently received face-to-face training in using the new NHS Pathways triage system.
- The trust provided a half-day's appraisal training to supervisors and team leaders. Staff were also given training on appraisals and how to make them meaningful. The staff we spoke confirmed that they had regular one-to-one meetings with their line manager and that they had had an annual appraisal: 88% of staff had completed an appraisal against the trust target of 90%.
- All staff were able to apply for continuing professional development (CPD) funding to help them in developing their careers. Applications were considered by a panel of three trust personnel. Staff were given support to undertake academic qualifications such as GCSEs, A levels and degree courses that included training for paramedics. They told us that 182 staff had accessed further training through the CPD fund.
- The trust had recently made an arrangement with Eastleigh College to provide vocational training courses. For example, there was training in learning disabilities, dementia care, end of life care, infection control and mental health awareness. The training was undertaken remotely by using a training pack. A number of call handlers and dispatch staff confirmed that they were working towards a level 2 in mental health awareness.
- Staff received regular updates on standard operating procedures but were sometimes unclear about specific actions. They were asked to speak to their managers if they needed extra information but often managers were no more knowledgeable because they were emailed at the same time.

Coordination with other providers

- The ECTs and EMDs in Hampshire worked closely with the coastguard when dealing with emergencies at sea, and they would coordinate response depending on the nature of the incident.
- The staff had local arrangements to call for police presence as and when needed.
- There was a dedicated line for urgent GP referrals and this could also be used to book ambulances. The trust

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organised training days for local GPs to further their understanding of the ambulance services and when to use emergency and urgent calls. These promoted good working relationships.

- There were arrangements with external mental health teams to ensure that ambulances were scheduled in advance if a patient was likely to be sectioned during a visit from a mental health worker. Workers would call using a dedicated line to inform the service of the date and time an ambulance was needed.
- Information was received from GPs and recorded on the computer-aided dispatch (iCAD) system. This included 'Do not attempt cardio-pulmonary resuscitation' (DNA CPR) instructions. Staff in emergency control rooms shared information with ambulance crews as needed.
- In April 2014, the trust instigated a project to improve the level and use of information recorded on 'special notes'. This was agreed with commissioners. The aim of the project was to reduce the number of patients being taken to an accident and emergency (A&E) department if they could be cared for in a community setting.

Multidisciplinary working

- We observed good multidisciplinary teamworking between the ECTs, clinical advisors and dispatch staff.
- The midwife based at the southern EOC told us that they worked as part of a rota with other midwives. This rotation included working in the community, which enabled them to ensure that their skills and knowledge were up to date.

Consent & Mental Capacity Act

- The staff we spoke with reported that they had not received any training on the Mental Capacity Act 2005, although it had been 'lightly' covered as part of their induction. This had been identified as an area for improvement by the trust.
- The staff had some understanding of patients' capacity. If they had concerns about a patient's capacity (for example, because of a learning disability, mental health condition) then they would ensure that an ambulance was sent according to clinical need. However, the staff did not understand that a person could temporarily lack capacity. Some told us that, if someone was intoxicated, they would try and persuade them to accept the offer of

an ambulance, but, if they refused, they would not send an ambulance. The trust had had one serious incident that had occurred relating to a patient who was intoxicated.

- A person's mental capacity could be assessed using the mental health care pathway and, if necessary, the ECTs told us they would hand the caller over to the CSD clinicians for further assessment and advice.
- Staff in the EOCs had been offered the opportunity to undertake further training relating to mental health. The Level 2 Certificate in Mental Health Awareness awarded by the Northern Advisory Council for Further Education (NCFE) would cover the Mental Capacity Act 2005.

Is access to the service caring?

Emergency operations centre (EOC) services were delivered by caring and compassionate staff. We observed staff talking to people in a compassionate manner and treating them with dignity and respect. The staff listened carefully to what was being said, checked information when necessary and were supportive and reassuring when responding to people calling in distress. Clinical staff on the clinical support desk (CSD) did welfare checks, calling people who had not been identified as needing an urgent response, to make sure they had not deteriorated. They also provided a 'hear and treat' service, advising patients on how to manage their health needs themselves.

Compassionate care

- Staff spoke to people in a compassionate manner and treated them with dignity and respect. They listened carefully to what was being said and rechecked information when necessary.
- We observed staff who were polite and professional with people who had dialled 999 inappropriately.
- The 'hear and treat' survey was the first telephone survey conducted by the national NHS survey programme in 2013/14. It surveyed callers 18 years or older who would have received telephone triage and advice from trained clinical support advisors when calling 999 in December 2013. Patients who had used the service were asked a series of questions about how well the staff and clinical advisors working in EOCs had performed in listening and communicating. Overall, the trust performance was similar to that expected nationally. One question was worse than expected for

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staff explaining whether or not the caller would receive a call back; one question was better than expected for staff explaining why an ambulance would not be attending.

Involving people as partners

- We observed emergency call takers (ECTs) speaking to people in a calm manner. They clearly explained the outcome of the call to the caller (that is, whether the caller should seek further advice from their GP, attend an urgent care centre or await an ambulance).
- ECTs listened and responded to callers' questions and clearly communicated further advice or actions that would be needed. Staff made sure the caller had understood any action they should take when the call had ended.
- Staff told us people sometimes became angry or upset if an ambulance was not needed and other advice was given. Although this did not happen often, there was a set procedure to follow should it occur.

Supporting people to manage their own health

- The CSD, which was staffed by nurses and emergency care practitioners, was able to provide immediate clinical advice and support to patients, ambulance crews and responders. The service offered 'hear and treat' help to patients, which included advising them to contact their GP or how to manage their own health needs. Information was available to patients about the CSD service, including contact numbers for obtaining further advice.

Providing emotional care and support

- We observed staff being supportive and reassuring in their responses to people calling in distress.

Is access to the service responsive?

Emergency calls were triaged through NHS Pathways and patients were allocated to the appropriate care pathway. This could be an ambulance, a GP appointment, or care in their own home or another community setting. Patients who were critically unwell and needed the air ambulance or specialist services had a separate triage process. GPs and staff in community hospitals had a direct line to call and were triaged separately. Staff in community hospitals told us that there could sometimes be delays in transferring patients to an acute hospital.

Information on frequent callers to the service was being used to coordinate care with GPs and manage demand. There was support for people who had difficulty accessing the 999 emergency call service because they could not speak English or they had hearing difficulties or a speech impairment. Information was available to meet the needs of patients who had a complex or chronic clinical condition. Complaints were handled appropriately but the investigation and response was taking longer than the trust's target time of 25 days. There was evidence of action as a result of complaints but some staff had not received feedback and learning was not shared.

Service planning and delivery to meet the needs of local people

- Most patients accessed the service directly by dialling 999 and were triaged according to the NHS Pathways national triage system based on clinical needs. The clinical outcome was communicated to the caller, an ambulance was dispatched if appropriate, or the caller or patient was advised to take other action (such as seeing their GP within a given time frame or visiting a minor injury unit).
- The trust had a Helicopter Emergency Medical Service (HEMS) desk in the EOC and this was used to identify cases for the air ambulance, Hazardous Area Response Team (HART) and pre-hospital care doctors (BASICS). The desk was staffed by paramedics who were able to liaise with ambulance crews, specialist crews and other emergency services to ensure that critically unwell or injured patients received high-quality timely care.
- GPs had a dedicated call line and were able to advise the ECT which category a patient fell into (for example, if an ambulance was needed within the next 30 minutes). There was also a dedicated line for mental health professionals wanting to arrange an ambulance for a predetermined time.
- The trust was working with commissioners to have an inter-agency policy and referral pathway for mental health patients and those with a learning disability or living with dementia. This was to be completed in 2013/14 to improve pre-hospital care. We did not see the outcome of this work as the implementation of these plans were still in progress.

Access and flow

- The dispatch team had responsibility for ensuring that a suitable vehicle and crew were sent to the scene. This

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could be a community first responder or a rapid response vehicle (RRV), depending on who was closest to the scene and which was clinically appropriate. A double manned ambulance (DMA) would also be dispatched at the same time.

- Staff in community hospitals expressed concern about the time allocated to transfer patients once an ambulance was called for acute care. They told us triaging system took time and they were unable to advise which category patients fell into, despite the fact that they were healthcare professionals.
- The trust had a database for frequent callers and this had started to be used to follow up with these patients' GPs to coordinate care.
- The dispatch team was appropriately alerted to patients with a known clinical condition or needs (for example, bariatric patients to ensure that an appropriate vehicle with the correct equipment was sent to the scene).

People are cared for in consideration of their needs

- The service had access to an interpreter service. The staff we spoke with told us that the service worked well and they could always access an interpreter when they needed one.
- People who were deaf, hard of hearing or speech-impaired could contact the trust by texting from mobiles once they had registered their mobile on the emergency SMS website. This facility was available in any type of emergency and was for people who could not use the standard 999 voice service or the text relay services provided by Action on Hearing Loss (the new name for RNID).
- Advance decisions about a patient's 'Do not attempt cardio-pulmonary resuscitation' (DNA CPR) status were communicated to the service via their GP. A note was recorded on the computer system and staff gave this information to the emergency crew responding to the call.
- The clinical advisors undertook welfare checks and called patients when an ambulance had not arrived within the target time frame, or if clinically appropriate to do so. Ambulance crews could also contact the clinical advisors while tending to a patient, if they needed support and advice.

Learning from complaints and concerns

- The trust had a complaints policy document to demonstrate best practice. Staff told us that they knew what to do if someone wanted to complain. They were aware of how to access the trust policy on handling complaints via the intranet.
- We found that complaints were handled in line with the trust's policy. Initial complaints were dealt with by senior staff on duty. If they were unable to deal with a patient's concerns satisfactorily, they would direct the patient to the Patient Advice and Liaison Service (PALS). PALS acknowledged the complaint immediately and responded to it within 5 working days. If the person still had concerns, they would be advised how to make a formal complaint.
- The trust's standard operating procedure showed that it would provide a formal response to a complaint 25 days after the complaint had been received.
- In 2013/14, the trust received 382 complaints; 81 (21%) of these complaints related to the emergency operation centre service. The main areas of complaint were noted to be about non-attendance of vehicles and staff attitude in relation to communication.
- The trust reported 23 formal complaints for the northern control centre between 1 April to August 2014. We did not see any data for the southern control centre. Twenty-one complaints related to delayed or non-attendance of an ambulance, 17 of these complaints were up held or partly up held. Two related to staff attitude and were partly up held. Ten complaints had taken in excess of 50 days to be closed.
- The control room duty manager told us that six or seven complainants a month were directed to PALS.
- Staff received individual feedback about complaints. One call handler told us of a complaint by a colleague about the way that they had handled a call; this had been investigated and the call audited. Overall, the call handler felt it had been a constructive experience with a positive outcome.
- Most staff, however, told us that complaints would be passed on to the senior staff member or shift leader on duty, and that in general they did not receive feedback about the outcome of complaints.

Is access to the service well-led?

The trust had a strategy for the service to develop clinical coordination centres across health and social care. Most

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staff we spoke to were unaware of the trust's specific vision or strategy for the service but recognised the trust's values. There were formal team meetings every three months but staff could not always attend these if they were not on duty. Dedicated time to attend had recently been introduced. Staff teams wanted individual team meetings more often to improve communication. The service monitored operation performance against national requirements and on a daily basis. Actions were noted to improve service performance and the performance of individual staff, but it was not recorded what action senior staff were taking in response to performance issues. Staff had also identified the need for more effective communication with the NHS 111 service to better manage demand. The trust did however, have some of the lowest referral rates from NHS 111 to 999 services and was continuing plans to reduce these further. Not all service risks were appropriately identified and sometimes mitigating actions were neither clearly identified nor recorded.

Staff had mixed views about the leadership and culture in the service. Some staff reported they did not feel supported by managers and it was 'all about targets' particularly in the northern EOC; others felt well supported by approachable managers. Most staff felt well supported within their teams and worked well with colleagues. There had been public engagement to encourage people to use the service appropriately, but feedback initiatives had not been developed. The service had identified areas where there had been improvements and innovation.

Vision and strategy for this service

- The trust's five-year strategy for the emergency operation centres was to develop clinical coordination centres. The trust aimed to amalgamate the service into a single virtual call centre and online centre; to increase the support to pre-hospital and out-of-hospital care; and to enable people to manage their own health when appropriate. The service aimed to provide:
 - rapid streamlined clinical assessment;
 - signposting with a comprehensive directory of clinical services;
 - direct access to clinical pathways with clinical networks, trauma teams, GPs and out-of-hours services;
 - advice and welfare checks for people who were ill, injured or concerned about their health; and;

- new technical developments, such as image transfer and mobile diagnostics.

- The trust's values for 2014/15 aimed to deliver high performance through teamwork, innovation, professionalism (setting high standards) and caring. Its vision was encompassed in the strapline "Towards excellence – Saving lives and enabling you to get the care you need".
- Most of the staff we spoke with were unaware of the trust's vision and strategy for the service. Some knew that there was information on the intranet that they could access. Staff told us that trust values were emphasised to them from day one. The staff were able to engage with the trust's values.
- The trust's vision and values were on display in the emergency operation centres.

Governance, risk management and quality measurement

- Team meetings were held for all staff groups but they were informal and actions were not recorded. There was no evidence of any issues being shared with senior management or issues from higher-level meetings being shared with the teams.
- There was a clear governance structure of meetings for emergency call takers (ECTs). These were held every three months; the issues discussed were reported to the control duty manager meetings, which reported them to the trust's Level 2 meetings, which reported them to the trust-wide senior EOC team meetings. Staff who were not on duty would not attend and, to encourage attendance, the trust had allowed staff not on duty to claim the time back. Staff were unable to comment on whether this had increased attendance because there had not been a team meeting since it had been introduced. Staff felt there should be team meetings for individual teams to improve communication, but EMDs and the clinical support desk (CSD) clinicians did not have a similar team meeting structure.
- The trust had an Aqua Team that audited all calls and monitored operational performance against national requirements on a daily basis. All calls were recorded and audited on a random basis. Calls were audited using the Pathways audit tools to ensure consistency and fairness.
- The EOC educator told us that all call handlers had three of their calls audited each month, and needed to

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show a minimum of 85% compliance. Call handlers told us they would receive written feedback on their performance. Poor performance (scoring under 86%) was followed up by line managers, and further training and support would be provided.

- Operation performance meetings were held monthly and discussed performance measures such as long waiting times; actions were noted. We requested the two most recent sets of minutes for the northern EOC Level 2 meetings but were provided with one set of minutes for July 2014. We could not see any evidence that call-answering times, number of calls stacked or abandoned, or number of calls with a vehicle arranged within 30 or 60 seconds (if relevant criteria had been met) had been discussed. Nor was there evidence that complaints, incidents or audits had been discussed.
- We reviewed the senior EOC minutes for the meetings held in May and July 2014. We saw that a range of issues had been discussed. Staffing and training had been agenda items at both meetings, although training focused on the NHS Pathways system and did not consider staff completion of mandatory or statutory training. Call-answering times were not reported in the May minutes but were noted in the July minutes, which stated, "At the weekend, call answering time was between 37 and 48 seconds"; there was no evidence of discussion about this, what the performance had been for the month, the likely reason, or how it could be improved.
- The complaints process had been discussed at one of the senior EOC meetings. However, details of the number or types of complaints had not been discussed.
- The operations directorate maintained a risk register. This included a range of risks specific to the EOC (for example, loss of IT, impact of rolling out NHS Pathways). Other risks were generic, affecting all operations (for example, severe weather conditions and inability to retain staff). The head of the northern EOC told us that all the risks had been considered and incorporated into the operations directorate risk register. However, we did not see all key risks listed. For example, the vacancy rates for dispatch staff, the higher than predicted demand, the increased potential for errors and the low uptake of mandatory training were all missing from the register.
- The risk register identified a risk and reported on the current situation, the likely impact and the mitigating controls in place. The risk-scoring system, however, was

not consistent. Each risk was scored before mitigating actions had been considered. Most of the risks had relevant information recorded against their likely impact and mitigating factors, although this was not the case for all. For example, the risk "Impact of rolling out new call triage system" recorded the likely impact as, "Managed through Project Board work streams". This did not consider the potential impact if the project plan did not operate effectively. Another example of a risk was "Inability to retain staff"; the mitigating action was "Review of progression for all grades of staff". However, there had been no consideration given to the cause of failure to retain staff.

- The staff we spoke with were aware of the whistleblowing policy and said that they would use this approach if they had serious concerns.

Leadership of service

- There was a clear leadership structure: ECTs reported to senior ECTs who in turn reported to the shift leader along with the dispatch operators and CSD, who reported to the duty manager. The duty manager was accountable to the head of EOC, who was accountable to the assistant director of operations. Roles and responsibilities within the teams were well defined and clear.
- Staff were aware of the management arrangements and told us that managers were visible within the department. The visibility of the trust directors and senior managers varied, although most staff knew at least one of the directors.
- Staff had mixed views about leadership. Most staff in the southern EOC told us they felt well supported by their line managers and worked well as a team. One member of staff spoke positively about the leadership of the head of the EOC and the changes that had been made (for example, virtual centres in the north and south). However, some staff in the northern EOC told us about the lack of support from managers.
- Staff told us about the monitoring of calls and the support if performance fell, but they felt there was little recognition from managers when they had done something well.
- We were told that in addition to the staff survey, staff had the opportunity to provide feedback at their one to one meetings with their line manager as well as their annual appraisal.

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- Overall, the trust had referral rates of 8% from NHS 111 to 999 services, and these were better than the service level agreement performance of 10%. Some staff told us that they were frustrated by the referrals from the NHS 111 also run by the trust. They considered that NHS 111 did not understand the impact that categorising calls as red had on the rest of the service. They considered that communication between the services was not always effective and the staff felt this should be improved by senior managers to make the services work as efficiently as possible. The trust, in fact, had some of the best referral rates achieved by services in the country and were continuing plans to improve these against the increase in demand for services.
- Staff we spoke from the northern EOC had mixed views about the culture within the service. All staff we spoke with reported positive teamworking; however, most felt that there was a lack of openness and that they would not share concerns with managers. Some staff reported that they found managers to be 'punitive', which would prevent them from being open. Others reported that they themselves would raise concerns because they were 'outspoken', but that they could understand why other staff members may feel uncomfortable about doing so; they commented that there were managers who were approachable but others who were not. A small percentage of the staff we spoke with reported that they were satisfied with management.

Culture within the service

- We found that staff were proud to work for the trust, liked the uniform and what it represented, and felt that they had an important role.
- They said they worked well as a team, supported each other and enjoyed their work. For example, one member of staff told us how they gave clinical advice to junior members of staff to ensure a supportive culture in the EOC.
- Staff told us they had confidence in their immediate staff colleagues, they worked well together and there was respect between people with different roles and responsibilities. One person described their colleagues as "family". We observed EMDs carrying out welfare checks to colleagues when they had attended a scene and found a person 'dead on arrival'. A call dispatcher told us that they would radio crews to speak to them rather than text.
- The staff told us that, with the change in shift patterns, they might not see their line managers so often, but they felt able to approach other managers on duty.
- Teamwork across the different disciplines within the control room was seen positively by some staff. However, others felt the layout of the room needed to be addressed to promote closer collaboration between the ECTs and EMDs. Most staff felt there was good teamwork within their teams, but that the lack of communication between the ECTs and EMDs could affect patient safety and efficiency.
- Staff morale varied with some staff being very positive while others felt that their views were not being listened to. The staff were concerned that experienced staff were leaving.

Public and staff engagement

- The trust had started an inappropriate use campaign. This asked members of the public to call 999 for emergencies and life-threatening situations, and to directly combat hoax and other inappropriate calls. The campaign involved giving information and showing a hard-hitting video to the public that illustrated how lives were put at risk when 999 was called inappropriately.
- The trust had organised a 'Name the bear' competition to improve 999 awareness among children in primary schools.
- The service had participated in the national Hear and Treat survey and was similar to other trusts.
- The staff told us the visibility of the trust directors and senior managers varied, although most knew at least one of the directors.

Innovation, improvement and sustainability

- The introduction of a midwife to the CSD in the Southern House emergency operation centre had improved the outcomes for expectant mothers and their new babies. The 24-hour labour line started as a pilot in May 2014. It gave women in labour access to advice and support, whereas the 'professional line' enabled medical professionals to speak to a midwife 24/7 during a woman's labour and birth. The services had over 1,600 calls in the first 8 weeks.
- The trust was updating its 'special notes' for patients with complex conditions. The information was provided by GPs and stored on the computer systems in the emergency control room where it could be located under a patient's name, address or NHS number.

Emergency and urgent care

Information about the service

The trust's emergency response services responded to 999 calls in Oxfordshire, Buckinghamshire, Berkshire and Hampshire for patients with life-threatening emergency and urgent conditions. In 2013/14, there was a face-to-face response from the ambulance service for 38,239 people and 41% of these were treated at the scene ('see and treat') without the need to be taken to hospital.

The service had 27 ambulance station resource centres, and 315 front-line ambulances and rapid response vehicles (RRVs). There were two air ambulances as part of the Helicopter Emergency Medical Services (HEMS), and one Hazardous Area Response Team (HART). The ambulance staff included emergency care practitioners (ECPs), paramedics, emergency medical technicians (EMTs) and the newer role of emergency care assistants (ECAs). A response to a life threatening emergency (Red 1 and Red 2 calls) would always include a paramedic or ECP as part of the response team. Approximately 1,353 staff worked in the 999 service. The trust had trained and worked with 946 community first responders and 359 co-responders within the fire, police and military services. The trust was running a number of schemes to increase volunteer support and enable volunteers to work with staff on a regular basis.

During our inspection, we visited three resource centres in Berkshire and five each in Hampshire and Oxfordshire as well as Milton Keynes and High Wycombe Resource centres in Buckinghamshire. We also visited eight accident and emergency (A&E) departments at Wexham Park, Royal Berkshire, John Radcliffe, Queen Alexandra, Southampton General, North Hampshire, Stoke Mandeville and Milton Keynes Hospitals. We spoke with 88 hospital staff including nursing staff and consultant medical staff in A&E departments, and staff in maternity departments, paediatric intensive care and neonatal intensive care. In the trust, we spoke with 147 members of staff including paramedics, technicians and emergency care assistants, team leaders, managers, clinical mentors, heads of service and staff from the 'Make ready' external contractor service. We spoke with six patients and their relatives. We observed 40 patients receiving care and did three mobile observations as observers on ambulance crews. We inspected 47 vehicles. We reviewed patient records.

Summary of findings

Front-line 999 services provided an emergency response to people with life threatening emergency or urgent conditions. Overall, the trust was meeting national emergency response times to respond within 8 minutes to 75% of patients who had had a cardiac arrest, had stopped breathing or had other life threatening emergencies, and to have a vehicle that could convey the patient to hospital arrive at the scene within 19 minutes. The trust had the highest percentage of for 'see and treat' in the country (that is, managing patients at the scene without the need for ambulance transfer to hospital). The re-contact rate within 24 hours of this treatment was higher than the national average in 2013-14 but was decreasing.

The trust used a Resource Escalation Action Plan (REAP) as a way of forecasting performance and service delivery. There was moderate to high pressure on the service during our inspection and the trust was communicating effectively with hospitals to align conveyancing decisions against waiting times and the capacity to receive patients. This included having hospital ambulance liaison officers (HALOs) to support the timely handover and safety of patients in A&E departments, and to monitor and respond to situations particularly at times of increased demand for services. The trust was monitoring long waiting times and had introduced measures to ensure that people were monitored while waiting and that high-priority calls took precedence. There was an impact however on people who may be in a healthcare setting but awaiting transfer to another hospital for acute care and for people at a distance from a resource centre. The trust was taking action to reduce long waiting times and projects were planned in different areas. There was effective planning and preparation for major incidents and the trust had worked effectively with partner organisations.

The service followed safety procedures overall, but needed to improve infection control practice and the management of medicines. Staff had a good understanding of the Mental Capacity Act 2005 and of safeguarding procedures although the timeliness of reporting concerns and referrals needed to improve. The

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performance of the external contractor to 'make ready' ambulances was monitored but the quality of their work required better supervision and monitoring. Ambulance crews had allocated time to check vehicles but told us they spent more time rechecking vehicles to ensure they were ready for use.

The trust was affected by the national shortage of paramedics and there were a high number of vacancies. The allocation and skill mix of staff were appropriate but staff worked long hours and some reported stress and fatigue. There was a rising demand for services that was above predicted levels. The trust had introduced shift changes to help manage resources to meet demand in emergency services and new rotas were being introduced to further improve the work life balance of staff. The trust used private providers to ensure service cover and these providers were appropriately monitored. Staff spoke positively about the quality of care they provided for patients and said they were proud to work for the trust. There had been a good level of communication on issues and they understood the need to match resources and demand and requested further ongoing dialogue around these issues.

National evidence-based guidelines were used to assess and treat patients. Patients experiencing a heart attack did receive pain relief although this was not always the pain relief that was nationally recommended. Patients experiencing a heart attack were transported quickly to hospital. Patients that had had a stroke had appropriate care but there could be delays in their transport to hospital. Some hospital staff identified the need for better pain relief for children in certain circumstances. The coordination of emergency care with hospitals and GPs was good overall, but needed to improve for heart and stroke care in Buckinghamshire and for mental health patients in crisis across the four counties. The trust was working with its partners and had action plans to improve care in these areas. The trust had good outcomes overall for the survival of patients who had had a cardiac arrest. The trust had improved the effectiveness of action taken when staff witnessed a cardiac arrest and was fourth best in the country this year (April to August 2014) a change from eighth best in 2013-14.

Staff were caring and compassionate. They explained treatment options to patients in a way that they, or their relatives, could understand. Patients, and relatives or carers, received good emotional support if they were in distress. There was support for vulnerable patients (such as those with a learning disability), bariatric patients and people whose first language was not English.

The trust had a clear vision and strategy for the service to provide mobile healthcare and to coordinate care in hospital, the community and people's homes. Staff were supportive of the strategy and told us they worked well together in teams and with their managers. There were good governance arrangements to monitor performance and quality and to manage risks although more action was needed on ongoing risks. The performance of the external contractor to 'make ready' ambulances was monitored but the quality of their work required better supervision and monitoring. Patient engagement was well developed through a variety of channels, such as social media, surveys, newsletters and liaison work. There were many examples of innovation and improvement.

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Are emergency and urgent care services safe?

Front-line ambulance services followed safety procedures but some needed to be improved. Incident reporting was increasing but staff identified problems with reporting because of remote access to the electronic system. They received feedback and learning was shared. Infection control practices were not always followed by staff. Most ambulances were visibly clean. Vehicles and some equipment were well maintained and serviced. Appropriate equipment was available but there needed to be specific equipment for children. Medicines were appropriately stored and tagged for ease of use in an emergency. However, in some locations, the security standards and processes for controlled drugs needed to improve and the storage temperature of medicines needed to be monitored.

Safeguarding procedures were followed; however, there could be delays in reporting safeguarding concerns and records did not always indicate if and when referrals had been made. Patient records were maintained manually to a high standard, and the service was planning to move to electronic records. 'Do not attempt cardio-pulmonary resuscitation' (DNA CPR) information was used correctly. Patients were appropriately identified and escalated for treatment if their condition deteriorated. Driving standards were monitored and action was taken to improve performance. Mandatory training figures were below target.

The trust was experiencing the impact of a national shortage of paramedic staff and there were a high number of vacancies. It had introduced shift changes to manage resources to meet demand, but staff were working extra hours and some were experiencing stress and fatigue. The trust described their work to introduce new rotas to further improve the work life balance of staff whilst continuing to meet the challenges of rising demand. There were concerns about 'last minute' scheduling and the skill mix of staff at two resource centres in Berkshire. This was recognised and action was being taken. The trust used a Resource Escalation Action Plan (REAP) as a way of forecasting performance and service delivery. There was moderate to high pressure on the service during our inspection and the trust was communicating effectively with hospitals to align conveyancing decisions against waiting times and the capacity to receive patients. This included having hospital ambulance liaison officers

(HALOs) to support the timely handover and safety of patients in A&E departments, and to monitor and respond to situations particularly at times of increased demand for services. There was effective planning and preparation to respond to major incidents, and this was done in conjunction with partner organisations.

Incidents

- In the Department of Health NHS Staff Survey 2013, 78% of staff reported errors, near misses or incidents witnessed in the past month; this was a lower figure than found in other trusts.
- There were 654 incidents reported by the trust to the National Reporting and Learning System (NRLS) between April 2013 and March 2014. Fifteen serious incidents were reported, and 13 of these were in the emergency ambulance services. The incidents mainly involved delayed ambulance arrival, or delayed diagnosis or treatment, and some were attributable to other providers and not the trust.
- The trust had introduced a new electronic incident reporting system in April 2014. There was an incident reporting form that was available to staff on the trust's website and since its introduction there had been an increase in the number of incidents reported. The staff knew how to report incidents; they confirmed that they received an automated email when a report was submitted and that they were informed of the outcome.
- However, incident reporting by staff was being hindered by their poor access to computers. Some staff told us they could log an incident on a computer at any stand-by point. Others said they had to go back to the station to log an incident. This would often mean staying on at the ambulance station past the end of their shift, delayed or non-reporting.
- Private providers, who were subcontracted to fill gaps in the service, completed paper incident reports that were then entered onto the trust's electronic reporting system.
- Staff told us learning from incidents happened in discussions at team meetings and via emailed clinical bulletins, which were also displayed on noticeboards at some resource centres. Aggregating shared learning was identified as an area for improvement by the trust.
- The trust had recently introduced 'SCAScade' to improve organisational learning from adverse incidents, errors and near misses. The series focused on anonymised cases where things have gone wrong and

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the learning was shared with staff via the trust's intranet. SCAScade editions had been issued relating to patients with panic attacks; patients with central chest pain discharged at scene; patients with anaphylaxis; intoxicated patients with head injuries and patients in Addison's crisis.

- SCAScade included a reflective tool for learning from incidents. All staff were encouraged to complete the reflective activity as part of their ongoing learning, though there were mixed views from staff about the effectiveness of this process but it was valued.

Cleanliness, infection control and hygiene

- There was an infection prevention and control lead who was responsible for delivering the trust's main infection control aim: "To reduce the variability of station cleanliness."
- The Department of Health (2013) NHS Staff Survey 2013 identified that the trust was worse than average when compared with other trusts for the percentage of staff who reported that hand-washing materials were always available.
- The trust had a 'Make ready' team that was run by a private provider to clean and prepare ambulance vehicles. Hand-washing materials were included in a checklist for resource centres but not for vehicles. We found hand cleansing materials were available on vehicles, although there were none in the resource centres in Berkshire. Some, but not all, ambulance crews regularly used hand hygiene gel.
- Personal protective equipment (for example, gloves and aprons) were available and we saw staff wearing these when attending to patients. Staff adhered to the 'bare below the elbow' policy. They were also observed washing their hands in the A&E departments and cleaning their hands with the hand gel provided for this purpose on the vehicles.
- Most ambulances were visibly clean but we noted some, in Berkshire, that still had dirt and dust in places, for example, on carry chairs, hand gel dispensers and tail-lift controls. This was after the 'Make ready' crew had cleaned. Some staff reported that the standard of cleaning was 'hit and miss' and dependent on which 'Make ready' team had completed the process. There were kits for cleaning up spills and body fluids, and vehicles could return to base to clean out the interior of the vehicle if needed.
- We observed that equipment was visibly clean and saw staff cleaning equipment between patients when necessary.
- Deep cleans had been done every eight weeks but as part of a cost improvement programme was done very 12 weeks. Deep cleaning was undertaken by the 'Make ready' team. Each vehicle had a disc to indicate when the last deep clean had been done and when the next was due. Overall, 484 vehicles had been deep cleaned against a target of 463 (April to June 2014). In July 2014, only 79 had been cleaned against a target of 107. In Oxfordshire and Buckinghamshire, all vehicles had had a deep clean within the past three months. In Berkshire, the standard of vehicle cleanliness varied and many vehicles were overdue by more than two weeks for a deep clean.
- Most ambulance resource centres were visibly clean but the standard of cleanliness varied. Disposable mop heads were used, and mop heads and buckets were colour coded to indicate their type of use.
- Clinical waste was disposed of appropriately; ambulance stations and ambulances were equipped with clinical waste and sharps disposal bins. At one resource centre in Berkshire, we observed that the clinical waste bags were not tagged and the clinical waste bin was not locked.
- Sterilisation procedures were not appropriately followed. For example, clean clinical equipment was being stored in some sluice rooms, which posed a risk of cross infection. The trust had identified that the sluice area did not fully prevent the risk of cross infection at the Helicopter Emergency Medical Services (HEMS) base in Thruxton. Plans were in place to build a new base, including sluice area, by December 2014.
- Ambulance crews were expected to have clean uniforms available. Uniforms were washed at 40 degrees Celsius, which was not hot enough to destroy bacteria and not in line with trust's infection prevention, control and decontamination policy (June 2014), which stipulated a temperature of 60 degrees Celsius.
- Equipment used for intubating a patient was stored out of its packaging. There was therefore no way to identify if the tubes were still within their expiry date, and there was a risk that the structural integrity of the product could be damaged and foreign bodies introduced into the tubes. This could increase the risk of patients developing a chest infection after intubation. We also observed a laryngoscope blade and handle that were

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not in a sealed packet. The trust told us they had taken advice from their microbiology advice service and had undertaken a risk assessment before deciding on continuation of this practice. They were also raising the issue with national directors of clinical care.

- Sixty-nine per cent of the 999 staff had completed infection control training in 2013/14. The trust target was 90%.
- A vehicle infection control audit was undertaken monthly and the results shared with staff; however, the 'Make ready' crews were not aware of actions identified for follow up.

Environment and equipment

- There were appropriate procedures to ensure that ambulance vehicles were serviced and had Ministry of Transport (MOT) test certificates. Mechanical equipment was serviced and labelled to show the date of the last service and when the next service was due.
- Ambulance staff told us that there was an effective and efficient system for reporting repairs and breakdowns, and that requests were quickly actioned. Spares of some equipment were held at the ambulance stations, so staff were able to access these quickly when there.
- On occasion, vehicles taken for training were not replaced by the support desk. An ambulance crew who had been without an operational vehicle told us it took more than four hours to obtain an alternative vehicle. However, a team leader said the episode was relatively unusual. Staff estimated that vehicle shortages occurred two or three times a month, and that the situation was resolved at the local resource centre.
- Ambulance crews were able to access appropriate equipment, including equipment to support the moving and handling of bariatric patients. Equipment to undertake automatic cardiac compression were deployed on team leader rapid response vehicle's (RRV's) across the trust.
- Equipment available to ambulance crews included items of newer equipment introduced to the service. These included sliding sheets, lifting cushions, sliding boards and turntables. Ambulance crews we spoke with explained that their use of this equipment was supported by the training in manual handling that they had undertaken in 2014. Crews told us that these aids were being used more often than previously, which they appreciated. One crew member told us they felt the

ambulances were "adequately equipped for every emergency and spares for equipment were readily available." They knew how to report missing or faulty equipment and to obtain replacements.

- Equipment on the ambulances had been standardised. There were loading lists for each type of vehicle and for the response bags (containing essential items that staff needed when they first arrived at a scene) to ensure that they were packed consistently. There was equipment on vehicles to provide treatment to both adults and children.
- Resource centres had dedicated restock areas and cupboards. Some centres stored equipment stocks on open shelves that were cleaned before use. 'Make ready' teams were trained to restock vehicles and there were annotated diagrams and guides as to what equipment should be in each vehicle and response bag. Items were found to be current and in date.
- Ambulance crews were allocated 15 minutes at the start of their shift to conduct spot checks on the vehicle and equipment. They told us that the restocking by the 'Make Ready' team was not always accurate and sometimes equipment was missing. These omissions were reported as incidents and there had been improvements, but staff told us the spot checks were essential.
- The 'Make Ready' crew ordered consumable stock items online through the trust's logistics department. There was a separate packing list used for the 'primary response bag' for the ambulance vehicle. The process was monitored to ensure correct stock control but there were occasional isolated shortages of equipment (for example, of splints or spinal boards), and these were reported as incidents. Broken or faulty items were replaced by the logistics department.
- The 'Make Ready' crew was monitored by a supervisor daily but this did not include an audit of their activity.
- Equipment to transport children safely was not consistently available. Ambulances had child safety seats but no child safety restraints for stretchers. New equipment to transport small children had been introduced, but could not be used until staff had received training. Ambulance crews were using improvised methods for transporting young children and, for many, the current practice was 'babes in arms'.

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For example, we observed that a child seat could not be used so a parent was secured to a stretcher and then the child secured to the parent. The trust was piloting a paediatric transport system for children aged 1–5 years.

- HEMS helicopters were fitted with standardised equipment across the two helicopters. They also had the opportunity to trial and evaluate the effectiveness of new pieces of equipment.
- All RRVs (single-staffed vehicles) and helicopters were equipped with a chest compression system to be used in the event of a cardiac arrest; it meant that staff did not have to perform manual chest compressions. Treatment was therefore more effective, Staff told us that their success rate for cardiac pulmonary resuscitation had increased from around 5% to 50% with the introduction of this equipment.

Medicines

- Medicines were dispensed off site by an external contractor, sealed and delivered to resource centres. The 'Make Ready' team was responsible for restocking medicines in resource centres and medicine bags that were carried by ambulance crews. The bags were colour coded to identify the medicines (for example, red bags contained drugs for cardiac arrests). The bags and medicines were labelled and logged on a computer system, which made it easier to manage stock control and track any drug errors. Ambulance staff told us the system was robust, although the 'make ready' teams that were handling medicines had not received any training or instruction about doing so safely.
- Medicines were appropriately stored in locked cupboards in the ambulance resource centres. There were clear records of the expiry date of drugs and paperwork was completed to identify the practitioner administering a drug to patients, the dose and time of administration.
- There was a different system for managing controlled drugs across the north and south. There were separate locked cupboards for the storage of controlled drugs and only identified paramedics had access to these cupboards. In Oxfordshire and Buckinghamshire, the drugs were delivered by the hospital pharmacy directly to the vehicles. The pharmacy had a photographic identity book for paramedics and a log book was used to record every time a paramedic used the drugs. However, in Hampshire, the governance and security processes in relation to the ordering and supply of

controlled drugs to front-line staff was inadequate. It was described by a senior member of staff as 'a chaotic system in the south. They judged it was high risk as hard to see what is happening but they did not believe it was affecting patient care. We observed that some standard operating procedures for the management of controlled drugs had not been signed or dated correctly. A pharmacy assistant was responsible for the main pharmacy store, including purchasing, storage and supply. This included transporting controlled drugs in an unlocked briefcase to the resource centres. This member of staff was also a controlled drug destruction officer.

- Medicines, including medical gases and controlled drugs, were appropriately checked on vehicles, both daily and weekly.
- Staff told us that they kept ambulance vehicles electrically charged at all times to keep the air conditioning working but the temperature of medicines was not regularly monitored when they were stored or transported. In Oxfordshire, the temperature of the medicines store room was monitored on a daily basis. We observed the data of the temperature checks for the past two months and found that the medicines had been stored within the acceptable limits. On a very few occasions when the temperature had exceeded the maximum storage temperature, the issue was escalated to the trust's pharmacy services. The medicines store room at the air ambulance base was warm on the day of our inspection, but there had been no temperature check
- Team leader staff we spoke with felt they had received thorough training in the handling and use of medicines, including new medicines. They were supported by, and liaised regularly with, the ambulance service's lead pharmacist.

Records

- All records were in a paper format. Patients who were not taken to hospital received a copy of a patient clinical record form that detailed the information about the visit, or other supporting information about their condition from the ambulance crew. We observed staff completing the records in full.
- Each patient taken to hospital had a patient clinical record that included all information about the patient's condition. A copy of the form was left with the receiving healthcare practitioner or hospital. In the A&E

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department reception, we observed that the ambulance crews liaised closely with the hospital reception staff to ensure that patient records were completed during handover.

- Completed records were placed in a dedicated storage wallet in ambulances and then stored in locked cabinets within resource centres. At one resource centre, we observed that there were clear procedures for scanning patient clinical records. It was the responsibility of senior 'make ready' staff to undertake record storage duties, which included the scanning of documents. The original documents were subsequently securely stored before being destroyed in confidential waste. A copy of the patient clinical record was available from the records system stored at trust headquarters. The record was available to staff without the patient's name, but fully available for medical or legal concerns.
- Patients' clinical records followed a medical model. The format of the patient clinical record form was clearly laid out and followed Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidance. We reviewed 14 completed records. The documents were clear and legible, and followed the medical model. Suitable assessments made included a thorough examination of life threatening conditions. However, on one record we identified a gap of five minutes in patient observations that was unexplained.
- Ambulance crews were sometimes required to complete a number of other documents for patients. For example, an incident might need the completion of a non-conveyance form, a cervical spine clearance form, a major trauma/trauma form and a safeguarding form. We observed that these forms were available at each ambulance resource centre and on each vehicle.
- The trust was implementing an electronic patient record system (ePR). Electronic recording devices were being installed in the front-line vehicles in Hampshire during the course of our inspection. Staff explained how the use of this system would improve recording and ensure that vital information was transferred to receiving hospitals. At the time of our inspection, patients' vital signs (such as blood pressure, pulse and ECG traces) could be viewed by receiving hospitals via telemetry. With the new ePR system, receiving hospitals would also be able to view other records made by the ambulance crews, such as the patient's presenting history and the treatment they had already been given.

- There were appropriate policies and procedures about DNACPR orders and end of life care planning. The staff we spoke with about DNACPR were clear about what documents were needed and what had to be recorded on the document, and that they needed to see the document before they respected a patient's wish not to be resuscitated. They confirmed the relevant documents were transferred to the receiving healthcare practitioner to ensure that the DNACPR decision was followed.
- Staff received training in 2014 about the completion of DNACPR forms and consent in relation to end of life care. If a patient was admitted to hospital from a care home, for example, the ambulance crew took the original DNACPR form with them to the hospital. If necessary, ambulance staff would also call the patient's GP to discuss.
- Monthly documentation audits were undertaken using a sample of patient clinical records.

Safeguarding

- There was a named executive director with responsibility for safeguarding, and a named safeguarding lead. The safeguarding team was small with one lead and three other members of staff. The trust was developing safeguarding champions to develop the agenda across the organisation, however, we did not identify any safeguarding champions from the frontline staff.
- The government published statutory inter-agency guidance called Working Together to Safeguard Children in 2013. This guidance identified that, if there was a risk to the life of a child or a likelihood of serious immediate harm, then local authority social workers, the police or National Society for the Prevention of Cruelty to Children (NSPCC) should use their statutory child protection powers to act immediately to secure the safety of the child. The ambulance staff in the emergency operations centre (EOC) may be the first people to become aware of a child or vulnerable adult at immediate risk.
- Ambulance staff had a good understanding of what safeguarding concerns might be for children and vulnerable adults. All were clear about the process for reporting and referring alleged abuse to the appropriate authorities. However, most members of staff we spoke with said they did not get feedback as to whether their referrals had been accepted for safeguarding.

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investigation, or about the outcome of safeguarding investigations. A forum was also available for staff to raise any concerns they had about risks related to safeguarding.

- All staff were required to complete the level 1 safeguarding training as part of the trust's mandatory and statutory training programme. In 2013/14, level 2 safeguarding training was rolled out to front-line staff and EOC staff, and 85% were reported to have completed this. Seventy-seven per cent of front-line 999 staff had completed safeguarding training for adults and children against a trust target of 80%. This was a combined total of those completing training at both levels 1 and 2.
- There was a standard safeguarding referral form to report safeguarding concerns. This was completed and faxed (using a secure fax number) to a secure server where it would be reviewed by a member of the trust's safeguarding team. The hard copy was then sent to the safeguarding lead through the internal post. However, because staff did not have a direct referral route to local authority safeguarding teams, there could be a delay in a local authority receiving safeguarding referrals, particularly out of hours and at weekends. Referrals were being forwarded within the expected 48-hour period, although this was being achieved by the safeguarding lead logging into the system out of hours and at weekends.
- From April to June 2014, there had been 2,080 adult safeguarding referrals and 654 child safeguarding referrals. The number of referrals had increased following the roll-out of the level 2 training to front-line and EOC staff. Staff told us they were confident to raise safeguarding issues but had not received feedback on outcomes.
- We reviewed 10 patient record forms for information about safeguarding alerts or escalations. Six records showed that safeguarding had been documented appropriately. Four records related to situations such as domestic violence, involving alleged physical abuse, self-harm, suicidal attempt and care home issues, where safeguarding concerns were evident but were not documented.
- A flagging system was used to identify patients, based on their address, whose behaviours could pose a risk to the safety of ambulance crews. Senior managers told us there had been a recent review and update of the

flagging system to check that it was relevant and accurate. This meant that front-line crews could take precautions to ensure their safety, such as calling for back-up from the police service.

- In Berkshire, the 'Health Hub', which supported coordinated access to health services, had outlined a process to support the referral of vulnerable children. A 'Safeguarding Child and Adult Algorithm' summarised on an A4 sheet 'What to do if you are worried a child or adult is being abused' was used.

Mandatory Training

- Seventy percent (April to June 2014) of the front-line vehicle (999) staff had completed their mandatory training. Staff who drove a vehicle, particularly those who might drive under blue light conditions, had attended driver training.
- Driving standards were monitored and action taken when drivers had accidents or exceeded speed limits. Many vehicles had CCTV or telematics that could indicate driving performance. The trust had its own internal points system to identify drivers who needed performance management or further training. There was about one accident per vehicle per year, but the trust did not produce formal statistics on this. Ambulance trusts benchmarked driving performance based on insurance premiums and the trust was not an outlier when compared with other trusts.
- Most training was via e-learning modules, but the staff found it difficult to access computers during worktime because you needed to be on an ambulance station computer. Staff did not have dedicated time for training. Some completed it in their meal breaks and could often be interrupted. Some teams were allocated a 'team day' for training and development. This was not consistent across all the localities but the trust was planning to roll this out.

Assessing and Responding to Patient Risk

- The ambulance technicians and ECAs told us they could get advice from a paramedic whenever needed, and a paramedic would also accompany them on a patient visit if asked.
- There were clear established pathways for assessing and responding to patients who had chest pain or were suspected to have had a stroke. The patient record form

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included a pre-hospital early warning score that could be used to inform the decision-making process and the urgency of the situation, particularly for staff working in the urgent care service.

- If a patient's condition deteriorated or changed, ambulance crews had access to emergency medical practitioners and clinical specialists for support and advice. A leaflet for staff gave information about the clinical support desk (CSD) and emergency care practitioner service, and included contact numbers for escalation. The CSD provided an enhanced clinical presence in the EOC, and immediate clinical advice and support for ambulance crews.
- Staff explained that, they could contact their team leader in the first instance. Staff also referred to local GPs and confirmed that they received call backs. GPs were also available for 24/7 call-out if the situation required. Clinical mentors could access the crisis team by telephone.
- There were processes in place for ambulance crews to request back-up from other ambulance crews if the situation required it. Ambulance crews told us that, if there was a concern about their own or anyone else's safety, then they would wait for the police to attend.
- Ambulance staff confirmed that lines of responsibility and accountability were clear within their team. This applied whether ambulance staff were responding to clinically required services requested by healthcare professionals, responding to life threatening conditions, or responding to non-life threatening conditions. We observed that this worked smoothly in practice, both at A&E departments and for crews on the ambulance, and was well embedded in operational procedures.
- Staff told us that their training included escalation. All were issued with airwave radios supported by the trust's airwave radio policy. This enabled staff to escalate appropriately.
- Staff also described how escalation may involve the use of the helicopter emergency service. The criteria to use the service included both the patient's clinical needs and their location.
- Reviews of patient record forms confirmed that clinical escalation was documented appropriately.

Staffing

- The trust had a significant number of paramedic vacancies that reflected the national shortage of paramedics. Information provided by the trust showed

that there were 217 (16%) vacancies in the 999 service compared with a planned figure of 160 (April to July 2014). These figures showed there had been no improvement since April 2014. Sickness levels were 5.8% against a planned rate of 5.1%.

- Staff were structured into teams with a 12-week work rota. The twelfth week was a 'relief week', when staff were available to cover shifts that were vacant in other teams because of staff vacancies or leave. Staff also worked extra overtime shifts and their hours worked were monitored by the electronic rostering system. In the Department of Health NHS Staff Survey 2013, 85% of staff said they worked extra hours; this was similar in other trusts.
- Dual-crewed ambulances needed staff with both clinical and driving skills. The rotas showed that there was an appropriate skill mix and all shifts were covered appropriately. Staff usually operated a 12-hour shift, although some shifts were staggered to match capacity and provide 24-hour cover. Rapid response vehicles (RRVs) were staffed by a clinical member of staff with at least one year of post-qualification experience. These staff were usually paramedics but sometimes technicians. We heard concerns about the safety of staff, particularly female staff, who worked alone at night.
- In Berkshire, however, staff described instances of incorrect scheduling and inappropriate skill mix. Staffing lists were published the day before and staff absences were not taken into account and inappropriate allocation occurred on at least a weekly basis. Weekends were not always covered consistently. We did not see any rotas to support this, but managers told us that some allocations were "last minute". The cancellation of shifts was not consistently communicated to teams. Staff cited instances when they arranged cover themselves in order to operate a shift, although they had been asked not to do this. Some team leaders had made their own arrangements to monitor staffing levels. Ambulance vehicle downtime could result in patients exceeding waiting times. During our unannounced inspection, we did not observe any concerns about staffing or skill mix.
- All staff reported that the service was stretched. They told us they often worked overtime because the volume of calls had increased. They were sometimes going beyond their finishing time to complete their work with a specific patient. They estimated that two out of three of their shifts ran over their finishing time, and that this

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had an impacted on their work/life balance. Some staff said they were usually able to take their meal breaks, but many reported that they might not get a meal break for 8 to 9 hours into a 12-hour shift. The staff told us they felt stressed and tired as a result, and this had led to a number of staff leaving the service. The trust described their work to introduce new rotas to further improve the work life balance of staff whilst continuing to meet the challenges of rising demand.

- Staff attributed short-staffing to difficulties in retaining newly qualified paramedics and a lack of opportunity for career progression. At the North Harbour resource centre, we were told that there were currently 28 staff vacancies, which was 10% of the staff complement. Staff were unaware of any plans for effective recruitment to these vacant posts. It was reported that exit interviews were not routinely held. This meant there was no structured process to audit the reasons for staff leaving the organisation.
- To mitigate staff shortages and ensure that the service provision was safe, the trust subcontracted work to private ambulance services.
- In some areas, community first responders (CFRs) had recently been introduced to the rotas, and staff spoke positively about working with these volunteers. The CFRs felt part of an integrated team.
- The Hazardous Area Response Team (HART) worked as a subteam of six that included a team leader and an educator. When all six team members were on duty, two would be used to staff RRVs. These two vehicles were in addition to the established front-line resource. Staff from HART confirmed that, if there was an incident that required a HART response, they would be released from the RRV to fulfil their HART duties.
- The trusts was proposing to change rotas so that staffing levels could more appropriately match demand. These proposals meant a change from 12-hour shifts to a more flexible combination of 8-, 10- and 12-hour shifts. The proposal to introduce new staffing rotas was the subject of consultation at the time of our inspection. Staff we spoke with felt the trust was “listening” to their concerns. In the resource centres, we observed a noticeboard with comprehensive information about rota changes and contact details for feedback from staff.

Anticipated resource and capacity risks

- The trust used the Resource Escalation Action Plan (REAP) as a way of forecasting performance and service

delivery over the next week. This was influenced by key influencing factors, such as increases in demand, seasonal or weather changes, or disruption to staffing levels. Six REAP levels were identified nationally with level 1 being considered as functioning as normal and level 6 classified as potential services failure. Mitigating actions were made depending on the REAP score. At the time of our inspection, the trust was operating REAP level 3, indicating moderate to high pressure on the service.

- The trust’s REAP protocol was documented in an operational policy. In response to the increased REAP level, operations staff were requested to ensure that appropriate actions were taken to sustain adequate support arrangements. For example, the rotation of team leaders between resource centres to support audit might be discontinued. Not all staff we spoke with were clear as to the operation of the policy and its impact. We did not observe the REAP level displayed in the Reading, Wexham or Bracknell resource centres we visited.
- The trust had undertaken rota reviews as a service improvement programme to ensure that staffing level risks were being managed. Staff had mixed views about changes to the existing rotas.
- There was an organisational policy that provided guidance about the actions required to ensure continuity of the service in the event of incidents such as power failure. However, processes to ensure the continuity of services in the event of a catastrophe rendering a resource centre unusable were not fully developed. At North Harbour resource centre, there was no local plan other than they would probably try to relocate resources to the old stations that SCAS still owned. At Hightown resource centre, we were told they would relocate to the larger Nursling site.
- The trust had had computer handover screens in hospital A&E departments since April 2010. These enabled hospital staff to see the patients who were coming in, and the ambulance crews and hospital staff were able to record accurately the times of arrivals and handovers.
- There was close working with the local hospital A&E departments. Daily teleconferences ensured that the ambulance teams knew about any resource problems at the hospitals. Electronic systems ensured that there was real-time monitoring of ambulances’ (and therefore patients’) waiting times at the hospitals. If there was an increased number of patients and reduced capacity to

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receive them at A&E departments, the ambulance service would implement a Hospital Ambulance Liaison Officer (HALO). A member of the ambulance crew or the HALO would then monitor the situation so that the ambulances could be redeployed on the road.

- The trust had a policy called 'Escalation in response to demand' that gave guidance about the actions to take in the event of specific increases in demand for the service. However, when we spoke with staff, it was clear that in their view there was always a high level of demand, to the extent that staff were pulled off training to ensure that there was an adequate workforce.
- Ambulance staff we spoke with were unaware of the forthcoming changes in driving regulations under Section 19 of the Road Traffic Act 2006. This required that any driver using a blue light and claiming exemption from the speed limit, when justified, must be on a national high speed register. It also prescribed that drivers must undertake a high speed training course (or be in the process of doing so) before they were permitted to exceed speed limits. The trust was planning to discuss this with staff following the consultation period.
- The trust had worked with partner organisations including fire and rescue, police and the environmental agency during the floods in early 2013 in the Thames Valley area. HART had worked throughout the region and specifically in Wraybury, Berkshire, 24 hours a day over 4 days to assist with the rescue and support operation.

Response to emergencies and major incidents

- The trust had an Emergency Preparedness, Resilience and Response (EPPR) plan that described the emergency response structures and plans for business continuity. There was also a major incident policy that described the emergency response structures and plans in the event of a major incident.
- The staff we spoke with were aware of the EPPR and major incident plans. They told us that, in the event of a major incident, staff reported for work and volunteered to help without further prompting. They had always received good support from the trust in the event of any major or critical incident. They spoke positively about communications with the police and fire services in connection with planning responses to major incidents.
- In general, staff we spoke with expressed confidence in the level of major incident training they had received.

Senior clinical staff had received a range of training in responding to major incidents (for example, the Joint Emergency Services Interoperability Programme [JESIP] training). Some staff were still to receive Major Incident Medical Management and Support training (MIMMS) to ensure their readiness for major incidents. One member of staff we spoke with had requested extra training to increase their knowledge of Chemical, Biological, Radioactivity and Nuclear (CBRN) decontamination procedures, but they had experienced some difficulty in accessing this.

- Team leaders undertook weekly checks of major incident equipment, and considered their teams competent to respond appropriately to a major incident. Guidance was also available for staff.
- HEMS told us they had completed multi-agency emergency planning exercises.
- The acute hospital trusts and major trauma sites informed us that SCAS had worked collaboratively with them on major incident planning and associated exercises.

Are emergency and urgent care services effective?

(for example, treatment is effective)

The service followed both National Institute for Health and Care Excellence (NICE) and Joint Royal Colleges Ambulance Liaison Committee (JRCALC) clinical practice guidelines. Overall, the ambulance service was meeting national target emergency response times for responding to life threatening conditions and there were only a few months in the year when targets had been breached. Rapid response vehicles (RRVs) and/or ambulance crews arrived at scenes within an appropriate timescale. Community first responders (CFRs) had also been trained to be first on the scene in response to emergency calls. Staff followed medical protocols in assessing patients and made effective use of other available protocols, standard pathways and relevant guidance.

Ambulances had appropriate equipment and staff showed skill and expertise in administering care to patients of various ages experiencing a range of conditions. Pain assessment was conducted using separate protocols for adults and children, and a range of pain-relieving medication was available. Some hospital staff identified

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the need for better pain relief for children in certain circumstances. 'Special notes' were used to identify risks for patients who may have previously presented a safety concern for ambulance crews. The trust was effective at treating patients without the need for conveyance to hospital; re-contact rates within 24 hours were decreasing and now below the England average. Patients experiencing a heart attack did receive pain relief although this was not always the pain relief that was nationally recommended in the care bundle. Patients experiencing a heart attack were transported quickly to hospital. Patients that had had a stroke had appropriate care but there could be delays in their transport to hospital. Some hospital staff identified the need for better pain relief for children in certain circumstances. The trust had good outcomes overall for the survival of patients who had had a cardiac arrest. The trust had improved the effectiveness of action taken when staff witnessed a cardiac arrest and was fourth best in the country this year (April to August 2014) a change from eighth best in 2013-14. The trust was taking action to improve patient outcomes.

The trust had effective communication with A&E departments and maternity services to coordinate emergency transport. There was effective multidisciplinary working with acute hospitals, community organisations and GP teams. There was also coordination of care along specialist pathways (for example, for critical care, children with diabetes care). However, care pathways for cardiac and stroke patients were not appropriately defined with providers in Buckinghamshire, and this was causing delays in transporting patients. Nor were care pathways well coordinated with mental health trusts and some police forces for mental health patients in crisis. Staff could ask for advice from the trust's clinical support desk (CSD), but they did not have the appropriate experience and training to provide effective care.

Ambulance staff had good induction programmes and received training, supervision and appraisal, although these could vary. Staff had training opportunities but this was affected by limited computer access and lack of dedicated time. Some staff were concerned about the lack of career development opportunities, particularly as the technician's role was to be phased out. The trust had started to invest in professional development programmes for staff, but staff needed to be more aware of these. Staff had a good understanding about consent and the Mental Capacity Act 2005.

Evidence-based care and treatment

- The ambulance service followed both the NICE and the JRCALC clinical practice guidelines. The national guidance was used to inform local practice. The latest JRCALC guidelines had been rolled out to all staff and staff had been trained in using them. Paramedics had been given a handbook on JRCALCC guidelines dated 2013.
- We observed that clinical staff on ambulance vehicles and in attendance at hospital carried the JRCALC guidance and referred to it in their assessment and documentation of patient care. The copies of JRCALC guidance that staff used were clearly in daily use.
- There was guidance available about conveying mental health patients to a place of safety under Section 136 of the Mental Health Act 1983 but staff had not had enough training in its use.
- NICE guidelines were circulated to staff through electronic bulletins on clinical updates and directives. We observed clinical directives on display noticeboards in resource centres or kept in resource files. The organisation was moving towards paperless working and there were some concerns that learning would not be shared effectively. In the North Harbour resource centre, for example, there were no printed copies of the clinical updates. There was a rolling electronic display screen where current information was displayed, but staff did not always have time to view the screen for recent bulletins or to access work emails.
- Service managers discussed a number of innovations and initiatives being adopted in the ambulance service to support evidence-based care and treatment. 'The condition of the month' was an example at the Oxford City resource centre where each team did some research around a particular condition and its treatment, and then presented this to the wider team. Staff found it a beneficial exercise because it helped them to keep updated with the recent advances in treating that condition.
- In Bracknell resource centre we observed an e-learning station where training aids were prepared for use across the trust and to support the development of JRCALC guidance.
- HEMS was a member of the Association of Air Ambulances, which enabled them to share best practice and learn from nationwide incidents.

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- The trust was involved in research projects led by the lead pharmacist and the divisional medical director. These included involvement in the paramedic 1 chest compression system to be used in the event of a cardiac arrest, and paramedic 2 drug trials, as well as some more local privately sponsored projects relating to, for example, the prevalence of diabetes. The leads reported that involvement in these projects had enhanced the awareness and understanding of front-line staff of the importance of evidence-based practice.

Assessment and planning of care

- The ambulance staff followed medical protocols in assessing patients and planning their care. Staff also made effective use of other available protocols, supporting guidance (for example, on stroke and myocardial infarction [heart attack]) and clinical pathways for a range of conditions. Patient documentation prompted ambulance staff to follow set assessment processes when attending to patients. We observed ambulance staff following the assessment process and the documentation was being completed appropriately. For example, the staff we spoke with demonstrated a clear understanding of the use of trauma pathways. A 'trauma unit bypass tool' was used during assessment and a major trauma triage tool checklist was completed.
- Staff called for advice appropriately and showed a good level of knowledge and skill in working with protocols. There was an online system available on the ambulance and staff used the protocols and treatment options appropriately. We observed that care and treatment were planned in line with the findings of the assessments and the standard pathways of care. For example, a patient who had fallen, but could not remember how or when they had fallen, was conveyed to hospital because there had been an obvious injury to the head and the person had no memory of the incident. The ambulance crew told us that this was the normal procedure for a person who had hit their head and was unable to remember the event.
- Guidance was available for staff on considering and assessing the needs of particular patient groups (for example, conveyance or non-conveyance of very young children, patients in police custody and those with symptoms of sepsis).
- The emergency care practitioner (ECP) team was available to provide assessment and treatment for

patients in the community. Leaflets were available about ECPs that provided guidance about conditions and situations that were appropriate for referral to the ECP team. These included medical trauma and surgical referrals, and provided guidance as to situations in which a patient should be transported to hospital.

- Staff explained that an increasing number of patients were treated at the scene by ambulance crews ('see and treat') without needing further transport to hospital. We were given examples of treatment for patients with asthma who could stay at home and be followed up by an out-of-hours GP, and of people who had experienced a fall who may be referred to the falls service after a falls risk assessment.
- An alternative pathway trial was taking place in South Buckinghamshire. An ambulance crew could call a consultant for advice for any patient who required medical review but who may not need to be admitted to hospital.
- Community first responders (CFRs) had been trained to be the first people on scene. CFRs were deployed effectively to support emergency response and were being integrated into front-line teams. A member of staff was responsible for developing the role of volunteers in the community. This included liaison with police and fire services, and linking responders with ambulance crews. Support networks within the trust were available for responders.

Response times

- When a 999 call was made, it was triaged and assigned a category that determined the response. There were nationally agreed categories. Red 1 calls were for patients with cardiac arrest or who had stopped breathing; Red 2 calls were for other life threatening emergencies. Red 1 and Red 2 calls together were referred to as category A calls and the trust was expected to respond to 75% of these within 8 minutes. In addition, there was another national target stating that a vehicle capable of transporting a patient should arrive at the scene within 19 minutes in 95% of cases.
- In 2013/14, the trust was meeting the Red 1 target overall with an average of 79.2%. It narrowly missed the target in July 2013 (74.9%). It was also within target for the first three months in 2014/15. For Red 2 calls, the trust was meeting the overall target with an average of 75.7%. It failed to meet the target in July and November

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2013 and in February, May and June 2014. For category A calls, the trust was meeting the target overall with an average of 96.1%. There was one breach of the target this year in June 2014 (94.8%).

- Staff told us they appreciated the format used for Red calls. They considered it presented the correct information to manage the patient and they felt the categorisation of calls was appropriate. Although requested, we did not see any audit data on the categorisation of calls.

Care delivery

- Staff showed considerable skills and expertise in administering care to patients of various ages who were experiencing a range of conditions.
- Patients' pain was assessed and any medication administered was recorded on the patient record form and in the vehicle log book. Pain relief was administered according to the level of pain and the type of injury. For example, we observed an ambulance crew giving pain-relieving medications to a patient with chest pain. The crew followed the right protocol in assessing and monitoring the pain level. The patient was satisfied with the care delivered by the crew.
- There was support for paramedic and other clinical staff in administering pain relief for patients. Pain assessment was conducted using separate protocols for adults and children, and a range of pain-relieving medication was available. For patients experiencing an ST segment elevation myocardial infarction (STEMI), for example, ambulance crews we spoke with were aware of the medication options available. The trust's performance in giving pain relief as identified in the care bundle needed to improve and the trust was taking action. A project on understanding pain management behaviour with paramedics was being undertaken with paramedics with the aim of also contributing to national research.
- The paediatric nursing staff in an accident and emergency (A&E) department felt that the paramedics did not always administer the right type of analgesia to children in pain. For example, a child with a compound fracture was given paracetamol when stronger analgesia was needed to control the pain.
- For patients who had experienced a fall but did not need hospital admission, ambulance staff could make a

direct referral to the community falls team within the area. A grading system was used to grade the severity of the fall, which then determined the urgency of the referral.

Patient outcomes

- Ambulance staff worked effectively to keep people at home rather than admitting them to hospital. The trust implemented 'see and treat' more effectively than any other ambulance service in England, with 43% of patients being referred through alternative care pathways, thereby avoiding unnecessary A&E admissions. The proportion of incidents managed by the ambulance service without the need to transport patients to A&E was 41.4% in 2013/14, which was better than the England average of 36%. The proportion was 43% (April to June 2014) compared with the England average of 36%.
- Re-contact rates for patients treated at the scene and then discharged represented about 2% of emergency calls closed over the past 3 years. The trust's recontact rates within 24 hours for those patients who had been treated at the scene and discharged were above the England average for every month between April 2011 and March 2014. In 2013/14, the trust's recontact rate was 6.7%, which was worse than the England average of 5.4%. The trust had performed better than in the first three months of 2014/15 with a recontact rate of 4.4% compared with 5.2% in England.
- The Department of Health has a number of ambulance quality indicators for patients who may have a cardiac arrest or stroke emergency. The trust was better than expected for the number of stroke positive patients receiving the appropriate care bundle but the worst for the number of patients arriving at a stroke unit within 60 minutes. The trust had identified this as an area for improvement. A stroke positive patient was identified as showing FAST symptoms. That is, the public campaign about - Face, Arms, Speech symptoms and Time to call 999.
- For ST segment elevation myocardial infarction (STEMI), which is a type of heart attack, the trust was worse than expected for patients receiving an appropriate care bundle. This was because the patients had not received appropriate pain relief. The trust had identified this as an area for improvement. The trust performed similar to expected for the proportion of patients who received treatment in hospital within 150 minutes. Treatment

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was either primary percutaneous coronary intervention [PPCI], which is a surgical treatment for heart attack patients that unblocks coronary arteries carrying blood to the heart, or primary angioplasty, which is a surgical procedure used to widen blocked or narrowed coronary arteries.

- The trust performed the best of all ambulance trusts for patients who had had a cardiac arrest returning to spontaneous circulation (ROSC) at the time of arrival at hospital. That is, reviving a patient when their heart had stopped. The trust was worse than average for the ROSC rate, however, for witnessed cardiac arrests. The trust has identified this as an area for improvement and was identifying extra training and studying behavioural attitudes of paramedics in terms of pain relief. The trust was the best of all ambulance trust for the overall cardiac survival rate for patients who have a cardiac arrest survival to discharge.
- The trust was using care bundles for patients presenting with hypoglycaemia, asthma, limb fracture and febrile convulsion. In July 2014, they were close to meeting the targets on these care bundles and were monitoring these to identify the root causes for improvement.

Competent staff

- Paramedics received a comprehensive induction programme that included emergency driving. Staff we spoke with told us they felt prepared when starting work after their induction period.
- Emergency care assistants (ECAs) completed a 12-week induction course before taking on clinical duties. The ECAs we spoke with told us this training was delivered and they felt confident in dealing with emergencies. However, they felt that career progression to become a paramedic was a challenge and disappointing. The trust was piloting a university route for ECAs to become paramedics and the first cohort for this pilot was due to start in September 2014.
- Preceptorship was used to provide support for newly qualified clinical staff during their first six months of employment by the trust.
- Most training was via e-learning modules, but the staff found it difficult to access computers during worktime because you needed to be on an ambulance station computer. Staff did not have dedicated time for training.

Some completed it in their meal breaks and could often be interrupted. Teams were allocated a 'team day' for training and development, but this was not consistent across all the localities.

- In 2014, 84% of staff had completed an appraisal against a trust target of 90%. Most staff we spoke with confirmed that they had received an appraisal in 2014. Appraisals focused on performance and development. For example, the patient record form was used to inform performance and appraisal reviews.
- Clinical supervision was planned for twice a year and staff were able to access this through clinical mentors. Some staff told us that clinical supervision only happened annually because of a shortage of clinical mentors but the trust confirmed that there were sufficient clinical mentors in place. Clinical supervision was based on competency and staff found the clinical mentoring sessions valuable. Extra training was provided if necessary to improve clinical skills. In Berkshire, team leaders also undertook regular (monthly to 6-weekly) one-to-one meetings with staff to review their performance and provide support for professional development. For some staff, this involved working a shift, or part of a shift, with their team leader or clinical mentor. Staff felt supported by their managers and peer colleagues. However, there were sometimes practical difficulties in arranging these meetings, particularly for part-time staff.
- Staff confirmed they were supported to maintain their registration.
- Staff were able to apply for continuing professional development (CPD) funding to assist them in developing their careers. Staff were supported to undertake academic qualifications that included GCSEs, A levels, degrees and postgraduate courses that included training for paramedics. A total of 182 staff had accessed further training through the CPD fund. Area educators also conducted training programmes.
- The trust was working with Oxford Brookes University to provide staff with extra opportunities to develop their careers by becoming a paramedic, and to counter the national shortage of paramedics. The training covered an 18-month period and included in-hours training. A foundation degree course was to start in January 2015. There were 20 places for internal staff and 10 places for

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external staff. The trust's investment had been significant in terms of the time taken to negotiate the resources and facilities for the programme and the release of staff from work duties.

- The trust was phasing out the role of technician as part of its wider strategic plans for ambulance services. Some staff expressed concerns that training to develop emergency care assistants (ECAs) into emergency medical technicians (EMTs) had been withdrawn. They did not know the reasons for this, and did not understand how an ECA could be supported to develop and progress in their career to become a paramedic. The trust provided information about the plans for progressing ECAs; however, staff on the front line were not aware that such plans were in place. Senior staff of team leader and management grades spoke appreciatively of the support they had received develop professionally into more senior roles.
- Staff had reported that training in dementia and learning disabilities was inconsistent and varied in quality, with some training only listing conditions that could affect the brain. A specific dementia e-learning training course had been introduced in August 2014 and 33 members of the front-line staff had completed it. Staff reported they had only received basic training in mental health conditions and they needed more comprehensive training and support.
- The trust had recently agreed an arrangement with Eastleigh College to provide vocational training courses (for example, training in learning disabilities, dementia care, end of life care, infection control and mental health awareness). Training was undertaken remotely by using a training pack. A number of call handlers and dispatch staff confirmed that they had been working towards their level 2 in mental health awareness.
- Area educators also conducted training programmes. For example, at one resource centre we saw that a mobile device for diagnosis and decision support in ambulance care was used to support the training of staff. There was a dedicated trainer in the southern region based at the Nursling resource centre; this provided a comprehensive learning area where staff could attend face-to-face training.
- HART had a strict roster that included dedicated training time so that team members could maintain the specific set of competencies needed for their role. All

attendance was monitored through an electronic system, as were appraisals. Staff received support to complete the required training competencies before qualifying as a full member of the team.

- HEMS reported that they undertook joint training with trauma teams, A&E departments, and anaesthetic consultants to ensure that they had the skills to deliver the care and treatment expected from an air ambulance crew.
- The trust provided training and support for staff working with subcontracted private providers of 999 ambulances. This included annual updates and training on safeguarding, clinical performance indicators, equipment standardisation, documentation and driver standards.
- Trauma risk management (TRiM) was in place to provide confidential support to staff who may be affected by traumatic incidents or conditions. Staff were assessed three days after a traumatic event and again after 28 days. There were 32 TRiM practitioners who gave peer support and advice, and there was also an external counselling service.

Coordination with other providers

- The trust had effective coordination with acute care pathways. Hospital staff reported that care pathways were followed appropriately for emergency calls. They identified that the trust prioritised calls effectively and patients had timely arrivals in A&E departments. Care pathways for maternity admissions were followed. These included referrals of early miscarriage and when patients should be brought directly to maternity units (for example, at John Radcliffe Hospital for patients over 16 weeks' gestation).
- Care pathways should be clearly coordinated as identified under British Cardiovascular Intervention Society guidelines. The care pathways for emergency cardiac and stroke care patients had been developed across the South Central area. However, in Buckinghamshire ambulance staff reported problems in communication and the admission processes. Ambulance staff said that they had recently experienced difficulties in taking cardiac or stroke patients to Wycombe General Hospital for admission. Buckinghamshire Healthcare NHS Trust reported that communications with the trust was beginning to improve to clarify the care pathways.

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- The trust had developed hospital guidance for emergency inter-hospital transfer. Staff at Stoke Mandeville Hospital told us that a protocol had been developed with the trust for the transfer of patients from the intensive care unit (ICU) to a specialist centre for patients who required time-critical' emergency inter-hospital transfer. This had worked well, and had maximised the efficiency of the resources for both the critical care service and the ambulance service. Patients who were stable but needed critical care were given a four-hour waiting time category for transfer, and this sometimes meant that patients were on a transfer bed with a transfer ventilator for a long time, which was a risk to their skin care. Staff in the acute trusts wanted more liaison on this protocol.
- The trust had also developed effective links with community organisations (for example, the Berkshire Health Hub, which provided a single point of access for community services in West Berkshire, particularly for children). There was effective links, too, with GPs and minor injury units. Ambulance staff explained that there were no formal arrangements for contact with outside agencies and these were developed locally. We reviewed a sample of six patient records, which confirmed that liaison with other providers, including social services, was documented appropriately.
- The trust had specialist care pathways with individual hospitals. For example, there was a diabetes care pathway at Queen Alexandra Hospital in Portsmouth to ensure that patients who did not wish to be admitted to hospital were treated appropriately. There was a dedicated paediatric retrieval team based at Southampton General Hospital and the ambulance service provided qualified emergency drivers to transfer children to the paediatric intensive care unit. (A paediatric retrieval team is a highly skilled team that has specialist training in the transfer of sick children from other hospitals to paediatric intensive care units.)
- The coordination of care for mental health patients was a concern. Ambulance staff reported that they were facing certain difficulties in caring for patients with mental health conditions, particularly those in crisis and who may need a place of safety (Section 136 of the Mental Health Act 1983). Crisis teams were not always available and there was inconsistent support from police teams. Staff reported that more training was needed to support multidisciplinary training and to develop effective care pathways.
- The trust subcontracted emergency work to private providers who agreed to work within the trust's policies and procedures to ensure that a seamless ambulance service was provided for patients. We spoke with a representative of one such provider who identified that the trust had robust procurement and monitoring processes to ensure that private providers were adhering to operational and clinical standards.
- The trust provided a service on Friday and Saturday nights in the city centres of Portsmouth (Safe Place) and Southampton (ICE Bus) to provide support, first aid and transfer to hospital if needed by members of the public enjoying a night out. This had been set up in partnership with other organisations such as the Hampshire police, the local council, volunteers and the local street pastors.
- Staff told us about ongoing work with external stakeholders to improve the quality of the service. One example was working with the police and fire services to improve the management of road traffic collisions.

Multidisciplinary working

- Staff reported good working relationships with other areas of the trust. We observed good communication between the call centres and ambulance crews. Ambulance crews could contact the CSD if they had any queries about a patient's condition or treatment and needed advice or support.
- Hospital staff across the South Central area spoke positively about caring, hands on, and professional delivery of care to patients by ambulance staff. They reported close working relationships and effective liaison, that ambulances were well equipped and that they received good clinical information at handovers. They saw the ambulance staff as part of the emergency team. We observed patient handovers between ambulance staff and A&E staff at both John Radcliffe, Stoke Mandeville and Milton Keynes Hospitals. The ambulance staff liaised with the nurses and doctors about the relevant patient information. The A&E staff commented positively on the communication about the impending arrival of patients, the handover of the patient and the information they had received.
- Ambulance staff said they had a good working relationship with the local hospitals and GP practices, and there was evidence of this in the low rate of transportation of patients to hospital. As a trust, 57% of all patients who phoned the 999 service were taken to hospital. This was the lowest percentage in the county

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when compared to other ambulance trusts. Hospital staff also recognised that the ambulance staff worked hard to prevent admission and alleviate the pressures on A&E departments. For example, senior staff told us, “They work very hard to try to prevent hospital admission. We are part of a strong team”, and a senior member of the medical staff in an A&E department said, “We are very spoiled with South Central Ambulance Service here.”

- The A&E department at John Radcliffe Hospital held bi-monthly urgent care group meetings with the ambulance service to discuss service improvements, patient experiences and complaints.
- Maternity services also commented positively about ambulance staff. They noted effective liaison in acute and community care to provide the best care for patients.
- Ambulance crews had ‘special notes’, many of which were developed with GPs. These covered patients with complex clinical conditions, and included end of life care decisions and ‘Do not attempt cardio-pulmonary resuscitation’ (DNACPR) orders.

Consent & Mental Capacity Act

- Ambulance crews, including clinical mentors and paramedic staff, had a good understanding of consent and the Mental Capacity Act 2005. They showed a full working knowledge of the Act and how the ambulance service interacted with other agencies in implementing its requirements.
- We observed staff seeking consent from patients or, in the case of a child, their parent, before delivering any care or taking them to hospital. Patients and parents were spoken to so that they were able to understand what care and treatment was being suggested, and were therefore able to make informed decisions. Ambulance crews checked that the patient or parent understood.
- The patient clinical record form included a consent section for the patient or their representative to sign to give consent for treatment or transportation. There was also a section for an assessment of a patient’s mental capacity if they refused treatment or transportation. We observed that staff completed this and ensured that the patient had capacity to make decisions before it was agreed that they would not be taken to an A&E department if this was their wish.

- Staff reported that they had received training related to the Mental Capacity Act 2005.
- Information was displayed in resource centres about mental capacity and consent. For example, the weekly staff newsletter included a mental capacity assessment flowchart for staff to use as a reminder.
- Team leaders undertook monthly audits of consent, and issues were followed up with staff.

Are emergency and urgent care services caring?

Patients were treated with compassion, dignity and respect by ambulance staff. Ambulance staff were sensitive and caring, and responded to the needs of vulnerable patients. Staff explained treatment and care options in a way that patients could understand; they explained and involved patients in decisions, including why they may not need to be conveyed to hospital.

Patients were supported to manage their own health by using non-emergency services when it was appropriate to do so. Patients, their relatives and others received emotional support when experiencing distressing events, including when someone had died.

Compassionate care

- We observed ambulance crews attending to patients at home, in ambulances and in A&E departments. They included vulnerable patients with limited mobility and psychiatric needs. Patients were treated with compassion, dignity and respect by ambulance staff throughout our inspection. Ambulance crews consistently showed patience and sensitivity to the needs of patients.
- Ambulance crews asked how patients wanted to be addressed, introduced themselves and were considerate about the person’s dignity, particularly when other people were around.
- The ambulance staff used blankets to keep patients warm and to protect their dignity if necessary. We observed that patients were secured safely in the ambulance and staff gave them their constant attention during the journey. Ambulance crews were considerate when entering an A&E department; they ensured that handovers took place in a private place and that screens were drawn round patients when transferring them to hospital trolleys or beds.

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- On one occasion, we observed that the ambulance crew was directed to transfer a patient into a cubicle that had not been tidied after a previous patient; equipment and a commode had been left there. The crew declined to transfer the patient into the cubicle, explained the reasons to the patient and A&E staff, and then cleaned and tidied the cubicle themselves.
- A&E staff who worked closely with the ambulance crews told us they received many patients from the service and could speak for the consistency of care that crews showed to patients during handover. Typical of the comments we received were, “Polite, pleasant, good team” and “Helpful”.
- In Berkshire, we observed ambulance crews working with a patient experiencing symptoms of mental illness. The staff demonstrated a calm and professional approach in responding to the needs of the patient. A&E staff who worked closely with the ambulance crews told us they showed good communication skills with patients with a learning disability, dementia or a mental health illness.
- Patients were overwhelming positive about the care provided. One told us that they were in an extremely vulnerable state throughout the intervention and felt at all times that the ambulance service staff treated them with respect and helped to preserve their dignity. One patient said, “The crew were great. The crew were kind, and listened to me.” Another told us, “The bottle of water was a life saver – I was nil by mouth, but at least I could lick my lips and speak clearly.”
- Other comments from patients or their relatives included, “Brilliant,” “Think they are lovely,” “Treated extremely well,” “Absolutely fantastic”, “Excellent care and attention,” and “Best pick up I have ever had.”

Patient understanding and involvement

- Ambulance staff took the time to explain what they were doing before there was any intervention and ensured that the patients understood. Proposed treatment and care options were explained in terms that patients could clearly understand. Any questions that the patient or their relatives had were responded to, and in this way staff gained the confidence of the patient.
- Patients were involved in decisions about transport to hospital. We observed ambulance staff discussing with

them whether or not to take them to A&E. In each case, the crew took the time to explain their reasoning and involved the patient in the final decision. Patients were informed as to the implications of their choice.

- All patients told us they were involved in and informed about their care. For example, one patient said, “The first responders arrived at the scene very quickly. They were reassuring, supportive and were always focused on my needs. The service was great.”
- Comments from patients and their relatives we spoke with in an A&E department included, “Kept me informed”, “Excellent, excellent” and “The crew always kneel down to my level; asked lots of questions; paramedic staff very professional, with good level of knowledge; procedure consistent.”
- We received feedback from school staff who reported several positive experiences whenever the school had to call an ambulance. We were told that the response cars were prompt in attending the scene. Paramedics talked calmly and clearly with the children and the staff were very professional.

Supporting people to manage their own health

- When it was appropriate to do so, ambulance staff supported patients using the emergency service to manage their health by using non-emergency services. The trust facilitated alternative pathways for patients who, once assessed, did not need hospital treatment. These included ambulance crews or clinicians at the call centre referring patients to their GPs, pharmacists or treatment centres. Once an initial assessment had been completed by the ambulance crew, an emergency care practitioner could be accessed to provide treatments (such as suturing) to reduce the need for the patient to attend an A&E.
- The ambulance service gave patients information leaflets on various conditions. These included general advice and support for patients to manage their own health conditions. A number of other leaflets about alternative-to-emergency services were available for ambulance crews to use in discussion with patients. We observed examples that included how to manage a nose bleed, what to do after a head injury and when to seek further medical attention. There were separate information leaflets for children, such as for head injuries.

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- The trust's website also promoted various health campaigns such as winter flu, 'Summer safe', 'Act FAST–Stroke'. It also gave information about various other services that people should consider in managing their own health.

Emotional support

- We observed ambulance staff giving patients emotional support. When they interacted with a patient with dementia, they crouched so as to be at eye level with the patient. They also checked, in a calm and caring manner, that the patient understood the process.
- Parents of two young children told us the crew was calm and supportive in a stressful situation, and that they had a caring and gentle manner. One woman told us that the ambulance staff were supportive when her husband was admitted to a hospital as an emergency. She said, "The paramedics looked after me in A&E while my husband was being attended to until they were called away to another incident. I was in a high degree of anxiety and the paramedics were thoughtful in reminding me of practical things, like taking my handbag/money and remembering my house keys so that I could get back into the house later. Their professionalism, efficiency and kindness could not be faulted."
- There was an information leaflet available for ambulance crews to use in discussion with the relatives of patients who had died. The leaflet was available in other languages, braille and audio. We reviewed comments from people whose relative had died, and they were positive and thankful. One relative said, "Mum wanted to thank you for the incredible care she received on numerous occasions."
- Relatives were kept informed of where the ambulance was going so that they were able to follow. When it was safe to do so, family members or friends were able to accompany a patient in the ambulance.

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

The emergency service was being planned around the needs of local people, and urban and rural issues were being taken into consideration. There was support for bariatric patients and for people with a learning disability

or living with dementia. However, ambulance staff had less training and experience to deal effectively with people with a mental health condition. Care pathways to coordinate responsive services for people in crisis were not well developed.

The trust was dealing with an increasing number of emergency calls and was developing alternative pathways to transport to hospital. The trust was above the national average for treating people at the scene without the need to take them to hospital, and whenever possible non-emergency services were used. Action was being taken on long waiting times and the trust had introduced measures to ensure that people were monitored while waiting, high-priority calls took precedence and to improve rural access. There was work with healthcare professionals and GPs to ensure an appropriate response, although this was not always seen as effective and some healthcare professionals in community and acute hospitals told us about longer waits which presented risks for patients. People from black and minority ethnic groups and those whose first language was not English were supported with advice and language aids when available in the ambulance.

Complaints were handled appropriately and action was taken to improve the service as a result. Staff received feedback from the investigation of complaints and learning was shared.

Service planning and delivery to meet the needs of local people

- The 999 response service was provided to people in Oxfordshire, Buckinghamshire, Berkshire and Hampshire. The service took account of urban and rural issues, and services were being planned and delivered according to local needs.
- For the treatment of patients not experiencing an acute condition, but who required, for example, secondary care facilities, ambulance crews could contact an external service, the Rapid Assessment Communication Clinic (RACC) for advice as to the support available in East Berkshire. This included a Saturday service.
- For urgent referrals of patients, 24-hour access was available by telephone to community health services through the Health Hub (provided by Berkshire Healthcare) for patients in West Berkshire. Ambulance

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clinicians could make urgent referrals by telephone with no requirement to complete an extra referral form. Mental health referrals were made through a dedicated telephone available 24 hours a day.

- An alternative pathway trial was being operated in South Buckinghamshire. For ambulance crews called to care homes, and after an assessment that the patient needed a medical review rather than admission to hospital, staff could contact a duty consultant for advice before taking the patient to a hospital A&E department.
- A demand management team had been piloted in South West and North Hampshire to identify the needs of people in relation to frequent calls, both from individuals and from institutions such as care homes. The project had worked successfully with falls teams and other providers to reduce falls, improve patient care and reduce unnecessary calls to the service.
- The trust provided a service on Friday and Saturday nights in the city centres of Portsmouth (Safe Place) and Southampton (ICE Bus) to provide support, first aid and transfer to hospital if needed by members of the public enjoying a night out. This had been set up in partnership with other organisations such as the Hampshire police, the local council, volunteers and the local street pastors.
- There were ambulances available that were equipped for ease of access for bariatric patients. The trust also had bespoke bariatric stretchers that fitted into the stretcher mounts of all front-line vehicles. These were placed at strategic locations throughout the trust and were sourced as required. HART would also support the road crews when it was necessary to move a heavier patient, and when a more detailed assessment of risk and how to manage it might be required.
- The proportion of incidents that were managed without the need for transport to A&E included patients discharged after treatment at the scene or onward referral to an alternative care pathway, and those with a patient journey to a destination other than A&E. The trust had been well above the England average for this indicator for the past three years (2011 to 2014). In 2013/14, 41.4% of incidents were managed without the need for transport, compared with 36% in England overall.
- The trust was monitoring long waits for ambulances and had identified that there would be some 999 calls and healthcare professional calls where patients experienced a longer response time because of changes in call category, peaks in demand for services, staff shortages and distances to scene. There was monthly monitoring of these issues and review at senior committee. In July and August 2014, the trust had identified 76 calls where there had been a long wait (beyond target times) for an ambulance. The trust had introduced escalation plans to ensure higher-priority calls took precedence, that clinical advisors supported people with welfare checks, and that staffing increased to meet peaks in demand and having stand-by points in rural areas which included facilities for staff and also IT access. Community first responders were also being developed as a good resource.
- Some staff in community hospitals identified long waits for ambulances because the patient was with a healthcare professional. They said that the transfer of patients to acute hospitals could take several hours. It was considered that, if the service was under pressure, the patient was already in the care of healthcare professionals. However, they commented that this was not always appropriate (for example, one hospital identified a patient who had had a stroke and had waited over two hours for an ambulance to arrive to transfer them to an acute hospital). The trust was working with healthcare professionals (including GP focus groups and within education) to ensure that they requested the appropriate response to patients who required attendance.
- The trust had developed a protocol for the transfer of intensive care (ICU) patients to specialist centres and hospital staff told us this had minimised delays for ambulance transfers. The hospital staff told us that there still needed to be agreement for non-clinical transfers of critical patients, that is patient transfers to enable an admission to ICU for critically ill patients from

Access and flow

- In 2013/14, the South Central region had 6% of all Red 1 calls in England and 4.6% of all Red 2 Calls in England. The trust had been dealing with a steadily increasing number of calls since 2012; in April to June 2014, the trust had 7.1% of Red 1 calls and 5.4% of Red 1 calls in England.
- Calls closed without transport were the number of emergency calls that received a telephone or face-to-face response from the ambulance service. Overall, there had been a small but steady increase in the percentage of closed calls in the South Central area between April 2011 and March 2014.

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surgery or presenting in A&E. These transfers were put in the four hour category and ambulances did arrive within this timeframe, often at three hours and 45 minutes. Staff said this was too long for patient on a transfer bed and with transfer equipment, such as ventilation. This was a risk to their clinical care and was also a risk to the patient awaiting transfer into ICU and hospital staff said this required further negotiation.

- Team leaders we spoke with explained that an operational report of their shift was prepared that enabled them to review their response performance and to compare how the performance of staff in their team compared with other areas. The report enabled them to identify which members of staff may have missed particular response times.
- The trust had a learning disability champion who was included in new developments and the on-going monitoring and review of services related to people with a learning disability.

Meeting people's individual needs

- Staff had undertaken training in dementia and felt confident in treating and communicating with people with the condition. A small focus group was established in Oxfordshire in conjunction with the local Alzheimer's Society. This gave people with dementia an opportunity to contribute to developments within the ambulance service.
- The trust had launched a DVD called 'First impressions'. This was used to inform ambulance staff about key issues to consider when they were called to a person who had a learning disability. Staff reported no concerns when managing and treating patients living with dementia or who had a learning disability. They said that whenever possible they would include the patient's relative or carer in any conversations about care to ensure the welfare of the patient.
- There were concerns about the provision of mental health services because specialist advice was variable across the area. In Berkshire, for example, there was access to specialist advice for patients experiencing a crisis but ambulance had experienced variations in the responsiveness of this service. In Hampshire, there was no access to out-of-hours crisis support. Ambulance staff told us that patients with mental health conditions represented a significant proportion of their workload, and many staff did not have appropriate specialist training for psychiatric conditions. When staff had

identified a patient with a mental health condition, they could complete a 'Feature form to note their concern. This information was available to other ambulance staff who needed to work with the patient, so they would be aware of the patient's needs. However, staff told us that the system did not always work if the ambulance was called out of area.

- The patient clinical record included sections for 'Religion and belief' and 'Sexual orientation' and we saw that these were completed.
- Staff were supported in being able to understand and meet the needs of individual patients from black and minority ethnic groups. Equality and diversity training was available and some staff had completed it. The trust operated a diversity group and the trust lead for equality and diversity supported staff in understanding the needs of diverse demographic groups.
- The staff we spoke with were able to give examples of how they had supported patients from black and minority ethnic groups. For example, pictorial and phrase books were available in each ambulance for staff to use with people whose first language was not English. Advice was available to staff on overcoming difficulties they encountered with language barriers. Staff told us they would use basic assessments to guide them, translation books and a language line. Relatives who could speak English often provided assistance. The ambulance staff accepted that this may not always be ideal but in an emergency it was often the quickest and most effective way to communicate with a patient.
- Information leaflets about services were available in other languages, braille and audio. A communication sheet laminated for use in an ambulance used Widget health symbols.
- The trust had a 'Do not attempt cardio-pulmonary resuscitation' (DNA CPR) policy. Staff were aware of the policy and guidelines for treating end of life patients, and had received training.

Learning from complaints and concerns

- Information on how to make a complaint was on the trust's website. Patients told us they knew how to raise concerns if necessary.
- Complaints were handled in line with the trust's policy. Initial complaints were dealt with by senior staff. If they were unable to deal with a patient's concerns satisfactorily, the patient would be directed to the Patient Advice and Liaison Service (PALS). PALS provided

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an immediate acknowledgement and responded to a complaint within five working days. If the person still had concerns, they would be advised how to make a formal complaint. The trust procedure was to respond to complaints within 25 days.

- Team leaders had had complaints and investigation training, and the trust had a complaints policy document to demonstrate best practice.
- In 2013/14, the trust received 382 complaints; 31% of these were related to the emergency and urgent care service; the main areas of complaint were about clinical issues and inappropriate staff behaviour. In 2013/14, the Parliamentary Health Service Ombudsman handled three referrals related to the trust, only two of which were investigated; none were upheld.
- The trust's complaints process was supported by PALS. In 2013/14, there had been 1,090 PALS contacts and 889 compliments about the trust service.
- Staff told us they received feedback from the investigation of complaints and concerns that supported their learning. Team leaders gave examples of feedback they had given to their teams after the investigation of complaints, either in meetings and through the appraisal process. Staff confirmed that feedback was given and action plans were developed. However, some staff we spoke with said they had not received feedback after complaints.
- The trust could show that it was learning lessons as a result of complaints. For example, a training programme had been implemented to reduce the number of issues related to staff behaviour.
- A community liaison and training officer (CLATO), whose role involved the supervision of voluntary responders, told us he had received written compliments from patients who were pleased with the service they had received from ambulance responders. Complaints from the public, if any were received, were usually caused by a lack of understanding of the remit of volunteers.
- A number of patient advice information leaflets were available for use for patients to manage their own condition.

Are emergency and urgent care services well-led?

The trust had a five-year strategy to develop mobile healthcare and increase the coordination of care in

people's homes and in community settings. The staff spoke positively about this vision for the service and felt engaged with the trust strategy. The staff understood and clearly displayed the values of the trust. Staff felt supported by their managers and worked well within their teams. The role of the team leader and clinical mentors was valued and appreciated by staff. Clinical governance arrangements were well developed. Risks were appropriately identified and managed. Staff could raise concerns but more action was needed to avoid complacency around ongoing known risks. The trust used private providers to ensure service cover and these providers were appropriately monitored. The performance of the external contractor to 'make ready' ambulances was monitored but the quality of their work required better supervision and monitoring.

Public engagement activity with the service happened through a variety of channels such as media, social media, weekly newsletters and community liaison work. Patient feedback, through surveys, interviews and liaison work, was being used to improve the service. Staff engagement was good and there was effective communications with remote and lone workers by email, phone and team meetings. The staff, however, had identified the need for more engagement about shifts and flexible working, and for the trust to recognise the impact of this.

The ambulance service had implemented many innovative and improvement projects. For example, the trust provided an exceptional learning resource to its front-line staff. The 'Simulance' was an innovative virtual classroom facility that enabled ambulance staff to experience realistic medical situations inside an ambulance saloon.

Vision and strategy for this service

- The five-year service strategy for mobile healthcare was to continue to save lives with emergency responders dispatched immediately and specialist clinical teams able to convey a patient to the most appropriate healthcare setting. Mobile clinical teams would support people in their own homes and the local community, offering advice, assessment, diagnosis and treatment at the scene. Technology would be used so that mobile clinicians could access patient care plans and clinical records electronically. The plan was for staff to work flexibly to accommodate the future nature of emergency

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and urgent care. The effective coordination of care would mean fewer people taken to hospital and the fleet of vehicles would change in future with greater emphasis on cars and small vehicles.

- The trust's values for 2014/15 aimed at delivering high performance through teamwork, innovation, professionalism (setting high standards) and caring. Its vision was encompassed in the strapline "Towards excellence – Saving lives and enabling you to get the care you need".
- The trust's vision and values was recognised and owned by staff. Ambulance service managers could tell us about the trust's five-year strategy and spoke with enthusiasm about the ambulance service. Staff related positively to the vision for the ambulance service expressed by the chief executive and felt engaged with the trust's strategy.
- The ambulance crew were aware of the changes happening in the service and the direction in which the trust was moving. They told us the nature of the service had become more 'urgent' than 'emergency' and that the trust was dealing effectively with this change.
- Information about the organisation's values was displayed in the resource centres that had noticeboards to display paper notices. In discussions and observations, it was evident that all staff displayed the values of the organisation. Staff showed in conversations a drive for quality and safety. Team meetings gave all staff opportunity to be made aware of organisational strategies.

Governance, risk management and quality measurement

- The staff had team meetings to review operational issues and performance, and incidents, complaints and audit data were discussed. Because of the nature of the work, crews were not always available to attend regular meetings. There was a clinical review group that checked clinical risks and sent alerts to staff by email. This gave the trust a level of assurance that staff had access to important data to help them in their day-to-day work.
- Performance was monitored and reported at station level. Information seen included that relating to the right care, and care bundles; infection prevention and

control; and medicines management. The staff we spoke with told us they were not always aware of the outcome of the performance audits and how the trust was performing against the outcomes.

- The service had a risk register that included areas of risk identified at both the operational and the corporate level. These risks were documented and a record of the actions being taken to reduce the levels of risk was maintained. Issues relating to recruitment, low staff morale, and inability to meet staff training and educational targets were included on the trust's risk register.
- The risk management strategy for 2014-15 was a trust-wide document and staff were aware of this. They were alert to risk and reported issues they were concerned about. A forum was available for staff to raise concerns about risks.
- Managers and team leaders identified some of the risks with the front-line service, and discussed how the ambulance service dealt with these. The correct deployment of the workforce was described as an ongoing challenge. Managers were trying therefore to 'hold onto' their highly qualified paramedic crews by offering high-level training, including clinical Master's degrees.
- The trust was monitoring long waits for ambulances and had identified that there would be some 999 calls and healthcare professional calls where patients experienced a longer response time because of changes in call category, peaks in demand for services, staff shortages and distances to scene. There was monthly monitoring of these issues and review at senior committee. The trust had introduced escalation plans to ensure higher-priority calls took precedence, that clinical advisors supported people with welfare checks, and that staffing increased to meet peaks in demand. There was work with healthcare professionals and GPs to ensure an appropriate response, although this was not always seen as effective and some healthcare professionals in community hospitals told us about longer waits.
- Team leaders and supervisory staff we spoke with were aware of potential issues and risks for clinical ambulance staff who may have working arrangements outside the service. Staff were aware of the trust's policy that covered this area. A secondary employment policy was in place and the service was assured that staff declared secondary employment and were available for

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work. Staff we spoke with felt the trust had a good working relationship with external ambulance services and were happy with the governance arrangements. There was no material or adverse impact on the care and treatment being provided.

- There was a policy for lone workers to follow to promote their safety; this included flowcharts of when to wait for back-up before attending an incident. Staff we spoke with who worked alone on rapid response vehicles (RRVs) did not express any concerns about their safety. They all told us they would request assistance from an ambulance crew or the police if needed.
- There were robust systems to monitor the performance of private providers of 999 services. There were monthly meetings to monitor clinical issues, complaints, incidents and operational performance. As part of their contract with the trust, private providers were required to install the mobile data system to enable the call centre to track them.
- The performance of the external contractor to 'make ready' ambulances was monitored but the quality of their work required better supervision and monitoring.
- The governance process for managing controlled drugs in the southern region of Hampshire lacked clarity. There was a lack of assurance over the safety and security of these medicines in respect of ordering, storage, supply and disposal, and the processes were described by a senior member of staff as "chaotic".

Leadership of service

- Staff told us they felt supported by the local management teams, members of which were visible and approachable. Supervisory staff who acted in a management role at the resource centres attended monthly senior management meetings at trust headquarters, which they said was helpful. They had regular contact with managers and felt supported. They said the area managers they reported to were "clinically led and patient focused." Managers told us they received leadership training.
- Team leaders worked in their own locations and were described to us as "highly visible clinical managers". Staff told us that this team structure had been in place for 2 or 3 years, and had made a significant and positive difference to clear and effective channels of communication. A team leader told us that "Staff feel quite remote down here," although they said this was less so for team leaders.
- Clinical team leaders were given small work teams to improve efficiency and communication channels. There were clear lines of responsibility from front-line paramedics through team leaders, area managers and senior management.
- The staff said they felt fully supported by their team leaders and gave us examples of the support they had received. They felt happy with their role, but also enjoyed supporting more junior staff. Team leaders with a number of part-time staff explained that they could have difficulty maintaining contact with members of their team.
- Staff we spoke with expressed their appreciation of the clinical mentor role; they felt they worked closely with, and were well supported by, their clinical mentor. Emergency care practitioners provided clinical supervision for ambulance crews. One practitioner we spoke with felt there was scope to expand the role of the clinical supervisor.
- Most ambulance staff told us that they worked in a strong team of people who worked well together.
- There was a varied picture from the ambulance crews about how visible the leadership team at board level were. Some had met the chief executive but not the other members of the board while they were on station visits. The staff felt that generally the trust senior management team was remote and sometimes simply issued commands. One example was that staff were not happy with emails from the senior management team telling them that they needed to reduce the time spent with patients at an incident. They felt they would prefer this type of information coming directly to them from their team leaders, so that the issues could be discussed.
- Other trust communications from the senior management team were appreciated. A member of staff we spoke with had received a letter from the head of service stating that they were to be congratulated for achieving a successful outcome from a cardiac arrest. The trust used this approach after every successful cardiac arrest incident.
- HEMS reported that they felt connected with the senior management team and could tell us about meetings and interactions they had had with them.
- The staff, in general, were able to identify the different leads, such as the infection control lead or safeguarding lead, and said they received good support from them.

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Culture within the service

- The staff told us there was an open and friendly culture at the ambulance stations and they felt confident to raise any concerns with their managers. Ambulance staff told us they felt they were communicated with appropriately and involved in what was happening.
- Staff spoke positively about the high-quality care and services they provided for patients and said they were proud to work for the trust.
- Ambulance crews told us they enjoyed their job although they felt their work/life balance could be improved. Each of the ambulance crews we spoke with appeared highly motivated and committed to their roles. Some of the crew mentioned the name of the chief executive and said he had made an effort to visit the ambulance stations. This was appreciated by staff and they felt he listened to but wanted more opportunities for consultation and engagement.
- We asked team leaders and supervisory staff to comment on the environment of targets they worked within. One supervisor responded that it was not their decision, but they had confidence in the organisation and in its ability to meet the targets through its resource planning. A team leader said they were proud of their team and their job, and felt they worked within an ethos that good and bad things could be shared.
- Some emergency technician staff told us that their role did not seem valued by the trust.

Staff engagement

- The trust had conducted an annual staff survey and had received a response rate of 59.7%.
- The trust had produced a weekly newsletter called “Staff Matters,” and we saw examples of this publication in the resource centres we visited. It contained up-to-date, topical information for staff, such as staff rewards, good practice, training and events. We also observed a station-level newsletter, ‘The Node’, which contained local news for staff that was also prepared by the trust.
- Staff engagement took place by communications with remote and lone workers by email and phone and in team meetings. Because of the difficulty for some staff to attend team meetings, they could also meet during planned educational attendances, and at some social events.
- The strategic changes within the organisation had brought some concerns for staff, specifically the changes

in rotas and shift patterns, and the phasing out of the technician’s role. Staff told us there had been a good level of communication on the issues, and they understood the need to match resources and demand. However, they considered that more engagement was necessary so that managers and senior staff in the trust understood the impact of the changes, and made sure they were handled appropriately and not rushed.

Public engagement

- The trust had taken various initiatives to gather information on patients’ experience of the service. For example, it had conducted a patient satisfaction survey for people aged over 65, the NHS Friends and Family Test, and a survey of the contacts made to PALS. The trust had made action plans for improving patients’ experience after the survey results.
- The results of the patient satisfaction survey for people aged over 65 showed that most callers were very satisfied with the care and treatment they had received from SCAS. Crews were perceived to be polite and considerate, and good at communicating.
- The trust did various activities to increase the awareness of ambulance services in the local communities. For example, the ambulance service had recently participated in an event organised by Oxfordshire Play Association. This was aimed at encouraging children and young people, and their parents or carers, to ‘try something new’, and provided information on services and activities available in the local and wider area.
- The trust undertook public engagement using a variety of media (for example, Twitter to impart clinical knowledge and expertise). During the hot summer, daily ‘tweets’ would remind people to drink sufficient fluids and use sunscreen. During the summer holidays, the messages had a strong focus around child safety. We noted printed copies of tweets sent by the public, praising the staff for good service. These were displayed on staff noticeboards for further engagement.
- Representatives of the trust attended local youth organisation meetings, village fetes and school assemblies. One of the resources they used was a child-friendly first-aid book printed specially to take to schools. This was an impressive initiative.
- The trust had a patient experience team, led by a head of patient experience, to respond to concerns and complaints in a timely and effective manner.

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- Crews and ambulances had visited groups of children with autism to build up relationships and break down barriers
- In December 2013, a survey was undertaken to elicit the experience of patients over 65 years old with a view to extracting any themes relating to dementia or carers' perspectives. The results showed that most callers were very satisfied with the care and treatment they had received from the service. Everyone questioned said they would be happy to use the ambulance service again.
- The trust was in the process of introducing face-to-face interviews with patients to elicit their views and feedback on their experiences with the ambulance service. These interviews were planned to take place in hospitals and minor injury units.
- In June 2012, the service ran two open days in conjunction with learning disability service providers in Buckinghamshire. Service users were able to look round an ambulance and speak to a paramedic. The event was aimed at raising awareness and allaying fears. Awareness of Autism Alert Cards, Vehicle Communication Sheets and Health Passports was also included in this event.
- Crews and ambulances had visited groups of children with autism to build up relationships and break down barriers.

Innovation, improvement and sustainability

- The ambulance service had implemented several innovative projects that had introduced improvements to the operation and management of the service.
- The service had plans to launch a new major trauma triage tool 'app' that could be accessed on smartphones. The app was designed by a paramedic and trainee consultant practitioner. It would help to ensure that ambulance crews always took critically injured trauma patients to the right hospital, based on their condition and location.
- The trust gave their front-line staff an exceptional learning resource. These were opportunities to undertake primary and secondary degrees. The educational resource centre at Bracknell provided an AV suite where films were made. These were particularly effective for learning because the staff were used in the making of the films. One film we saw had been made following new guidelines from JRCALC. By using innovative means of passing on this information, learning took place in a memorable fashion.
- A new and cutting edge initiative was the introduction of a 'Simulance'. This was a large command vehicle fully equipped with simulation learning activities. It was an innovative virtual classroom facility that enabled ambulance staff to experience realistic medical situations inside an ambulance saloon. The trust had presented this project at a national conference earlier in 2014, and the simulator was now part of the training resource. Training sessions could be recorded and playback used to provide further learning opportunities.
- The future sustainability and quality of care were discussed with the senior training manager. He told us that there was a "home-grown" initiative in place, whereby community first responders (CFRs) could be trained to move into emergency care assistant (ECA) positions, and ECAs could be provided with full training to paramedic level if suitable candidates were available.
- Trauma risk management (TRiM) was in place to provide confidential support to staff who may have been affected by traumatic incidents or conditions. Staff were assessed 3 days after a traumatic event and again after 28 days. Thirty-two TRiM practitioners gave peer support and advice, and there was also an external counselling service. The early intervention had both reduced sickness absence and improved the welfare of staff.
- GP triage arrangements were mentioned to us as an innovative development by several staff. Local GPs gave clinical advice to ambulance crews on scene and enabled access to alternative care pathways when this was more appropriate than taking a patient to a hospital A&E department. We encountered examples of this working in practice when we spoke with ambulance crews.
- HEMS showed innovative practices and learning taken from combat zones. They now had the equipment and skills to provide blood transfusions and perform ultrasound and blood gas tests before arrival at hospital. In some circumstances, this bypassed or reduced the time a patient had to spend in the A&E department and meant they could receive treatment immediately on arrival to the hospital. HEMS were also planning to introduce a night service, so that the service would be available 24 hours every day.

Patient transport services

Information about the service

South Central Ambulance Service provided patient transport services (PTS) for people who met the eligibility criteria within the populations of Oxfordshire, Milton Keynes, Buckinghamshire, Berkshire and Hampshire. The PTS facilitated vital access for many patients with planned healthcare appointments. The trust provided 678,000 patient journeys in 2013/14.

The PTS works in four teams which are county based. Teams in Oxfordshire and Buckinghamshire are currently managed through northern emergency operations centre (EOC) in Bicester, and teams in Berkshire and Hampshire through the southern EOC in Otterbourne. The service had 147 vehicles which included ambulances and wheelchair accessible vehicles. Two of the ambulances were equipped for bariatric patients; these were shared across all areas of SCAS. The service's ambulance care assistants drove these vehicles. Approximately 375 staff in the PTS. The service also commissioned three independent ambulance providers and taxi services to support their PTS work, along with 143 volunteer car drivers.

During our inspection, we visited the northern EOC and the southern EOC; three resource centres in Berkshire, two in Hampshire and three in Oxfordshire. We visited four local hospitals where we met patients in outpatients, renal dialysis units and discharge lounges. During our visit, we spoke with 24 patients, 11 relatives or carers, 48 trust staff (including managers, call centre planners and dispatchers, and ambulance care assistants) and 3 staff from private providers. We spoke with 21 staff working in local hospitals. We inspected 13 vehicles and observed care on 3.

Summary of findings

Patient transport services (PTS) provided non-emergency transport for patients who, for example, attended hospital outpatient clinics or day hospitals, or were discharged from hospital. Commissioners had identified eligibility criteria for the service and the trust was working with 12 clinical commissioning groups to monitor performance and compliance. Staff followed the eligibility criteria and were also working to improve the signposting of people to other services if they did not meet the criteria. Procedures to ensure the safety of services needed to improve, specifically around incident reporting, equipment checks and safeguarding procedures. 'Do not attempt cardio-pulmonary resuscitation' (DNA CPR) orders were understood and used appropriately, but staff had limited awareness of the Mental Capacity Act 2005. Most vehicles were visibly clean. There were staffing vacancies and staff felt stretched, particularly in the dispatch team where this had an impact on the planning and scheduling of transport. The trust was using volunteers and private providers to cover driving shifts. There needed to be better governance arrangements for private providers and driving and employment checks for volunteers. Anticipated resource and capacity risks needed to be better managed. For example, problems with the new IT system had caused a serious disruption to the transport arrangements for patients during our inspection.

Dispatch staff did not always have appropriate assessment information, from hospitals or patients or from their own records. As a result patients sometimes did not have an appropriate vehicle or equipment, and transport sometimes had to be reorganised. The system to plan journeys was manual and often reactive based on a lack of timely and coordinated information and this had caused delays to patient transport. Computer aided dispatch was being developed.

The trust was not meeting performance targets and this was having an impact on patients' care and treatment. Patients were experiencing delayed and missed appointments for outpatient consultations and diagnostic scans, and renal dialysis, and some were choosing to curtail their treatment in order not to risk

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missing their transport home for fears of excessive delay. There were good examples of multi-disciplinary working with GPs and health professionals in hospitals. Trust had been working with other providers to improve the coordination of care and some progress had been made.

The staff were caring, compassionate and dedicated to improving the service. Training was available but many staff had not undertaken this training to support them in undertaking their roles. Patient surveys were regularly undertaken; these were positive but identified delays. Patients we spoke with were similarly positive about the staff. However, they were concerned that the service was not effective and that they were not given enough information about delays, missed appointments and the eligibility criteria. Call handlers were overwhelmed with calls about service delays and only half of all calls were answered.

Many patients told us they had been distressed and anxious waiting for transport, but did not know whom to contact within the service. There was good support for vulnerable patients (for example, those with dementia or a learning disability), and carers and escorts could travel in the ambulances too. A policy for the transport of children was under development. The trust had a clear strategy for the development of PTS to support safe non-emergency travel between people's homes and healthcare settings, but most staff were unaware of this strategy. Governance arrangements needed to improve in order to assess and manage risks. Although staff worked effectively in teams, many wanted the management and leadership of the service to improve and for the trust to prioritise PTS alongside the emergency 999 service. Patient feedback was gained through regular surveys and there were good examples of changes to improve the service as a result but staff did not always receive the feedback from the surveys. There had been a number of innovation and improvement projects within the service.

Are patient transport services safe?

Patient transport services (PTS) needed to improve procedures in order to provide safe care and transport. Staff had not received training on how to report an incident, and they did not receive feedback or share learning on reported incidents. Vehicles were well maintained, serviced and clean. Most equipment was well maintained, serviced and appropriately clean, but some necessary equipment was not always available. Some automated external defibrillators (AEDs), for use when a patient is in cardiac arrest, were not easily accessible or regularly checked. Staff could administer a limited range of medicine and could administer oxygen in circumstances when it might be deemed necessary.

Safeguarding procedures were not always followed and some staff could not recognise concerns in relation to the abuse or neglect of vulnerable adults and children. Ambulance crews had electronic personal digital assistants (PDAs) to update them on scheduling and necessary patient information. This system was not in use in Berkshire where manual records were being used temporarily. 'Do not attempt cardio-pulmonary resuscitation' (DNA CPR) information was used appropriately. The update of mandatory and statutory training was low.

There were a number of staff vacancies, and bank staff and private providers and volunteer drivers were being used to cover shifts. Volunteer drivers did not always have the necessary checks to ensure driver safety and their competence in working with vulnerable people. There were also safety concerns for patients who were left unattended for long periods when lone crew members were working on ambulance vehicles. The trust was working to increase staffing levels and had undertaken recruitment in key areas to ensure that staffing numbers and skill mix were appropriate. There were also vacancies in dispatch teams who felt stretched, and these had an impact on the planning and scheduling of work.

Anticipated resources and capacity risks were understood and action was taken to improve the service, for example, better IT to reduce the number of delayed and missed appointments. However, the service had IT problems that had seriously disrupted patient transport on the day of our inspection. Environmental factors such as rural location and road traffic were not routinely taken into consideration

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in planning. The planning and scheduling of work were done manually; this was often reactive and at short notice, the trust planned implementation of a new computer dispatch system aimed to improve this process.

Incidents

- In the Department of Health NHS Staff Survey 2013, 78% of staff reported errors, near misses or incidents witnessed in the last month; this was lower than the percentages in other trusts.
 - The trust reported no serious incidents in the PTS.
 - The trust had introduced a new electronic incident reporting system in April 2014. This required staff to report incidents to their team leaders and complete an online report form. In the Oxfordshire and Buckinghamshire areas, we found that some staff were not aware of this new system, and not all had been trained in its use.
 - Some PTS crews said they were unable to access the incident reporting system while out on the road or at their own satellite stations. To report an incident, they needed to make a special journey to a station that had computers. They told us that there was no time in the working day to travel to other stations and they would just telephone their team leader instead.
 - The team leader and supervisors in the Hampshire area told us that reported incidents were investigated by senior managers, and themes and trends were discussed at governance meetings. There was no systematic process for giving feedback to staff who had reported incidents or to share learning more widely. A manager told us staff received feedback via email and in person, but staff told us this did not happen or was inconsistent.
- Trust-wide, 67% of PTS vehicles had been deep cleaned, 18% were overdue a deep clean by a few days; a further 15% were overdue by more than two weeks. Deep cleaning was scheduled for every six weeks. In Oxfordshire and Buckinghamshire, there was no robust system for ensuring that vehicles were released to the 'Make ready' team for deep cleaning. Deep clean records were incomplete. The records for August 2014 noted that only 36 of the 42 vehicles in Buckinghamshire and 49 of the 50 vehicles in Oxfordshire were listed for deep cleaning. In Hampshire, the vehicles we inspected were visibly clean but 23% of vehicles were overdue for deep cleaning. In Berkshire, 30% of vehicles were overdue, 18% by more than two weeks. One vehicle we looked at was dirty. One patient with sight impairment told us the windows of the vehicles were often dirty. They said, "It matters to me as I struggle to see."
 - All the vehicles we looked at contained equipment for spillages, gloves and cleaning equipment. There were disposable cleaning mops. However, the trust policy for use of colour coded mop heads and buckets was not being implemented in every area. Some mop heads were not colour coded to ensure that adequate infection control and hygiene procedures were maintained.
 - There were arrangements in place for sharps bins to be collected bi-monthly.

Cleanliness, infection control and hygiene

- Infection prevention and control policies and procedures were available and accessible to staff and crew on the trust's intranet.
- The PTS booking system asked patients if they had any infections, and the planners would then accommodate those with infections on suitable transport.
- Some PTS staff had not completed the infection prevention and control training. Records showed that as of March 2014 only 61% of PTS staff were up to date with this.
- The Department of Health NHS Staff Survey 2013 identified that the trust was below average, compared

with other trusts, for staff reporting that hand-washing materials were always available. Personal protective clothing, such as gloves and aprons, were used by crews when needed. They also used hand gel before and after handling patients. Hand-washing facilities were available in areas we inspected.

Environment and equipment

- The service had access to appropriate equipment, including specialist bariatric lifting aids.
- Equipment was reported to be regularly serviced, tested and appropriately cleaned. Medical devices on the transport vehicles had been maintained by contractors. We found that stickers on some equipment indicated it was overdue for service.
- The trust did not have a reliable system to ensure that all the vehicles had all the required equipment to provide patient care. There was an electronic system in use in Oxfordshire, Buckinghamshire and Hampshire to check the vehicles before they were used. Staff recorded these checks on their hand-held PDAs, which allowed

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them to confirm that all had been checked. However, the checklists did not include items such as automated external defibrillators (AEDs) or oxygen masks; also staff might use different vehicles in one day and would not necessarily complete a checklist for each vehicle. Not all stations carried stores of equipment so staff had to drive to other stations to refill their stores.

- In Berkshire, there was no standardised equipment checklist to show staff what equipment should be on a vehicle. A manager told us the new PDAs would include a vehicle check list that would need to be signed off before details of journeys would be visible. However, at the time of our visit, this system was not yet in place in Berkshire.
- The service in Berkshire was moving from a radio system to hand-held devices. About two weeks before our inspection, the radio system had been switched off. The PDAs had not yet been issued and at one location there was no available power point for charging the devices. During the transition period Berkshire ran on paper, updates and additional work was passed to crews using the radio and mobile phones, or by crews calling in via land line. Staff reported that this was unreliable and sometimes lacked confidentiality. The trust informed after our inspection that all PTS vehicles now had handheld devices for communication and updates.
- In August 2014, a report showed that 17% of the vehicles in Buckinghamshire were classed as 'vehicle off road'. This reduced the number of vehicles available for PTS transport. PTS crews were able to take a faulty vehicle for repair and maintenance as needed or as planned.
- There were governance arrangements for the checking of AEDs. The trust commercial risk register had identified an inability to track, date, replace and repair equipment, which led to outdated equipment remaining in use. The trust had agreed a maintenance schedule for all AEDs in August 2014.
- The trust did not have a policy about carrying AEDs on their PTS vehicles. The team leaders and crews believed that vehicles with stretchers carried AEDs, but one vehicle that carried a stretcher did not have an AED. There was therefore a risk that crew driving this vehicle might assume that an AED was on board.
- The Fiat vehicles with stretchers, purchased in the past two and a half years, carried an AED as standard equipment. However, these were difficult to access because they were placed behind fixed seating, they

were hard to remove from their mounting and the user test screen was not visible until they had been removed. This meant that the AED was not easily accessible in an emergency.

- AEDs were not regularly checked to see if they were working and the battery was charged. There was no system to determine how and when they were to be checked. There was therefore a risk that they would not be sufficiently charged to be effective in an emergency. There was no system for recording and checking the equipment needed to use the AED, such as gloves, razors, tough cut scissors and defibrillator pads.
- Dispatchers in the north used a new computer. They could no longer see patients' outbound journeys and collections on two different screens, and this caused logistical problems in the planning and dispatching of vehicles.
- Dispatchers and planners provided the PTS crews with information via the PDA system. Examples included a patient's home address and any equipment that may be needed. Staff indicated on their PDAs the time they completed their jobs. There was a delay in updating changes if a job was amended in any way. Private ambulances and volunteer drivers did not have any PDA system; planners created a worksheet for them manually and they would telephone the drivers, thereby introducing an element of delay.
- There was a standard operating procedure for lone workers and their PDAs were tracked to identify where they were.
- Patients would often be asked to provide their own child seat because there was a limited supply within the ambulance service at some sites. There was a standard operating procedure for risk assessment of patients' own equipment. Managers told us they completed these risk assessments and we saw a copy of one.
- The PTS resource centre in Reading was not fit for purpose. The facilities were two Portakabins™. The carpets were stained and space was limited. Managers told us these had been 'temporary' arrangements for 15 years. They also told us they were unable to get any repairs done because of the temporary nature of the premises.
- Medical devices on the transport vehicles were maintained by contractors. However, this process and its record keeping were not robust. Managers gave conflicting information and described several different processes regarding who reported and maintained

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these records. We were not given any records during our inspection and were unable to find the vehicle defect log that we were told were on the vehicles. This risk was listed on the trust's commercial risk register together with a plan for mitigating action.

- During our unannounced inspection, we found some of the emergency and first-aid equipment was out of date on some PTS vehicles; this was replaced during the course of our visit.

Medicines

- The trust's medicine management policy dated July 2014 stated that "a patient's own medicines may be administered by the specified trust employees, where a trust treatment plan had been completed and signed off by the Executive Director for Patient Care". The policy also stated: "Administration to the patient should be in accordance with a prescription written by an authorised health professional or in accordance with the AACE Clinical Practice Guidelines, Trust protocol or PGD or in the case of patients own medicines, the signed trust treatment plan." The trust's standard operating procedure (89/14) stated that band 2 ambulance care assistants were not able to administer oxygen and must therefore adopt the role of driver in order to do so.
- The PTS staff told us they were able to administer aspirin, dextrose oral gel, nitrous oxide 50% and oxygen 50% (Entonox®), and oxygen when they had received training. Staff told us ambulances carrying oxygen were always staffed by one band 2 and band 3 ambulance care assistants to be able to administer this oxygen if required.
- Oxygen was safely stored. If carried on an ambulance, it was regularly checked and we saw the checklist in place to ensure safe storage. Patients brought their own mask and tubing if they needed to self-administer oxygen.
- Patients' own medicines were assessed by their referring healthcare professional and the PTS manager before accessing the service. The information was given to the crew via their PDAs. Patients were able to take their own medicines with them and were responsible for them. Medicines that were dispensed by a hospital pharmacy for a patient's homeward journey were kept in sealed bags by the patient.

Records

- Dispatchers in the north used a new computer. They could no longer see patients' outbound journeys and

collections on two different screens, and this caused logistical problems in the planning and dispatching of vehicles. Also, the patient journeys were displayed in different colours, but the planners and dispatchers did not know what the colours meant. This meant that the dispatchers could not ascertain where problems might arise in journey times, and therefore could not be proactive in changing these.

- There were clear systems and processes for managing patient information. Electronic records were maintained on the trust's IT system and regularly updated with, for example, change of address.
- A PTS ambulance crew told us patient information was held on the PDA system, which meant timely access to patient information was readily available. The PDA system was linked to the trust's system and provided up-to-date information on people who used the service.
- Patients who had an end of life care plan were identified on the PDA system. A crew told us that any patients identified as having a 'Do not attempt cardio-pulmonary resuscitation' (DNA CPR) order on their PDAs were checked with the hospital staff before leaving the hospital to ensure the details provided were correct. However, we found no documented evidence to support this.
- The PTS ambulance crew told us they did not usually handle patients' records but, if required, they would pass the relevant sealed records to another healthcare professional, or their relative or representative.
- All calls to and from the emergency operation centres were recorded and could be accessed in the event of a complaint or investigation. These calls were not audited for quality or quantity data.
- Dispatchers relied on their own directories of telephone numbers for hospital departments, but each dispatcher had compiled their own because they were unable to access a reliable database on their computer systems.
- PTS managers confirmed that appropriate checks had been undertaken for volunteer drivers and that these records were held. However, we requested records relating to these checks and did not receive them.

Safeguarding

- There was a named executive director with responsibility for safeguarding, and a named safeguarding lead. The PTS staff did not know that there was a safeguarding lead within the trust. The safeguarding team was small with one lead and three

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other members of staff. The trust was developing safeguarding champions to develop the agenda across the organisation, however, we did not identify any safeguarding champions in the PTS.

- All staff were required to complete the level 1 safeguarding training, which was an e-learning training package. This was also covered in the trust's induction.
- PTS staff told us they had received safeguarding training level 1 at induction, which for some staff was many years ago. Information provided by the trust showed that only 46% of PTS staff were up to date with their safeguarding training. The trust had a plan to roll out face-to-face level 2 safeguarding children training to PTS staff in 2014/15.
- Not all the PTS staff we spoke with were able to describe the different types of potential abuse to vulnerable adults and children, to recognise the signs of abuse or to explain how to report a safeguarding alert.
- PTS staff told us that they would report any concerns to their team leaders or to the staff at the operation centre. However, team leaders did not always recognise when a situation required a safeguarding alert. For example, one team leader had reported an incident on the electronic incident reporting system that later had to be reported as a safeguarding alert; They had been prompted to do this by the staff monitoring the system. Team leaders knew how to send a safeguarding alert by fax but were unaware of how to send one more promptly.
- The trust had an audit plan for 2013/14 in which a safeguarding audit was planned to be carried out by March 2014. The audit was to involve internal reports, the quality and safety committee and the clinical review group, but the trust's records showed that the audit had not been carried out by the time of our inspection.

Mandatory training

- The trust had identified the statutory and mandatory training requirements for all staff involved in the delivery of PTS. It aimed for 90% of staff to have completed this training every 12 months, or every three years for some training. For the number of eligible PTS staff, only 74% had completed training in information governance; 67% in health and safety; 62% in fire awareness; 61% in infection and prevention control; 57% in moving and handling; 51% in conflict resolution; and 12% in equality, diversity and human rights.

- PTS staff accessed training for fire, information governance and manual handling via e-learning. Staff based at satellite did not have access to a computer. They therefore could not participate in e-learning or receive information from the trust that would inform their practice, such as learning from incidents. Staff at satellite stations had to travel to other stations to use computers.

Assessing and responding to patient risk

- There had been two medical device alerts raised in the previous 12 months relevant to PTS. One was about securing wheelchairs appropriately in vehicles and the other about ensuring that field safety notices were adhered to. The trust booking system asked if a patient's own wheelchair complied with International Organization for Standardization (ISO) standards. If the patient did not know, or the chair did not comply, the booking was taken to transfer the patient into a wheelchair supplied by the South Central Ambulance Service (SCAS). For patients' safety, wheelchairs were securely fixed and patients were required to wear the safety straps for their seats. The crews also ensured that people's belongings were safely stored to prevent damage or injury during a journey. The action taken on field safety notices was not identified, however, the trust policy on the central alerting system (CAS) was overdue for renewal from November 2012.
- A PTS crew told us that, if a patient became unwell during their journey, they would notify their supervisor for further guidance. If they were near to a hospital, they would take the patient to the accident and emergency (A&E) department. They would not complete an incident report in relation to the unforeseen event.
- PTS ambulance crews told us they had not had to respond to concerns about vulnerable patients because all had been supported by a carer, family member or representative. They said they would notify their supervisor to inform the operation centre to update their records about vulnerable patients if their escorts were not available.
- Planners at the northern EOC always provided two crew members when transporting patients who were known to be aggressive or sectioned under the Mental Health Act 1983 or aggressive. An escort accompanied a crew of two when providing a service to prisoners.
- The trust identified that risk assessments were undertaken to manage and reduce the risks to patients

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left unattended in PTS ambulances because of staff working alone. PTS patients were identified as suitable for a single crew by clinicians or by the patient on booking. Crews would identify any concerns and could upgrade to a double crew for the return journey. Patient records are updated for future bookings. The staff, however, told us of safety concerns about patients being left unattended in a vehicle while a crew member working alone took other patients to their appointment. Staff told us patients could be left for up to an hour. There was therefore a risk of patients becoming distressed and anxious while being left unattended.

Staffing

- Information provided by the trust showed that there were 48 (15%) vacancies against a planned vacancy target of 28 (April to July 2014).
- There was a trust-wide year to date sickness rate of 5.4% against a planned rate of 5.1%. However, at the time of our inspection, there was a significantly higher than average rate (11%) in Berkshire PTS. A number of staff were experiencing long-term sickness. Managers were aware of this and explained the process for managing and supporting staff. Absence was covered by bank staff and private providers.
- Overall, there were concerns about staffing levels. Staff in Hampshire confirmed there were sufficient numbers of staff to meet the needs of the service. The team leader and supervisors in Hampshire told us they had recently recruited staff for the start of a new contract on 1 October 2014. However, PTS crews in Oxfordshire and Buckinghamshire reported a marked increase in their workload in the past few months due to illness, holidays and vacancies. The Stoke Mandeville station had received five new recruits and did not see staffing as a concern.
- In Berkshire, managers and ambulance care assistants told us recruiting and retaining sufficient staff were challenges for the service. This was identified as a risk on the service risk register. At our inspection, there were four vacancies for ambulance care assistants, which was a vacancy rate of 6.5%. Although recruitment took place regularly, managers told us it was difficult to maintain full-time staffing levels because of the cost of living locally. The service had recruited a number of bank staff to cover shifts, as well as using private party providers.
- The northern PTS operation centre had three dispatch staff whose shifts were from 7am to 7pm. In the

afternoon there were two staff. The work rate in the afternoon increased as the vehicles were dispatched to return to hospitals to pick patients up, yet the number of staff was reduced. The dispatchers were constantly interrupted by the call handlers and radio calls from PTS crews. Dispatch staff had raised concerns with management a number of times about the lack of staff in the afternoons.

- A senior member of the northern EOC said they were significantly understaffed. A major issue that took up considerable time was the negotiating of funding for the large number of extra-contractual patient journeys from areas outside the PTS area. In the northern EOC, two members of staff worked as call handlers and negotiators; they dealt with a large number of extra-contractual transfers for patients' journeys that did not fall within the trust's clinical commissioning group (CCG) contract. The call handlers in the southern EOC confirmed that they would also contact a patient's CCG to obtain authority regarding finance if the patient was out of the PTS area.
- The southern PTS operation centre staff had identified concerns with the current rota and had designed their own rota. Staff worked within the working time directive set out by the Advisory, Conciliation and Arbitration Service (ACAS). The team leader and supervisors in the southern EOC told us they also used bank staff employed by the trust.
- Staff were able to contact PTS control between 6.30am and 11pm. Outside these times, there was a duty manager contactable on a dedicated telephone number. Staff said they were able to speak with managers both during and outside working hours if they needed support or advice.
- The PTS crews were aware of the lone-working policy and said any concerns would be reported to their supervisor. They could also use their PDAs to allow other crew members to respond quickly in an emergency situation.

Anticipated resource and capacity risks

Service changes

- During the week of our inspection the PTS were undergoing operational changes to the service delivery model as a result of improved and upgraded technology and new ways of working. This included the move to our single IT system from two isolated versions to allow

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greater flexibility, visibility and resilience in delivering the planning, tracking and management of patient journeys. In addition the telephony system was changing to a virtual system to facilitate our new ways of working.

- The trust had recently updated the computer system used by PTS staff in the northern EOC. The impact of the change on the booking system, staff capacity and the risk of failure was on the risk register.
- The online booking system was not working during our inspection. Staff said this was due to the updating of the system. The operation centre team was unaware that the system was not working until they were told by hospital staff and patients trying to use it. Staff at the operation centre had not been told when the system would be working again. One senior member of staff did not know when it would be backed up, but anticipated within a week.
- Managers were not aware of the risk associated with the replacement of the online booking system and there was no plan to resolve the subsequent difficulties. The northern EOC had no clear processes to cope with the IT failure. This had a direct impact on patients who waited long periods for their journeys or could not have transport. The hospital departments were also affected because they had to supply staff to stay with patients in closed departments while they waited for transport. GPs trying to book transport for patients were unable to access the booking system using their usual GP codes, because these had not been imported into the updated system.
- Staff at Churchill, John Radcliffe and Stoke Mandeville Hospitals, GPs and patients had called into the operation centre to try and book journeys. However, because of the increased number of people trying to call the centre, this could take more than 30 minutes. There was no increase in staff to accommodate the increased number of callers, and no escalation procedure to mitigate for the lack of the online booking system. Staff became overwhelmed with the number of incoming calls, and patients and hospital staff became frustrated at the lack of both the facility and information.
- In the northern EOC, the IT failure resulted in 32 patient journeys being unallocated at 3.30pm on Wednesday, 10 September. The dispatcher said that there would normally be only about 5 unallocated journeys by this time. We observed dispatchers calling hospital

departments to alert them to delays in transport, but some hospital departments did not answer their telephones. Some departments notified the dispatchers that there were yet more patients waiting for transport.

- Changes to the computer system also identified patients 'pending' booking, but the process of releasing patients and planning for the next day meant that there was a risk that some patients could be missed.
- The team leader at the southern EOC told us their discharge staff had confirmed the system had recently "failed". However, they reverted to a paper copy system; this enabled them to manage their workload and had not disrupted the management of the ambulance crews.

Planning journeys

- The trust had contracts with CCGs and private providers for the allocation of resources. Private ambulance crews were used when all the trust's vehicles and crews had been allocated. Over 22,000 journeys (9%) were carried out by private providers, including taxis in the north of the trust where 7,990 (35%) of patient journeys were carried out in Aylesbury Vale and Chiltern.
- The trust had used private providers of PTS and volunteer drivers when its own resources were unable to meet demand. It had a validation process for these providers that included vehicle insurance checks and employee criminal record checks with the Disclosure and Barring Service (DBS). DBS offers criminal record checks that help employers make safer recruitment decisions. Private providers were monitored monthly but governance arrangements were inconsistent and there was variation in monitoring of for example, complaints, incidents and operational performance
- Patients who required minimal assistance were allocated to cars driven by volunteers. The PTS in Berkshire had four volunteer drivers providing patient transport in their own cars. It was unclear who was responsible for recruitment, safety checks and ongoing management. Local managers told us the volunteers were managed by the Volunteer Car Driver Scheme centrally. However, we requested records relating to these checks and did not receive them.
- The shortage of ambulance staff in the afternoons had a direct impact on the dispatch and coordination of

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ambulance journeys to and from hospital departments. Staff said this caused distress for patients because crews were unable to say what time they would return to pick them up, or even if it would be the same crew.

- Ambulance crews organised their own workloads to ensure that patients were not left for long periods, but sometimes this caused more problems. We observed an ambulance crew who picked up a patient to go to Banbury and then picked up two more patients because they knew the transport for those patients would be late. They notified the dispatchers who had started to record the change on the system but were interrupted. Half an hour later, a crew went to pick up one of the patients for Banbury and found they were not there. This had happened as a direct result of the difficulties faced by the dispatchers in dealing with information, communication and interruptions.
- There were no PTS staff in the northern EOC at weekends. Admissions, discharges, transfers and renal patients were handled by the southern EOC. These journeys would be planned on a Friday by the planners based in the north.
- The team leader and shift supervisors in Hampshire described how staffing arrangements were planned to meet the requirements of the trust's new PTS contract for the whole of Hampshire, which would take effect on 1 October 2014. The numbers of staff and ambulance crews, and the skills mix, were determined by the nature of the contract to ensure there were sufficient personnel with the appropriate skills to safely run the service.

Environmental factors

- The trust had a winter/summer pressure procedure to deal with seasonal risks to the service.
- The trust had implemented a robust poor weather plan following the floods in 2013. It had given a commitment to the hospital renal units that their patients would take priority in the event of poor weather. This meant that renal patients' treatment would not be cancelled because of poor weather conditions. This plan had been followed and proven to be effective in 2013.
- Hospital staff told us that over previous winters PTS staff had been "absolutely fabulous. They went out of their way. They were fantastic." They added that during recent flooding the service did what it could and what it achieved was amazing.
- The trust's commercial risk register recognised a lack of business continuity plans for the service with a target

date of October 2014 for completion. A manager told us about planning for winter, which included providing snow tyres and four-wheel drive vehicles for access during severe weather.

- The northern planners did not receive information about planned roadworks or traffic incidents that could delay ambulance crews. They relied on the PTS crews to call to make them aware. This meant that planned journeys could take longer than anticipated and the crews could potentially carry out fewer journeys. At the end of each day, a planner sometimes had to find resources from private providers to collect remaining patients.
- The impact of the PTS crews' longer journey times due to road works and increasing workloads was that they could miss their meal breaks, which could affect their ability to concentrate while driving.
- In Berkshire, most staff told us about the challenges they faced locally with heavy traffic. This was a risk to journey times and often led to late arrivals and departures for patients. While everyone was aware of this risk, it was not identified on the service risk register and plans for mitigation were not available. During our visit, one ambulance crew member told us that the ambulance was due to start work at the hospital at 10am; however, we spoke to them at 11.15am and they told us they had just arrived because they had been delayed owing to an accident on the motorway.

Are patient transport services effective?

The service used eligibility criteria designed by commissioners to ensure that patients were appropriate for transport. The PTS also signposted people to services when they did not meet the criteria. National clinical guidelines were available in the event of any patient needing medical care. The dispatch team did not always have appropriate assessment information, from hospitals or patients or from their own records to ensure that patients always had an appropriate vehicle or equipment and transport sometimes had to be reorganised. The system to plan journeys was manual and often reactive based on a lack of timely and coordinated information and this had caused delays to patient transport. Call handlers were overwhelmed with calls about service delays and only half of all calls were answered.

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Service targets were set by commissioners to promote good outcomes for patients. However, the trust performance against these targets was generally below the standards required. Patients were experiencing delayed and missed appointments for outpatient consultations and diagnostic scans, and renal dialysis, and some were choosing to curtail their treatment in order not to risk missing their transport home for fears of excessive delay. Some hospital clinics were shortened to accommodate the transport service, and this had an impact on patient care. National guidelines for renal patients were not being met and we found that some patients were curtailing the length of their dialysis to ensure that they could get transport on time. A pilot project with the renal dialysis service at the Royal Berkshire Hospital had improved arrival and pick-up times for patients.

The staff in the EOC did not have an appropriate induction but the care assistants had a planned induction programme. Staff had little awareness of consent, the Mental Capacity Act 2005 or dementia care, but training was being developed. Further training opportunities were available to staff but computer access and work pressures prevented attendance. There were opportunities for staff to gain further qualifications. The staff did not receive regular supervision, and appraisal rates were below the target set by the trust. Services were not well coordinated with providers (for example, for hospital outpatient clinics and discharge), but there was work ongoing in some places to improve this. Staff worked well in multidisciplinary teams to share information with GPs and hospital and community staff.

Evidence-based care and treatment

- All policies and procedures were accessible for staff via the trust's intranet and had been updated in line with national guidelines. Team leaders told us that all changes in policies and procedures were passed on to staff via e-mail or the 'Staff Matters' newsletter. This was confirmed by staff we spoke with.
- Call handlers used a data questionnaire designed by the commissioners of the service to assess a patient's eligibility for the service. The areas covered included disability, equipment and escorts. We found the questionnaire, although efficient, did not cover areas such as mental health, behaviour and language, which

meant the call handler may not be able to fully assess a patient's care needs. Any issues that arose from the questionnaire were referred to the operations manager for further assessment.

- The online booking system allowed the patient, or the person making the booking on their behalf, such as a GP or hospital staff, to record all their mobility requirements, necessary equipment, special needs and medication. Examples included physical access to the patient's home, and the number of staff needed for the journey to ensure the patient's safety. Once this information was entered on the system, it was kept for future bookings and could be updated.
- Call handlers approached the CCG for permission to transport patients when there was any doubt as to a patient's eligibility (for example, travelling out of area).

Assessment and planning of care

- The online booking information was used to allocate a suitable vehicle and PTS crew. There were times when insufficient information entered onto the system meant that planners were unaware that the patient had limited mobility. There was therefore a risk that patients would not have appropriate transport and the journey would have to be aborted; patients would miss their appointment and there was a financial implication to the trust. This had been recognised on the risk register, and an audit was planned to measure the impact.
- Some hospital staff told us there had been delays in PTS risk assessments of patients who were dependent on stretchers returning to their home. They also told us that such risk assessments were not always effective. For example, one patient had to be returned to the hospice because the risk assessment had not been carried out correctly and the crew had not been able to negotiate the stairs and corners.
- The trust audited aborted journey. They had identified that there had been 53 patients who had required a second booking in order to provide the correct mobility. This was 0.16% of all aborted journeys in September 2014.
- The planners in the operation centres arranged patient journeys 24 hours in advance. They had crew and vehicle information and manually booked the pre-booked appointments. For example, a planner based at the northern EOC had all the crew and vehicle information for the next day and was able to use these resources to plan 682 journeys around two counties.

Patient transport services

There was a high volume of discharges from hospital, and, more rarely, some extra outpatient appointments, that had to be added into the schedule on the same day at short notice.

- The planners also had what they called a “missed list”, when they could not arrange transport because they did not have information on necessary medicines or equipment, and had to find this out. The dispatchers told us the missed list was produced overnight; it averaged 100 for the Berkshire team and 40 for the Hampshire team, and was provided to the dispatchers each morning. They then had a target of dispatching 80% of their missed list within 1 hour of the crew ‘being ready’, with a further 20% to be allocated within two hours of the crew being ready. The dispatchers told us they met these targets daily, although we saw no evidence to confirm this.
- Staff told us the work usually left unallocated was for people who were ambulatory and would use an approved taxi company if needed.
- Resources were allocated in accordance with people’s needs; those who were mobile were allocated to the volunteer car drivers. Those who were receiving renal dialysis were allocated to specific crews who knew them.
- The planners would also reallocate jobs to crews when staff called in sick. Staff were required to call in 2 hours before the start of the shift they could not attend. This had an impact on patients. For example, crews allocated to the renal patients worked from 7am to 8pm, with a two-hour stand-down period when they were not needed. We observed that these crews were used for extra journeys that were booked during the day; this had a direct impact on renal patients whose crews were not available at the time they were due to be collected.
- The planners did not have computer support to plan logistically. They and the dispatch staff grouped people from the same location, which enabled the service to be more efficient. A new system was being introduced that would automatically group locations together, and this would reduce the time staff spent working on allocations. Training sessions had been arranged and staff told us they were aware of the new system and the training sessions.
- Schedules were developed and given to dispatchers who were in constant contact with ambulance crews. The ambulance crew were issued with personal digital

assistants (PDAs). These provided contact details and transport appointment times. They enabled the crew to record the start and end of each journey in ‘real time’, which meant the dispatcher could identify when a crew became available.

- PTS crews radioed the operation centre to advise that they were not going to be able to make the journey to hospital in time for the patient’s appointment. Dispatchers would then call the hospital and advise the clinic, who gave a timescale for the PTS crew to arrive within. However, this did not occur consistently, and we identified several examples where neither patient nor hospital staff knew what was happening with the transport.
- We observed a colour-coordinated system in use: red, amber and green (RAG). This highlighted and denoted the length of time overdue for dispatch. Staff in the southern EOC told us the system enabled them to focus on outstanding dispatches quickly and efficiently. Staff in the Northern EOC told us that they did not know what the colours meant
- Team leaders and managers told us that they had conference calls daily at 1pm. These meetings were to review the day’s bookings, crew availability and any other resources required. There were usually two private ambulance crews booked daily as a back-up resource.

Care delivery

- Staff in the northern call centre told us they were significantly short-staffed in the afternoons, which was having a direct impact on their ability to dispatch and coordinate patient journeys from hospitals.
- We observed calls in the northern EOC. Call handlers were overwhelmed with calls as a direct result of the online booking system not working. We observed one call handler take a booking over the phone for transport the same day; later the hospital chased up the transport only to find that the call handler had mistakenly booked it for the next day. This put extra pressure on the dispatchers to allocate a vehicle to the patient immediately.
- We observed calls in the southern EOC, and these were handled appropriately and effectively. For example, arrangements were made for two patients to go home: one needed stretcher assistance and the support of two crew members; the other had a recognised ‘Do not attempt cardio-pulmonary resuscitation’ (DNA CPR) order.

Patient transport services

- During our visit, patients and hospital staff voiced their concerns about waiting times. Some hospital staff said they felt the PTS did not recognise the impact of prolonged waiting times for transport had on patients. In Berkshire, for example, patients and hospital staff all gave us examples of when patients had arrived late for their appointments, patients had not been picked up at all, and transport had been sent on the wrong day, cancelled at the last minute or not arrived at all. During our inspection, a support driver received a list of patients for collection that day at 10.37am. The first patient on the list had an appointment at 10:30, which meant they had already missed their appointment before transport had been allocated. Another patient arrived with their escort at 12.10pm for an appointment at 11.15am. They told us the vehicle had arrived the previous day by mistake; it had been rebooked for the correct day, but then arrived too late for the hospital appointment.
- Patients experienced long waits for transport where they visited a hospital for a number of appointments. There was poor communication between the hospitals and the trust to ensure that the ambulance crew picked the patient up from the right department. The dispatchers showed us examples of when ambulance crews could not find the patient when they returned to the hospital department they had dropped them off at; they then aborted the patient journey. This meant that the hospital would have to call the operation centre to rearrange transport for the patient to go home.
- Hospital staff gave us examples of when patients had been taken by PTS to the wrong address; the ambulance crews had returned the patients to the hospital.

Drop off and pick up performance

- The trust had a number of different contracts set up with commissioners. They all had slightly different key performance indicators, although the overall thresholds were similar: for example, for 90% of patients to arrive no earlier than 30 minutes for an appointment and to be collected within 45 or 60 minutes of an agreed time; for late arrivals to be no longer than 30 minutes for an appointment. Overall the trust was not meeting these targets, ranging between 69% and 95% on most indicators.

- There were a number of key performance indicators for call answering times that ranged from less than 25 seconds to 1 minute. Overall, the trust was not meeting these targets.

Patient outcomes

- Staff from Horton General, Stoke Mandeville and Churchill Hospitals' outpatient departments were dissatisfied with the organisation of patients arriving and being collected from clinical outpatient appointments. They identified and gave examples of severe delays, as well as regularly missed appointments. There was a significant impact on patient care, treatment and wellbeing. Many patients were waiting for transport for between two and four hours. Some had missed their medication times and one patient had urgent treatment at another hospital that was delayed. Many patients who arrived late for a scan were unable to have to have their scans on that day. Many patients were not collected despite confirmed pre-bookings. One patient had missed a vital prognostic positron emission tomography (PET) scan at John Radcliffe Hospital. Staff told us he had become severely distressed, and described this as "psychological harm". Some patients regularly shortened their renal dialysis sessions so as to be certain that transport would be provided. Others had cut short their physiotherapy sessions for the same reasons.
- The National Institute for Health and Care Excellence (NICE) quality standard 15: Patient Transport (March 2011) stated that patients with chronic kidney disease receiving haemodialysis or training for home therapies should have transport within 30 minutes of their clinical treatment. Trust data indicated that fewer than 20% of patients were transported within 30 minutes.
- Two patients at Churchill Hospital Renal Unit told us that vehicles were not always on time and this had a knock-on effect on the time they could spend on the dialysis machine. Patients travelling by SCAS transport for renal dialysis treatment were at risk of not receiving their full session of dialysis. There were two treatment slots for dialysis; morning and afternoon sessions. There were agreed collection times of 1–1.30pm and 6–6.30pm. Some patients received a shorter dialysis treatment time when they arrived late for their appointment. Others received a shorter dialysis treatment time when their treatment started late due to delays in collecting the patients from the morning

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session. Patients receiving dialysis treatment in the afternoons were disadvantaged when there was a delay in transport, because their session could not begin until the morning patients had been picked up. The transport at the end of the day would arrive at around 6pm to collect the afternoon patients. Staff at the renal unit at Churchill Hospital reported that these patients were anxious about their transport home, because they sometimes had to wait many hours. Staff reported that some patients chose to cut short their dialysis treatment in favour of transport home at the expected time.

- Planners understood the importance of allocating renal patients' journeys, and recognised that performance was not being met in this area. Data for the four renal units at Milton Keynes, High Wycombe, Stoke Mandeville and Churchill Hospitals showed that, for over 2,100 patient journeys (January to May 2014) and 25% of patients were collected late from their renal appointments and 17% arrived late.
- Hospital staff told us that some outpatient departments remained open for longer when waiting for transport, but many closed and patients were taken to a different department or left unsupervised in waiting areas.
- We did not receive any data to indicate how often the PTS provided the right vehicle and equipment in response to the clinical needs of patients.
- Patients' responses about the effectiveness of the service were variable. Some said they were happy with the PTS crew but unhappy with the service provided because of the overall waiting time. Some spoke of the anxiety and inconvenience delays caused them. One patient told us they were "very distressed" with the long wait. Another said "[I] now expect and just accept this." Yet another told us, "I've been sat here for a long time. The [hospital] staff have been good, but the [hospital] staff haven't been given a time when I will be collected. It's very frustrating. I've got carers coming this evening; I don't know whether to cancel them."

Competent staff

- The trust had an effective induction programme for ambulance care assistants. The programme lasted five weeks and included relevant training. Once this was completed, staff were mentored on the ambulance for a period of between two and six weeks. However, one ambulance care assistant told us they did not have any induction when they began working for the service.

- The induction for call centre staff was not effective. The northern PTS call centre staff received two days' induction training five years ago. Since then, they had taught each other their roles. The call handlers who had joined in the recent past had listened to calls with an existing call handler and then were taking calls themselves. The staff were responsible for liaising with the commissioners, the public and hospital staff, checking eligibility criteria, undertaking risk assessments, planning and delivering services and handling complaints.
- PTS staff were required to have a four day 'first person on scene' (FPOS) training during induction and PTS drivers received advanced driver training. All PTS staff were required to have cardiac first responder training every six months. The trust had also identified that all its PTS crews should be trained on the community first responder standard in first aid, manual handling techniques, advanced driving skills, defibrillator use, dealing appropriately with numerous medical conditions including mental health, and conflict management. The staff told us they needed more training in these subjects.
- PTS staff accessed training for fire, information governance and manual handling via e-learning. Staff based at satellite stations did not have access to a computer. They therefore could not participate in e-learning or receive information from the trust that would inform their practice, such as learning from incidents. Staff at satellite stations had to travel to other stations to use computers.
- The PTS staff had not received any face-to-face training in caring for people living with dementia or who had a learning disability, but this training was available as an optional e-learning module.
- The trust had advertised extra training sessions as summer workshops; these were advertised on the intranet. We saw that team leaders had printed the advertisement for these workshops so that staff in the satellite stations who did not have access to the intranet were made aware. One team leader told us that none of the staff in their team had attended the workshops because of holidays and work pressures.
- Staff could access training on appraisals. Team leaders carried out annual appraisals and 79% of staff had a current appraisal. Objectives were set, but they were not linked to the trust's vision or objectives. Managers said

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appraisals should take place in four stages during a year. However, they told us they were behind with these. One manager explained that they did not have time to appraise the 25 staff allocated to them.

- All newly employed PTS crew staff were recruited as band 2; all band 3 staff were recruited internally from those in band 2. PTS staff who did not have any qualifications to let them progress to the next pay band were assisted to get the qualifications they needed to progress.
- Call handlers had their daily logs monitored by supervisors who commented on their performance. When a call handler had received a challenging call, they were offered a break and a chance to debrief.

Coordination with other providers

- Patient bookings were often uncoordinated with hospitals. We found concerns with the booking of transport for patients on discharge from hospital. The PTS ambulance crew told us they often arrived as requested but the patient was not ready (because of lack of medicines, for example). In these circumstances, they said they took direction from the dispatchers as to whether they stayed and waited for the patient, or were redirected to another patient. If the latter, the dispatcher would arrange another collection time with the hospital. Hospital staff told us this led to poor communication from the PTS operation centre, with staff not being made aware of ambulance return times or subsequent delays.
- The trust had liaison offices in major hospitals across the region where staff were the public face of the PTS division. They dealt with booking queries, any problems that occurred on the day (such as late arrivals, changes in patients' appointments) and, most importantly, ensured that every patient was conveyed so that they received the treatment they needed. We saw this in practice at Wexham Park Hospital. However, many hospital staff told us they were unable to contact the trust either in person or by telephone to confirm transport or find out how long a delay might be.
- In Berkshire, there was a new project to reduce early arrival times and late pick-up times for patients using transport for renal dialysis appointments. The service had introduced a weekly meeting with the hospital clinic team to review concerns and identify problems. We saw a copy of the notes from one meeting. Staff and patients told us that waiting times had improved since

the start of the project. During April to July 2014, the number of patients arriving no earlier than 30 minutes before their appointment time had increased from 46.5% to 68.9% (against a target of 85%). The number of patients collected no more than 60 minutes after their treatment had increased from 84.1% to 94.8% (above the target of 85%).

- Feedback from the renal unit at Churchill Hospital stated that the named point of contact at SCAS worked closely with senior staff in the unit; there were monthly meetings to identify key issues and incidents to improve the service. Hospital staff showed us data that demonstrated that over the past six months there had been an improvement in partnership working. They told us it was "the best it has been for the last 18 months to 2 years". Staff in the renal unit told us that, when transport failed to arrive, they could use the volunteer car scheme.
- Some hospital staff said they were not told if patients were going to be arriving late, or when they would be collected. Staff had difficulty getting through to the operation centre because their calls were not always answered.

Multidisciplinary working

- The team leader at the northern EOC had good relationships with hospital bed managers. They worked together closely to identify and plan high-priority discharges. PTS staff did not have a named contact at Stoke Mandeville Hospital to liaise with over patient transport issues to ensure that there was good access and patient flow.
- Staff in the discharge lounge at Milton Keynes Hospital spoke highly of the organisation and attitude of the PTS team. They showed how the staff at the hospital worked in conjunction with the Milton Keynes PTS team to ensure that patients were discharged in a timely way. We saw that the discharge lounge was empty because all the patients had been picked up. This was partly achieved by there being a dedicated team to transport patients home from the discharge lounge. There was concern that the trust was soon to alter the current arrangements, which would mean that the PTS teams would constantly change.
- There was evidence of multidisciplinary working between staff and other organisations (for example, GP surgeries). During our visit, we observed cooperation between GPs, other healthcare professionals, the operation centre and PTS crews.

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- Discharge coordinators in hospitals ensured that patients leaving a hospital or clinic were able to continue their recovery safely. We observed the operation centre staff and PTS crews liaising with the discharge coordinators in hospitals to ensure safe transport for patients.
- Staff had been given details of patients who had advance care plans, 'special notes or 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) orders. We saw these were detailed on the trust's computerised system and the information was passed to the ambulance crew via the PDA system.

Consent & Mental Capacity Act

- The trust had a Mental Capacity Act policy dated October 2010, which was due for review in September 2014.
- Staff had received training on the Mental Capacity Act 2005 during their induction, which for some was many years ago. However, e-learning training modules about dementia, autism and the Act were available to all staff on the trust's intranet.
- The trust provided a PTS for mental health patients. However, managers were unable to provide any information other than that in Berkshire the service was entirely provided by a private provider. Staff had not had mental health training and this had been identified as an area for improvement by the trust.
- Staff in Berkshire showed a good understanding of consent procedures and their legal responsibilities in relation to capacity. Staff in Oxfordshire, Buckinghamshire and Hampshire said they were not clear how to obtain a patient's consent.

Are patient transport services caring?

Patient transport services (PTS) were delivered by caring and compassionate staff. Staff treated patients with dignity and respect, and they delivered care that took into account people's wishes. Staff involved patients during their journey. Patients spoke positively about the kindness of staff. They told us they were involved in their care and transport although they did not have enough information about whom to contact in the event of a delay or a missed appointment. Many patients were confused about who to discuss the service with and they told us they would discuss the service with hospital staff.

Some patients became anxious and distressed if they had to wait for transport. PTS staff tried to alleviate their concerns but they were not always available to provide emotional support, either on the phone or in person.

Compassionate care

- Throughout our inspection, we witnessed patients being treated with dignity and respect. All staff listened to patients and responded positively to questions and requests for information during their journey.
- Staff spoke with pride about their work and how they enjoyed their role of "looking after" patients. One member of staff said, "I love the caring side of my job. You can make a patient's day by just having that small conversation." Hospital staff told us, "PTS staff are lovely with the patients."
- We observed that the operation centre staff were calm, knowledgeable and compassionate. One patient at Churchill Hospital said that the staff were kind and considerate when they telephoned to book their transport.
- Call handlers were compassionate when helping to book escorts for patients. One example was when a patient was a carer, and attending his appointment would have meant his wife would be left without care. The call handlers arranged for his wife to accompany him to his appointment.
- When dispatchers saw that patients were going to be late for their appointments, they endeavoured to call the hospital department to ensure that they could still see them; however, this did not always happen because dispatchers could not always contact patients and hospitals to inform them of delays.
- PTS crews explained procedures to patients on accessing the vehicle and during their journey (for example, how they were going to secure their wheelchair). We observed they ensured that patients were always comfortable.
- We saw patients being supported by the ambulance crew on arrival at the hospital by being helped to find the correct clinic.
- Patients spoke positively about the PTS crews. For example, one said staff were "courteous and respectful", and another that the crew were "polite and friendly" and they "felt safe with the crew." Comments from patients included: "Lovely, all of them. I wait in the lounge. I am shattered. They take me home and up to my flat in the wheelchair. They go in with me and make sure I'm all

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right.” “I’m a bit shaky; they see you to the door. I’m happy with that. I take my stick on the ambulance and they leave it with me and put my seat belt on.” “They are always polite.” “They all do extra. If I wanted windows or curtains closed, things I can’t do myself...”

- PTS staff told us they ensured that patients were comfortable when they got home (for example, checking the heating was on and food was available). They told us that, on occasions, they had left their blankets with patients when they had returned them to a cold home. They showed compassionate care for their patients while ensuring their needs were met.
- Patients told us they often travelled with the same PTS staff and had “got to know them very well.” We observed good interaction and staff awareness of the patients’ needs.

Involving people as partners

- We spoke with patients about the information they received in relation to the service. They said they felt that they had been involved in decisions about their appointment times. One patient told us that everything had been explained “satisfactorily” to them.
- Patients told us they were not aware of the eligibility criteria for accessing PTS because their travel arrangements had been made through their GP surgery, which dealt directly with the PTS. Staff rarely called patients to tell them that their transport would be late and patients were not kept informed.
- In Berkshire, patients told us that, if there was going to be a delay in picking them up, PTS staff “always” phoned to tell them and also let the outpatient department know they would be late. We saw this in practice at Wexham Park Hospital.
- Patients told us they would have liked more explanation as to why there were prolonged waiting times, because this would have given them a better understanding.
- Patients were often confused about who was providing the transport service. For example, if their travel was booked by the hospital then they believed that the hospital was the provider. Patients told us that, if they had any queries about the service, they would contact the hospital to find out what was happening. Hospital staff confirmed this. However, hospital staff had become frustrated at having to respond to patients’ queries without any accurate information about delays and so they could not provide meaningful information.

- Patients’ feedback on the PTS booking system varied. Some did not have any concerns while others told us they had had their appointments cancelled several times. Staff in the oncology department told us they were keeping a log of the problems that occurred so the information could be fed back to the PTS.

Providing emotional care and support

- We observed that call staff tried to alleviate patients’ fears when they rang the centre to get a time for their transport. However, calls took a long time to answer and many patients had put the phone down without speaking to staff.
- PTS staff told us how they would support patients if they were anxious or had complex needs. They said they sometimes received prior notice, which enabled them to manage the situation more easily.
- Both staff and crews told us they had been trained in conflict resolution and were able to use distraction techniques if needed to support patients.

Are patient transport services responsive?

Patient transport services (PTS) provided non-emergency transport for patients who, for example, attended hospital outpatient clinics, day hospitals, or who were admitted to or discharged from hospital. The services across the South Central area had different eligibility criteria and the trust was working to provide services against different contractual and performance expectations. There was support for bariatric patients and those with a learning disability dementia. However, there was no policy for transporting children.

The service had a significant number of early arrivals, late pick-ups and missed appointments. Call handlers were overwhelmed with calls about service delays and only half of all calls were answered and the time taken to respond to calls was not always within the trust’s own targets. Patients said they were happy with the ambulance crews but not with the effectiveness of the service provided because of the overall waiting times. Information was available in different languages and the service had access to interpreters. People’s religious, cultural and individual preferences were taken into consideration.

Patient transport services

Complaints were handled appropriately and there was good evidence of action taken as result of complaints. Some staff, however, told us did not always get feedback and learning was not shared. There was a lack of clarity about the relationships between the patients, the hospitals and the trust. This led to patients being confused about how, or to whom, they could make complaints or send compliments about the service.

Service planning and delivery to meet the needs of local people

- The trust provided PTS non-emergency transport across Buckinghamshire, Berkshire, Hampshire and Oxfordshire. It had recently won a contract to run PTS in Hampshire from 1 October 2014. Transport was provided for people who were unable to use public or other transport because of their medical condition. Eligible people included those who were attending hospital outpatient clinics, being admitted to or discharged from hospital wards and needing life-saving treatments (such as radiotherapy, chemotherapy, renal dialysis or treatment for deep vein thrombosis).
- The trust had different eligibility criteria with nine clinical commissioning groups and six other commissioners across Oxfordshire, Buckinghamshire, Berkshire and Hampshire, so access to PTS differed. The eligibility criteria were available on the trust's website and accessible to people booking online. The call handlers explained them to those who booked by calling the operation centre. Patients who were no longer eligible were given the contact details of other services such as the volunteer car driver service or the Red Cross.
- Transport was also available to a patient's escort or carer when their particular skills or support were needed. For example, it might be appropriate for those accompanying a person with a physical or mental incapacity, a vulnerable adult or a patient needing an interpreter. Patients who were under 16 years of age or had a learning disability were eligible for an escort.
- The trust had a procedure for providing transport when a patient's consultant approved a request for them to receive treatment that could not be provided locally. The planner told us these were extra-contractual referral journeys. Drivers were informed of these allocations in enough time to plan ahead.
- The trust had vehicles that were specifically equipped for bariatric patients and the staff were trained in using

the equipment. We observed bookings for bariatric patients in Hampshire, Oxfordshire and Berkshire, and these required two ambulance care assistants. Hospital staff said the PTS had a "great bariatric service". For example, the PTS staff and the Churchill Hospital renal unit had worked closely to ensure that a patient could receive their treatment three times a week and be transported safely using the bariatric equipment.

- The PTS was open until 7pm. After this time, journeys for patients were organised by the hospitals. The trust was in the process of developing a 24-hour service.

Access and flow

- The operation centres failed to meet their target for the answering of calls. The trust had set an overall threshold of 90% but the results showed an operation centre response of 45.2%. Targets for calls answered within 1 minute, 5 minutes and after 5 minutes were also not being met.
- The majority of calls to the operations centre were enquiries from patients waiting for transport. For example, a patient booking had been overlooked with no availability on the next patient transport shift. The dispatcher arranged for a taxi to take the patient home. Another enquirer was informed that transport would not be available until 4.30pm, the call having been received at 2.35pm: a delay, therefore, of 2 hours.
- Hospital staff across the South Central area told us of the significant and severe delays, and missed appointments. Delays in discharging patients had an impact on bed management. When patients missed appointments that needed to be rebooked, or when clinics finished early to accommodate the vagaries of the PTS, this reduced capacity within outpatient clinics. The hospital staff told us they were often unable to book transport, contact the trust or find out when transport would arrive for patients who had been kept waiting.
- The trust had a significant number of missed appointments. We did not receive data across all contracts. However, in Berkshire, for example, there had been 122 appointments missed during the period February to July 2014 as a result of transport delays or errors.
- The service had identified a high number of patient appointment cancellations. There had been 5,796 appointment cancellations (August 2013 to July 2014). Of these 822 (14%) appointments were cancelled by patients at the last minute when the PTS crew had

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already been allocated to work. The team leader told us the operations manager reviewed and managed all cancellations, which enabled the operation centre to manage and plan the delivery of the service appropriately. A voicemail messaging service had been introduced to remind patients of their appointments.

The team leader reported that this was having a positive impact on non-attendance of appointments, which enabled the operation centre planners to reallocate PTS journeys. The voicemail messaging service also confirmed appointments that had been cancelled by patients, to ensure that the control room's information was current.

- Patients who had made a booking were advised to be ready for vehicles transport two hours before their appointment. They took this to mean that the ambulance crew would arrive two hours before their appointment; this has led to dissatisfaction among some patients who believed that vehicles arrived late. Some patients were getting up very early for morning appointments.

Meeting people's individual needs

- PTS staff told us they were made aware of vulnerable patients from the information provided by the operation centre. We observed that the personal digital assistant (PDA) system was giving the PTS crews information about patients' needs.
- When people had been identified as living with dementia, they were allocated a crew of two. PTS staff told us they often transported patients living with dementia and they were supported by family members or a healthcare assistant. The PTS staff had not received any training in dementia, but the trust was in the process of developing a training programme and, in July 2014, and had engaged staff in its design.
- PTS staff had not received any training in the care of people with a learning disability. However, we saw a patient with a learning disability being escorted from the hospital department into an ambulance. This person was treated with dignity and respect, and safely ensconced, with adequate explanation before their seatbelt was secured.
- PTS provided transport for escorts or carers where their particular skills or support were needed by the patient. According to the trust's website, these journeys had to be booked in advance; however, managers told us that ambulance care assistants had discretion to accept

escorts or carers onto the vehicle when appropriate. Staff gave us examples of when they would allow an escort or carer to travel for medical or emotional reasons, and what the process for this was. Patients confirmed that escorts had been permitted to travel with them.

- PTS staff told us that escorts were permitted to travel with children or adults with a learning disability, and also those with emotional needs. We saw this in practice at Wexham Park Hospital, and patients and relatives told us how much they valued this service.
- Staff told us they were able to transport children, although they did not do so often. Two of the depots we visited in Berkshire had a store of baby and child car seats for use in ambulances. In Oxfordshire we were told that patients would often be asked to provide their own child seat as there was a limited supply. We requested, but were not given, a policy or standard operating procedure document for the transport of children.
- Planners supported patients' religious, cultural or individual preferences. For example, one person asked to have a female driver and another said they did not wish to have a driver with "a snuffle" because of their medical condition. The planners acknowledged their requests, which were entered on the system.
- The service had access to interpreters if needed. Staff also told us escorts were permitted to travel with people for whom English was a second language, in order to support communication. Staff at the Winchester and Eastleigh resource centre told us they were considering creating a booklet with set phrases in different languages.
- Staff had a sheet with pictures and symbols to help people with communication difficulties.
- PTS staff and crews had little knowledge of advocacy services but said that, if people had the support of an advocate, it would be highlighted on the system.

Learning from complaints and concerns

- The trust had a complaints policy document to show best practice.
- Staff told us they knew what to do if someone wanted to complain. We found that complaints were handled in line with the trust's policy. Initial complaints were dealt with by senior staff. If they were unable to deal with a patient's concerns satisfactorily, the patient would be directed to the Patient Advice and Liaison Service

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(PALS). PALS acknowledged a complaint immediately and responded to it within 5 working days. If the person still had concerns, they would be advised how to make a formal complaint.

- Managers told us they contacted people by telephone or face to face so that they could discuss concerns. They felt this was more effective than communicating via multiple letters. One manager said, “I see everyone personally if they have a complaint. I don’t wear a uniform as it can be intimidating.”
- The trust’s standard operating procedure showed that the trust would respond formally to a complaint 25 days after it had been received. In Berkshire, we saw copies of complaints received and the investigation reports, along with the final letters sent to the people who had complained.
- Team leaders had had complaints training and PTS managers and three investigation managers had accessed external complaints management training.
- The trust informed us that PTS patients were routinely given feedback cards which were carried on all PTS vehicles, and a copy of the card is also available online.
- Overall, patients told us they knew how to make a complaint and, if applicable, were happy to report any concerns. They told us they had no issues or concerns with the PTS crews but they did have concerns about the service. They were not sure, however, to whom they should make a complaint and many thought it should be the hospital. In Berkshire, for example, there was a lack of clarity for patients on how to complain or to whom. They thought that the PTS was delivered by the hospital and staff at the hospital told us they had to pass on complaints to the appropriate team. Patients told us: “If I wanted to complain I would tell the ward clerk here.” “Once or twice they haven’t shown up. I rang the ward.”
- The trust reported (April – July 2014) an increasing number of PTS complaints which were about staff attitude, communication and delays. There were actions taken as a result of complaints, for example, changes to fleet and the renal patient project.
- Staff at satellite stations did not have access to computers that allowed them to receive information about how the trust was learning from complaints. Instead, the team leaders supplied folders with information. However, the information did not include

any sharing of complaints or learning from experiences. Staff had asked for noticeboards in the satellite stations so that they could be kept informed, but this had not happened.

- The PTS staff and crews also told us they had not received feedback regarding any complaint or concern raised.

Are patient transport services well-led?

The trust had a five -year strategy for the patient transport services (PTS) to grow and improve. This included using internal resources and computer aided dispatch to more effectively to coordinate care, as well as to signpost people to other available services as appropriate. The commercial and short-term nature of PTS was well understood by the trust, which was positioning itself to compete effectively in this environment. The staff were not aware of the trust’s strategy and were uncertain about the future of the service. They were also unaware of the trust’s values. However, they remained committed to focusing services on the patient.

Governance arrangements needed to improve, and procedures to assess and manage performance, quality and risks to be developed further. There needed to be better monitoring of some key risks, such as the failure of the IT system, had not been identified, assessed and managed appropriately. Information on complaints, incidents and audits was discussed at directorate level but not cascaded to staff teams. Not all staff had access to team meetings that would enable them to discuss any issues or concerns with their colleagues. There needed to be better monitoring of private providers and volunteer drivers.

Staff had mixed views about the leadership of the service. Some felt well supported; others did not, and expressed a lack of confidence in their managers. Overall, many staff were frustrated by working hard to deliver a service that was not always effective for patients. Staff worked effectively in their teams and had respect for each other. Staff engagement needed to improve. Many of the staff felt the PTS was like a ‘Cinderella’ service in comparison to the emergency 999 service, and they did not feel properly informed or consulted on key service changes. Patient feedback was gained through regular surveys. These identified problems with communication and transport that was too early, late or failed to arrive. There were good

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examples of changes to improve the service as a result but staff did not always receive the feedback from the surveys. There had been a number of innovation and improvement projects within the service.

Vision and strategy for this service

- The trust's vision and five-year strategy for PTS was to enable people to travel safely between home and healthcare settings, and to resettle people at home after discharge. The intention was to grow and enhance the PTS so that it was working more closely with 999, NHS111 and healthcare professionals to share resources more effectively, offer more services and signpost people to other available services as appropriate.
- PTS were to be modernised and this included a single virtual computer aided dispatch system, dynamic scheduling and electronic communication with road staff.
- The trust recognised that contracts for PTS nationwide were being acquired by private providers of ambulance services. It had put a strategic plan together, and over the past two years had restructured the organisation to become viable for the forthcoming tendering for contracts. The trust had worked with all the different clinical commissioning groups (CCGs) to gain a deeper understanding of the contractual requirements and to build good working relationships.
- The trust had just won a contract for all of Hampshire, and the existing four PTS contracts in Oxfordshire, Buckinghamshire, and Berkshire were due to be merged into one contract that would be up for tender in 2015. The South Central Ambulance Service (SCAS) was preparing to tender for this contract by updating its IT systems to allow for virtual call centres and dynamic planning.
- The trust also recognised that constant tendering for contracts created its own instability and uncertainty for staff about the future of services, and that this was affecting staff morale. An updated employee assistance programme was advertised in its weekly newsletter, 'Staff Matters', in May 2014 to respond to this issue.
- The trust's values for 2014/15 aimed at delivering high performance through teamwork, innovation, professionalism (setting high standards) and caring. Its vision was encompassed in the strapline "Towards excellence – Saving lives and enabling you to get the care you need".

- Staff told us they were generally unaware of the trust's strategy, vision and values and we did not find the vision and values on display within the PTS. However, the staff clearly and correctly verbalised their main professional focus as looking after patients. For example, in Berkshire, a manager told us they were not aware of a specific vision for the service but that it was always about getting better and doing it properly. A PTS crew member in Oxford did not know about the vision and strategy for the trust but told us "the main objective is to keep the renal contract", "I'm not really concerned with the team leader's objectives; my concern is my patients."

Governance, risk management and quality measurement

- Some teams held meetings every two or three months at satellite stations. Not all of these were formally recorded for those staff who could not attend because of shift patterns. We observed the minutes of two meetings held in June 2014. These showed that, when issues were raised, a person was allocated to act to resolve them. However, the minutes did not identify what issues had been discussed at the previous meeting and since been resolved. Some staff told us they did not have team meetings. This meant they were not given the opportunity to discuss issues or concerns, or air their views, with their colleagues or staff leaders and supervisors.
- Volunteer car drivers were managed within local teams. There was an annual general meeting but no strategic or overall management.
- Complaints, incidents and audits were discussed at directorate level, but staff were unaware of the nature or outcomes of these discussions. Staff said they had not received feedback on the outcome of incidents or complaints. Information was not effectively disseminated to all staff because they did not all have team meetings or could not easily access a computer to check emails.
- Staff told us they were unaware of the trust's whistleblowing and safeguarding policies. The trust was aware of this and arrangements were in place for staff to receive training as part of their 2014/15 training programme.
- The trust measured quality against key performance indicators (KPIs) set by the commissioners of each contract. There were monthly reports outlining

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performance, identified actions and outcomes. The trust did not seek assurance about the quality of care provided to PTS patients through any audit process or observation of staff performance.

- The operations risk register had assessed and planned actions to mitigate risks that had been identified, although we did not see specific action plans. The register had identified that there was a risk in using private providers. There was currently a validation process, standard operating procedures, training and financial validation of private PTS providers. Providers were also required to update the trust with changes in staff, and to hold weekly teleconference meetings to manage the relationship with the trust. Although we saw the process for the management of the private providers, we did not see any evidence to confirm that this was happening.
- The operations risk register had also identified the risk that incorrect information in the booking system would mean that patients' needs would not be met in terms of staff requirements or equipment. The trust's action for this was to audit the number of transport changes because of mobility issues once a patient had been booked on a monthly basis. There had been 53 patients who had required a second booking in order to provide the correct mobility. This was 0.16% of all aborted journeys in September 2014.
- There were some risks identified that were either not on the operations risk register or mitigation action was not clear (for example, anxious patients being left unattended in PTS vehicles for long period because of the lone-worker system). Staff told us they were aware of the lone-working policy. The risk with the new online booking system had also not been identified and the absence of procedures had caused difficulty with missed and late appointments.
- The PTS in Berkshire was a commercial division of SCAS. The trust had to bid for contracts via a tender process. If successful, it was commissioned for a fixed period of time and within a financial envelope to provide the service. As a result, longer-term planning for improvement and innovation was challenging. The risks associated with this were identified on the trust's commercial risk register. This also identified the risk of essential patient journeys not taking place.
- There was a system for PTS crews and volunteer drivers to vehicle insurance checks and to have DBS checks every three years. The governance surrounding

volunteer drivers' DBS checks was not robust. They had been asked to complete a DBS form in July 2014. However, there was no process to ensure that they had all been received by the trust and demonstrated that they were satisfactory. Private providers were monitored monthly but governance arrangements were inconsistent and there was variation in monitoring of for example, complaints, incidents and operational performance.

- Driving licence and vehicle checks were carried out by an external organisation. Not all the staff had signed up to the scheme, but the team leaders were in the process of tracking those staff and volunteer car drivers who had not yet done so.

Leadership of service

- The management structure of the PTS was headed by the Director of Strategy, Business Development, Communications and Engagement. The organisational structure had the Assistant Director of Commercial Services overseeing operational managers for each of the four counties covered by SCAS. Team leaders had specific roles (for example, one was responsible for vehicles, consumables and facilities), and reported to operational managers. Team leaders each had a team of around 20 staff.
- Team leaders were the first point of call for all ambulance staff for the reporting of incidents, safeguarding and equipment issues. They also provided information from the trust (for example, on governance issues and strategy). Staff gave a mixed response as to the effectiveness of their team leaders, even within the same team, and these ranged, for instance, from "good working relationship with management" to "communication is a problem".
- There was no manager position at the northern EOC; this had been replaced by a supervisor. The operation centre had issues with staffing in the afternoons, and there was no effective management structure that allowed these to be escalated. Staff said they took the worry of their work home with them, because they were concerned that they had not done enough.
- When the online booking system failed, it caused considerable disorder in the northern EOC. There was no effective escalation procedure to managers, and no plan to ensure that there were enough staff to take the bookings by telephone.

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- The team leader and supervisors told us they knew who the senior managers were within the trust. We found this information had not cascaded down to staff who did not know any of the senior managers above the level of operations manager.
- Most staff told us local managers were approachable and they felt valued and supported by them. They said they could go to them with their ideas and concerns, and were confident of a positive response. However, some PTS ambulance crew assistants had concerns about leadership and management within the resource centres. Some staff said they saw little point in approaching their supervisors because they felt “nothing ever got sorted”. They were frustrated by working hard to deliver a service that was not always effective for patients.
- A the team leader told us there were mechanisms in place to support staff in their role. These was identified by regular supervision and opportunities for personal development. The operation centre staff said that support from the team leaders and managers was good.
- Staff told us a counselling service was available to them if they needed it.
- The team leaders and supervisors told us their “door was always open” and staff could come in for a chat to discuss any issues or concerns. However, PTS staff told us they had always dealt with matters among themselves and “preferred to sort things out this way instead of going to their supervisors”.
- There had been an incident where a patient had become unwell and needed an emergency ambulance crew. The team leader provided pastoral care for the PTS crew and carried out a debriefing session.

Staff engagement

- PTS staff confirmed that they received communication via email from trust senior managers but they told us, “98/99% refers to front line. It’s not related to us. It feels like we are different services”. They also said, “No one listens to PTS staff – we are an unheard voice.” “Within the trust PTS is right at the bottom of the pile. In ‘Hot News’ (the internal magazine) we never get a mention but we work hard.” Managers, however, told us that the trust newsletter (‘Staff Matters’) was beginning to include PTS news and updates, and trust-wide staff newsletters for May and June 2014 did have items specifically relevant to PTS staff.
- Some of the PTS crews did not have access to computers and so were unable to receive their emails at work. Although staff could access them at home, team leaders found that communication with staff in satellite stations was more effective face to face.
- Management perceived the team leaders to have the most important role in relaying information. Staff told us communication could be difficult because of shift patterns, and sometimes information was wrongly interpreted or passed on incorrectly.
- Staff reported that there was no process to escalate concerns that had an impact on patients’ care. For example, there was no evidence that there had been engagement with the hospitals about parking availability for PTS vehicles. Staff found it difficult to park at Churchill Hospital because of spaces being taken by other vehicles as a result of poor road markings.
- The staff told us they had been engaged in the design of the forthcoming dementia training. However, they were not consulted on key service changes. For example, they told us they feared that changing the operation centre to 24 hours would mean that older patients would be discharged at night. They also told us that there had been no proper consultation on the IT system changes.

Culture within the service

- We found most staff were loyal and flexible. Many had worked for the trust for a number of years and were committed to continuing to do so.
- Staff told us they worked well together and there was obvious respect between people with different roles and responsibilities. There was an overwhelming view among staff that services worked well because of everyone’s ‘goodwill’.
- Team leaders’ roles included keeping staff informed of the contracts and tendering processes, and supporting them through times of uncertainty. Staff at all levels were aware of the challenges within the service, such as long waiting times for patients. They showed a commitment to addressing these challenges and improving the service.
- Staff morale varied with some staff being very positive while others felt their views were not listened to.
- The operation centre staff told us morale within the team was good, and staff worked well together and supported each other. PTS ambulance crew assistants said they worked well together as a team for the benefit of patients.

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Public engagement

- The PTS vehicles each had a poster to encourage patients to complete a form to feed back their views on the service. This was an opportunity for those who did not use a computer. The trust also provided a link on its website that enabled patients to give feedback about their experiences of the PTS. Patients told us they had been helped to complete a survey by hospital staff in the renal dialysis unit.
- The trust had recently held a public event about PTS. Most issues identified referred to the inflexibility of the service in terms of timing (for example, vehicles arriving too early or too late). Poor communication was also highlighted, particularly when patients had to wait for hours for their transport.
- The trust carried out quarterly surveys of people using the PTS. Between April and June 2014, the response rate was 20% (that was an approximate expected response to surveys) and the data showed that most respondents (97%) were satisfied with the service they had received, and 96% would recommend the service to their friends and family. This was a 4% increase on the 93% received in the last quarter of 2013/14. A significant number of patients identified early and late drop off and pick-up times. For example, in Berkshire, Buckinghamshire and Hampshire, surveys indicated that approximately 15% of patients were picked up late and 35% were picked up early.
- Each division within the PTS had been given a copy of its results, which included written comments to assist in developing an action plan. We saw the results of a previous Berkshire PTS survey (July to September 2013) and the action plan for improvement that had followed.
- All staff mentioned by name were to be advised of the positive comments made about them during a one-to-one meeting with their line manager. Staff told us they were aware of the patient surveys but not of their overall outcomes. The team leader told us they analysed patient surveys and addressed the issues and concerns they identified. For example, some patients said they did not want the radio on during their journeys because it was distracting. We observed that PTS crews had acted accordingly.

- The trust had a link to its website that provided patients with details of the service and how they could access it. There was also a patient experience questionnaire that enabled patients with internet access to feed back on their experiences with transport.
- PTS staff and the Churchill Hospital renal unit were working together to contact all renal patients quarterly for feedback.

Innovation, improvement and sustainability

- The team leader told us that they encouraged staff to improve their working environment. This had resulted in staff creating a new rota system, which they said was both practicable and sustainable. In the Adderbury resource centre staff had taken initiatives to reduce their “carbon footprint”, for example, they used different light sources and had trialled electric cars.
- The call centre had introduced a voicemail messaging reminder service. This was intended to reduce the number of patients who did not attend their appointments at the hospital.
- A crew member told us they were currently training staff in the use of a paediatric restraint system to transport children. The equipment fitted each child firmly and provided safe control during transport. Crew members told us the system was currently on trial by the emergency service.
- The trust had worked in partnership with senior staff at the Churchill Hospital to produce an educational film for PTS planners to improve their working relationships.
- The trust plans to introduce a 24 hour online booking system. Calls would automatically be directed to the first available operator. All call operatives would have access to all the information available about PTS journeys throughout the trust. The trust said that this system would increase flexibility because it could operate either site independently should the other be unavailable, with incoming calls automatically routing to the active site.
- The trust planned to introduce a dynamic dispatch software system. This system would recognise each vehicle’s capability and grade of crew, and then allocate appropriate journeys. It would mean a better service for patients, and more efficient and effective use of resources.
- There were some concerns that the savings from cost improvement programmes may not be achieved. Many were to increase efficiency but the highest risk was the

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recruitment of band 2 care assistants instead of band 3.

The service had identified the need to continue to monitor incidents and complaints and survey results and ensure that the recruitment and training was robust.

Outstanding practice and areas for improvement

Outstanding practice

- We observed many examples where staff demonstrated outstanding care and compassion to patients despite sometimes working in very difficult and pressured environments. Staff “lived” the values of the trust “Towards excellence – Saving lives and enabling you to get the care you need”.
- Representatives of the trust attended local youth organisation meetings, village fetes and school assemblies. The trust had developed a child-friendly first-aid book printed specially for schools and the wider local community.
- The trust provided an innovative learning resource to their frontline staff using the educational resource centre and film centre at Bracknell. The staff were involved in making films which supported learning around new guidelines from the Joint Royal Colleges Ambulance Liaison Committee (JRCALC).
- The trust had introduced a lifesaving automatic external defibrillator (AED) locator mobile phone application. By using GPS, this app locates the nearest AED in the event of a cardiac arrest. In total, the app identified over 800 AEDs across four counties.
- A new initiative was the introduction of a ‘Simulance’: a large command vehicle fully equipped with simulation learning activities. It was an innovative virtual classroom facility in that it gave ambulance staff the opportunity to experience realistic medical situations inside an ambulance saloon.
- Operation centres had direct access to electronic information held by community services, including GPs. This meant that the staff could access up-to-date information about patients (for example, details of their current medication).
- Trauma risk management (TRiM) was in place to provide confidential support to staff who may have been affected by traumatic incidents or conditions. Staff were assessed 3 days after a traumatic event and again after 28 days. Thirty-two TRiM practitioners gave peer support and advice, and there was also an external counselling service. The early intervention had both reduced sickness absence and improved the welfare of staff.
- The Helicopter Emergency Medical Services (HEMS) showed innovative practices and learning taken from combat zones. The team now had the equipment and skills to give blood transfusions and perform ultrasound and blood gas tests. In some circumstances, this bypassed or reduced the time a patient had to spend in the accident and emergency (A&E) department, and meant they could receive treatment immediately on arrival at the hospital. HEMS was also planning to introduce a night service, so it would operate 24 hours every day.
- The introduction of a midwife to the clinical support desk (CSD) in the Southern House emergency operation centre had improved the outcomes for expectant mothers and their new babies. The 24-hour labour line started as a pilot in May 2014. It gave women in labour access to advice and support, whereas the ‘professional’s line’ enabled medical professionals to speak to a midwife 24/7 during a woman’s labour and birth. The service had over 1,600 calls in the first eight weeks.
- The trust provided a service on Friday and Saturday nights in the city centres of Portsmouth (Safe Place) and Southampton (ICE Bus) to provide support, first aid and transfer to hospital if required for the public enjoying a night out. This had been set up in partnership with other organisations such as the Hampshire Police, the local council, volunteers and the local street pastors
- The trust had a clinical lead in mental health and learning disability. This role was unique among ambulance trusts. The lead had established a national mental health group for ambulance trusts, and worked with partner agencies such as the Royal College of Psychiatrists and the College of Policing. The introduction of mental health practitioners into the EOC was supporting operational practice and care to mental health patients.
- The trust had worked in partnership with Oxford Brookes University to provide staff with extra opportunities to develop their careers by becoming a paramedic, and to counter the national shortage of paramedics. A foundation degree course was to start in January 2015. The training covered an 18-month

Outstanding practice and areas for improvement

period and included in-hours training. The trust's investment had been significant in terms of the time taken to negotiate the resources and facilities for the programme and the release of staff from work duties.

Areas for improvement

Action the hospital **MUST** take to improve

The trust must ensure that:

- Staff uptake of statutory and mandatory training meets trust targets.
- Staff in EOC and PTS understand the Mental Capacity Act 2005.
- All EOC and PTS staff receive safeguarding training to the required level so that they are able to recognise signs of abuse and ensure there are robust arrangements in place for staff to report concerns within the agreed timescale.
- Emergency call takers answer calls, and the emergency medical dispatchers dispatch an ambulance within target times.

Action the hospital **SHOULD** take to improve

The trust should ensure that:

- Procedures for incident reporting continue to improve and staff in EOC and PTS have appropriate training and are able to report incidents directly. There must be timely investigation of incidents, staff must receive feedback and learning must be shared.
- The risks around IT vulnerability in the EOC and PTS are appropriately managed.
- Infection control practices are followed and ambulance stations (resource centres) and vehicles are effectively cleaned and deep cleaned.
- There are suitable arrangements to ensure that equipment regularly checked and fit for purpose.
- Staff are aware of the appropriate steps to take to reduce the risks to patients left unattended in PTS ambulances because of staff working alone.
- Appropriate equipment is available in all areas for the transport of children in PTS and this continues to be rolled out for emergency transport.
- Volunteer drivers in PTS have the appropriate safety and employment checks before working within the service.

- The trust to continue to work with partners and ensure the planning and scheduling of PTS improve to prevent delays and missed appointments, and to reduce the impact on the clinical care, treatment and welfare of patients.
- The governance and security arrangements for the management of controlled drugs need to be improved in Hampshire.
- Recruitment of staff in all areas continues and there are specific staff retention plans in response to identified reasons as to why staff leave.
- Staff in PTS receive appropriate training on dementia care, learning disabilities and all staff continue to receive training in mental health conditions.
- Anticipated resource and capacity risks in PTS continue to be appropriately identified, assessed and managed.
- Pain relief continues to be appropriately administered for patients with ST segment elevation myocardial infarction (STEMI) and pain relief for children is effectively monitored.
- Continue to work with acute trusts to review protocols for the non-critical transfer of hospital patients.
- There is better coordination of care between providers, in particular for cardiac and stroke services in Buckinghamshire and mental health services.
- Complaints are responded to within the trust's target of 25 days. All staff in EOC and PTS receive feedback from complaints and learning is shared.
- Operations staff in PTS are appropriately resourced to be able to answer telephone calls.
- Patients (or people acting on their behalf) using the PTS are made aware of how to complain or send compliments about the service.
- Staff in PTS have regular supervision and the trust should raise awareness amongst staff about the professional and career development opportunities within the trust.

Outstanding practice and areas for improvement

- The formal structure of team meetings is in place for all staff groups and staff are given the opportunity to attend, share information and raise issues or concerns.
- Staff have a better understanding of the trust's vision and strategy as it applies to their service in EOC and PTS and staff communication continues around service changes and development.
- Leadership in the northern EOC and PTS supports staff and action is taken to improve staff morale where this is low.
- Staff in PTS receive feedback from the completed patient satisfaction surveys.
- There are better governance arrangements within EOC and PTS to share information with staff, so that staff can raise concerns and risks are appropriately identified, assessed and managed.
- There are better governance arrangements for private providers in PTS and make ready services.