East Midlands Ambulance Service NHS Trust

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

East Midlands Ambulance Service NHS Trust (EMAS) covers the six counties of Derbyshire, Nottinghamshire, Leicestershire, Rutland, Lincolnshire and Northamptonshire. This is an area which has a population of around 4.8 million people and covers approximately 6,425 miles. The trust employs 3,290 staff over 60 locations.

We carried out a follow up inspection of the East Midlands Ambulance Service NHS Trust from 21 to 23 February and 3 March 2017, in response to a previous inspection as part of our comprehensive inspection programme of East Midlands Ambulance Service NHS Trust in November 2015. In July 2016 we served the trust with a Warning Notice in which we required them to make significant improvements to the quality of health care provided. This was specifically in relation to ensuring there were sufficient staff with the right skill mix and sufficient vehicles as well as requiring the trust to ensure staff received appropriate training, support and appraisal to carry out their roles.

Focused inspections do not look across a whole service; they focus on the areas defined by the information that triggers the need for the focused inspection. As the trust were no longer commissioned to provide patient transport services in Lincolnshire we did not look at that core service.

During this inspection we looked at:

The safety and effectiveness of Emergency and Urgent Care Services.

The safety and effectiveness of the Emergency Operations Centres.

Safety, effectiveness and well led at provider level.

The overall rating for East Midlands Ambulance Service remains unchanged at requires improvement although safety for emergency and urgent care services is no longer inadequate but requires improvement.

Our key findings were as follows:

- The trust had made significant improvements as required by the July 2016 warning notice. However we remained concerned about response times.
- Response times for Red 1, Red 2 and A 19 calls were consistently below the national target and patients were not receiving care in a timely manner.
- There were variable standards of incident investigation, limited recommendations, lack of learning at an organisational level and a lack of evidence that recommendations had been actioned.
- There was a lack of consistency in the management of risk due to trialling a revised risk register proforma.
- Staff did not know about the Duty of Candour requirements or their responsibilities under it and the trust had not consistently fulfilled their responsibilities under the Regulation.
- We found pockets of concern about the potential bullying and harassment of staff who were not confident to report this. We found instances where policies and procedures relating to staff wellbeing were not followed in practice.
- Not all staff had been trained on the use of and supplied with filtered face piece masks (FFP3). Those that had been supplied with a mask did not always have them available for immediate use.
- The trust were not compliant with the requirements of the Fit and Proper Persons Regulation.
- Whilst the trust had a clear vision and strategy, frontline staff were not aware of these.
- Whilst training completion rates for statutory and mandatory training had significantly improved, mandatory training completion rates for equality and diversity and risk management modules were too low and there were challenges in two specific divisions around completion rates in general.
- The trust had taken appropriate actions which had been successful in increasing the number of front line staff.
- Standards of cleanliness had improved.
- The majority of equipment and vehicle checks were appropriately completed.
- There was an increased number of operational vehicles available to deliver emergency and urgent care services.

Summary of findings

- Medicines were stored securely and the management of controlled drugs was in line with the trust's policy. However, we had some concerns about the lack of robust audit trail for access to controlled drugs on solo responder vehicles.
- There were notable improvements in the security of patient records.
- Potential risks to the service were anticipated and planned for in advance.
- The trust had taken action to provide frontline staff with the knowledge and information they needed to respond to a major incident.
- People's care and treatment was planned and delivered in line with current evidence-based guidance, standards and best practice.
- Patient outcomes were mainly above or equivalent to national average levels.
- Staff had received timely appraisals which had been perceived by most to be a meaningful process.
- Improvements in training and development opportunities were evident and staff told us about them.
- Where patients received care form a range of different staff, teams or services this was effectively coordinated.
- Staff were confident in their understanding of the principles for patient consent and the Mental Capacity Act 2005 and they followed them.
- There was a governance framework able to support the delivery of safe, high quality care.
- There was a high level of confidence in and respect for the leadership of the acting chief executive.
- There was increased confidence in the effectiveness of the board and frontline leaders were better equipped with skills and knowledge.
- The culture of the trust from board to frontline staff was overwhelmingly patient focussed. Our inspection team observed caring, professional staff delivering compassionate, patient focussed care in circumstances that were challenging due to the continued demand placed on the service.
- Staff engagement and satisfaction had improved since our last inspection.

We saw several areas of outstanding practice including:

- The trust had run a highly effective recruitment campaign and received a national award for equality and diversity in recruitment.
- The trust were trialling a pre-hospital sepsis treatment in North and North East Lincolnshire. Where patients presented with the symptoms of sepsis, blood cultures were taken and a pre-hospital dose of intravenous antibiotic therapy administered to the patient. This saved valuable time and provided prompt lifesaving treatment. The results of the study had not been published at the time of our inspection but early indications showed positive outcomes for patients. The trust was the only ambulance trust in England providing pre-hospital care to this group of patients.
- The trust had extended the provision of a mental health triage car in Lincolnshire and also to include patients in Derbyshire increasing the provision of appropriate care and treatment for patients with mental health conditions.
- We observed caring, professional staff delivering compassionate, patient focussed care in circumstances that were challenging due to the continued demand placed on the service.

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

Importantly, the trust must:

- The trust must ensure patients receive care and treatment in a safe way by meeting national and locally contracted response time targets for Red1, Red2 and A19 categorised calls.
- The trust must take steps to improve EOC call taking response times therefore reducing the number of calls abandoned and the length of time callers are waiting on the phone.
- The trust must ensure all staff know how to report incidents. The trust must ensure serious incidents are appropriately and consistently investigated with lessons learnt acted upon and shared widely.
- The trust must ensure all staff understand the Duty of Candour Regulation and their responsibilities under it.
- The trust must ensure all staff access and attend mandatory training with particular focus on compliance rates for equality and diversity and risk management training.
- The trust must ensure all staff are fitted for and trained in the use of a filtered face piece mask to protect them from air borne infections.
- The trust must increase the percentage of frequent callers who have a specific plan of care.

Summary of findings

- The trust must ensure there are systems in place to ensure staff have received, read and understand information when there are updates to trust policies, procedures or clinical practice.
- The trust must ensure they comply with the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014).

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Background to East Midlands Ambulance Service NHS Trust

East Midlands Ambulance Service NHS Trust (EMAS) covers the six counties of Derbyshire, Nottinghamshire, Leicestershire, Rutland, Lincolnshire and Northamptonshire. This is an area which has a population of around 4.8 million people and covers approximately 6,425 miles. The trust employs 3,290 staff over 60 locations.

The trust covers an ethnically diverse population with 85% white British residents. The largest represented ethnic minority is Asian. The region has the second lowest overall population density in England. There are high levels of deprivation in Lincolnshire, Northamptonshire and Nottinghamshire. Leicestershire and Nottinghamshire have areas of high population density whilst Derbyshire and Lincolnshire have large areas of rurality.

We carried out a follow up inspection of the East Midlands Ambulance Service NHS Trust from 21 to 23 February and 3 March 2017, in response to a previous inspection as part of our comprehensive inspection programme of East Midlands Ambulance Service NHS Trust in November 2015. In July 2016 we served the trust with a Warning Notice in which we required them to make significant improvements to the quality of health care provided. Focused inspections do not look across a whole service; they focus on the areas defined by the information that triggers the need for the focused inspection. During this inspection we looked at:

Emergency and Urgent Care Services – safe and effective

Emergency Operations Centres – safe and effective

Provider - well led.

As part of our inspection we visited trust premises including offices, training areas, ambulance stations and emergency operations centres. We also visited hospitals and other health care locations to speak with patients and staff about their experiences of the ambulance service.

Our inspection team

Our inspection team was led by:

Chair: Gillian Hooper, Independent Consultant

Head of Hospital Inspections: Carolyn Jenkinson, Care Quality Commission

The team included CQC inspectors, inspection managers, a national professional advisor, a pharmacist inspector, an inspection planner and a variety of specialists: paramedics, senior paramedics, a consultant paramedic, a clinical general manager, operational managers, an emergency operation centre manager, a call handler, and a director of strategy.

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 team inspected the following:

- Emergency and Urgent Care
- Emergency Operations Centres

Prior to the announced inspection, we reviewed a range of information that we held and asked other organisations to share what they knew about the trust. These included the 22 clinical commissioning groups (CCGs), NHS Improvement, and NHS England.

Summary of findings

We held interviews with a range of staff in the service and spoke with staff individually as requested. We talked with staff from acute hospitals who used the service provided by the trust. We spoke with patients, carers and / or family members and reviewed patients' treatment and other records.

We carried out the announced inspection visit between 21 and 23 February 201 with an unannounced inspection on 3 March 2017.

What people who use the trust's services say

Patients were overwhelmingly positive about the caring and compassionate staff at this trust who were delivering patient focussed care in challenging circumstances.

Facts and data about this trust

East Midlands Ambulance Service NHS Trust serves a population of 4.8 million people across an area of approximately 6,425 square miles covering the counties of Derbyshire, Leicestershire, Lincolnshire, Northamptonshire, Nottinghamshire and Rutland.

As of December 2016 the trust employed 3,0 staff across over 60 locations. The trust had around 550 vehicles, including emergency ambulances, fast response cars, specialised vehicles and patient transport vehicles. As of December 2016 the trust had two emergency operations centres, located in Lincoln and Nottingham, and 60 ambulance stations.

Between December 2015 and November 2016 the trust received 939,499 emergency and urgent calls. Of these 659,480 calls resulted in an ambulance attending the scene of the incident.

In 2015/16 the trust reported a turnover of £154.1 million and a deficit of £12.2 million. For 2016/17 the trust predicts a turnover of £173.1 million and a deficit of £4.5 million.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? **We rated safe as requires improvement because:** • We found variable standards of incident investigation, limited recommendations, lack of learning at an organisational level and a lack of evidence that recommendations had been actioned. • Staff did not know about the Duty of Candour requirements or their responsibilities under it and the trust had not consistently fulfilled their responsibilities under the Regulation. • Mandatory training completion rates for equality and diversity and risk management modules were too low and there were challenges in two specific divisions around completion rates in general. • Not all staff had been trained on the use of and supplied with filtered face piece masks (FFP3). Those that had been supplied with a mask did not always have them available for immediate use. However: • There were systems in place to safeguard patients from abuse which staff were familiar with and used effectively. • Training completion rates for statutory and mandatory training had significantly improved. • The trust had taken appropriate actions which had been successful in increasing the number of front line staff. • Standards of cleanliness had improved. • The majority of equipment and vehicle checks were appropriately completed. • There was an increased number of operational vehicles available to deliver emergency and urgent care services. • Medicines were stored securely and the management of controlled drugs was in line with the trust's policy. However, we had some concerns about the lack of robust audit trail for access to controlled drugs on solo responder vehicles. • There were notable improvements in the security of patient records. • Potential risks to the service were anticipated and planned for in advance. • The trust had taken action to provide frontline staff with the knowledge and information they needed to respond to a major incident.	**Requires improvement** 

Summary of findings

Duty of Candour

- Although all staff we spoke with discussed the principle of being open and honest with patients, they had little knowledge of their responsibilities under the Duty of Candour Regulation. We saw from a review of incident investigations that the trust had not always fulfilled their responsibilities under the Regulation.

Safeguarding

- At our last inspection we found insufficient staff had completed level two safeguarding training. The trust set a mandatory target of 90% for completion of mandatory safeguarding training by the end of March 2017. As of November 2016 this target had already been met across the trust, with 91.4% of staff having completed the training.
- The trust had effective systems and processes to safeguard patients from abuse and staff understood and implemented these processes effectively.
- We found one occasion where there had been a failure to follow statutory safeguarding procedures. We escalated this to senior leaders and the trust began an immediate investigation.

Cleanliness and infection control

- At our last inspection we found standards of cleanliness were inconsistent in emergency and urgent care services. The management of domestic and clinical waste was not always safe and appropriate. The trust had made some improvements to the management of its waste and in most areas we inspected it was managed in line with legislation and guidance. In those areas where we found this not to be the case the trust confirmed they had taken action following or during our inspection to address our concerns.
- Infection control audits for ambulance stations, ambulances and staff were planned as part of the trust's quality everyday initiative. There were infection prevention control (IPC) audits completed quarterly at divisional level and the central IPC team also carried out an annual audit. We found improved standards of cleanliness.
- The trust had performed well in their flu vaccination programme with 61.1% of staff vaccinated for winter 2016/17.
- Following our last inspection the trust were issued with a requirement notice as 39% of staff had been fitted for and trained in the use of filtered face piece masks. These are masks used to protect the wearer from infection. On this inspection data supplied by the trust showed as of January 2017 an average of 61.4% of staff had been fitted with filtered face piece

masks and trained how to use them against a trust target for March 2017 of 100%. Divisional compliance ranged between 80% for Northamptonshire and 32.3% for Nottinghamshire, with compliance in Derbyshire at 56.47%, Leicestershire at 64% and Lincolnshire at 74.5%. The majority of staff we spoke with had been fitted with and trained in the use of their face masks however in Leicestershire, 11 of the 29 staff we asked had not got their masks with them on the vehicle. Staff who had not received one were waiting for an additional fitting. There were some staff who were unclear on which specific infections would trigger its use. One member of staff demonstrated how it was worn.

Environment and equipment

- At our last inspection we found that not all vehicle and equipment checks had been carried out to the determined frequency. During this inspection the majority of vehicles we inspected had safer vehicle checklists appropriately completed. Frontline leaders were carrying out documented spot checks of completion and addressing their findings. In December 2016 the trust approved a new management of medical devices policy. Details of all medical devices had been entered onto a database system and a dedicated team were responsible for the management of medical devices. The majority of equipment we inspected was in date for servicing and maintenance. However, we found staff were not following the correct procedure for checking suction equipment.
- At our last inspection we found there were not always sufficient emergency vehicles to safely meet demand. Since the last inspection the trust had purchased 66 new double crewed ambulances. With 26 existing vehicles requiring replacement the trust had taken delivery of 92 new vehicles but with an overall increase in numbers of 66. The fleet services manager told us this increase allowed the trust to meet the need for downtime for routine servicing and also respond to surges in demand.

Medicines

- At our last inspection we found medicines, including controlled drugs were not stored and managed safely. At this inspection we found the security of medicines and control systems had been improved.
- However, we found some concerns about the management of controlled drugs (CDs). The access and security arrangements for CDs on vehicles meant that if there was a discrepancy it would not be possible to determine who had accessed the CDs.

The trust had undertaken a risk assessment and also identified this as a security issue. However because there had been no reports of any serious CD incidents no further action had been taken to reduce the potential risk.

- CD records on ambulances and within designated ambulance stations should be countersigned by a witness. It is seen as good practice by NHS Protect in order to ensure a robust audit trail of controlled drugs. However, it is also recognised that when clinical staff work alone that obtaining a witness every time is not always possible. Paramedics we spoke with recognised that it was important to obtain a second witness for accurate controlled drug records. Records we looked at sometimes showed only one signature however CDs on vehicles were checked by two staff at the start of each new shift as part of the vehicle check list. Vehicles that had not been used for a few days did not have these routine CD checks. There was therefore a potential risk that any discrepancies on these vehicles would not be immediately identified.

Records

- At our last inspection we found paper patient report forms were not always stored appropriately and securely in trust premises and in such a way on trust vehicles as to maintain patient confidentiality. During this inspection we found there were notable improvements to the security of patient records with a change in storage arrangements and in the trust's procedure for the storage of confidential waste. Information governance relating to patient records had been included in the trust's mandatory training programme.

Incidents

- Between January and December 2016 there had been no never events reported by the trust. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- During 2016, there had been a number of reviews of the trust's patient safety incident process by external bodies and partners. This was completed to obtain an understanding of the serious incident profile and learning from root cause analysis (RCA).RCA is an investigation process used to work out why something happened. The trust's reporting and investigation of serious and high level incidents procedure had been reviewed in August 2016 to bring in it line with the updated national

incident reporting framework. The scope of the procedure had been widened to include high level incidents. External reviews found the trust were under-reporting patient safety incidents. The trust had subsequently amended the categorisation of patient safety incidents which had raised the numbers to the levels expected.

- A Serious Incident is any incident (or series of incidents) that prevents, or threatens to prevent, an organisation's ability to continue to deliver an acceptable quality of service. In accordance with the Serious Incident Framework 2015, the trust reported 48 serious incidents (SIs) which met the reporting criteria set by NHS England between January and December 2016. Of these, the most common type of incident reported was "treatment delay meeting SI criteria" (25 serious incidents, which was 52% of the total). For the same period we reviewed the incidents recorded on the trust's electronic incident recording system and found 43 serious incidents recorded. The trust said this was because following investigation, some serious incidents had been downgraded on their own system.
- At our last inspection we had found incident investigation was inconsistent. We also found there was a lack of evidence of learning from incidents and where learning was identified it was not consistently shared with all staff. During this inspection we reviewed five serious incident reports and subsequent investigations in detail on the trust's electronic system and discussed them with senior managers. We found variable standards of investigation, limited recommendations, lack of learning at an organisational level and a lack of evidence that recommendations had been actioned. However we reviewed 18 serious incident investigation reports relating to the emergency operations centres and found detailed investigations with recommendations and action plans which had been monitored monthly.
- At out last inspection we found staff did not report all appropriate incidents. During this inspection we found staff in emergency and urgent care services were aware of what constituted an incident and how to report it, however 14 out of 15 staff in the emergency operations centre (EOC) when asked did not know how to report incidents. Information on how to report incidents was available on the trust's intranet and staff also had access to paper forms for reporting.

Mandatory training

- At our last inspection we found mandatory and statutory training completion rates did not meet the trust's own targets and we issued a warning notice requiring the trust to address

this. Compliance rates with mandatory and statutory training had improved significantly. An overwhelming majority of staff reported the quality of training had improved over the last 12 months. Staff also reported that training had not been cancelled due to operational demands.

- In the emergency and urgent care services eight out of eleven modules making up the trust's statutory and mandatory training had achieved, or were on track to achieve compliance for the majority of divisions.
- In the emergency operations centre (ECO) five out of eight modules making up the trust's statutory and mandatory training had achieved, or were on track to achieve compliance.
- We found targets had not been met and were not expected to meet compliance rates across the trust for equality and diversity and risk management training. We also found Leicestershire division had particularly low compliance rates for annual resuscitation training, annual manual handling training, annual infection prevention control training and information governance training. Northamptonshire division had particularly low compliance rates for annual resuscitation training and annual infection prevention control training.
- At our last inspection we were concerned that staff had not received any recent training in mental health awareness which meant they may not have had the skills to deal with patients in mental health crisis, with mental health conditions or the knowledge to work within the Mental Capacity Act 2005 (MCA). The trust had incorporated a new mental health training programme as part of the statutory and mandatory training. This had begun in September 2016 with an initial completion target for end March 2017 of 20%. The trust had already exceeded this target by the end of October 2016 where 28.8% of staff had completed this training. There was a two year role our programme for this training.

Staffing

- At our last inspection we found the trust had insufficient numbers of staff with an appropriate skill mix to meet safety standards and national response targets. During this inspection we found the trust had taken appropriate actions which had been successful in increasing the number of front line staff. As part of the trust's wider improvement plan, the trust's workforce plan had focused on recruiting and retaining sufficient staff and ensuring they had the correct skill mix to meet the demands of the service. As of 30 November 2016, the trust reported an overall vacancy rate of 5.7% with a whole time number of 173 vacancies. Skill mix had improved from 75% qualified, 25%

unqualified to 84% qualified, 16% unqualified. However from April to November 2016 the availability of front line staff did not meet the number of resources that were required across all divisions, despite achieving the numbers agreed by commissioners.

- The trust had completed a successful recruitment campaign using a variety of methods including social media, their new careers website, a campaign to recruit qualified paramedics from overseas and they had developed partnerships with higher education institutions. This recruitment campaign had been recognised nationally with a national equality and diversity recruitment award in 2017.
- In the staff survey for 2016 the number of staff reporting satisfaction with resourcing and support, had improved as had the number of staff reporting satisfaction with the quality of work and care they were able to deliver.
- The trust offered a clinical apprenticeship scheme at level four as well as at level two and three in business administration. Some staff who had previously been on apprenticeship schemes with the trust were in substantive employment following their apprenticeship.

Anticipate resource and capacity risks

- At our last inspection we found lengthy delays at some acute trust emergency departments taking receipt of patients transported by EMAS were impacting on the trust's resource and capacity to respond safely. Since our last inspection the senior leadership team had engaged extensively with other providers and stakeholders to ensure patients remained safe during prolonged waits for handover to acute hospital teams. They had agreed appropriate standard operating procedures for escalation and for protecting patients. They had also worked hard to focus the health economy on the risks to patients in the community because ambulances were unable to leave acute hospital emergency departments.
- The trust had a comprehensive business continuity policy and process, which we saw working effectively during a period of severe weather.
- The trust used a capacity management plan (CMP) to assess and respond to changes in demand. The aim of CMP actions were to maximise responses to the most seriously unwell patients. Following a review of the trust's CMP there were now four levels to the plan with level four being the highest escalation.
- Establishing the number of staff required to meet the fluctuating demand was managed via a central resourcing

Summary of findings

team. Data from the previous five years was used to inform resource planning. Seasonal trends as well as more predictable changes to demand, for example special events were all taken into account to determine staffing and vehicle resource requirements.

Major incident awareness and training

- At our last inspection we found the trust had not ensured arrangements to respond to emergencies and major incidents were practised and reviewed in line with current guidance and legislation. During this inspection we found the trust had taken actions to provide front line staff with the information and knowledge they needed to respond to a major incident. A specific training database had been established to record all emergency planning and incident command training and learning from major incidents. Operational staff had attended multi-agency simulation exercises since our last inspection. One hundred percent of staff in the emergency operations centre had completed initial operational response training which the trust told us included elements of major incident training.

Are services at this trust effective?

Requires improvement

We rated effective as requires improvement because:

- Response times for Red 1, Red 2 and A 19 calls were consistently below the national target and patients were not receiving care in a timely manner.
- Data showed deteriorating performance in call answering response times.

However:

- People's care and treatment was planned and delivered in line with current evidence-based guidance, standards and best practice.
- Patient outcomes were mainly above or equivalent to national average levels.
- Staff had received timely appraisals which had been perceived by most to be a meaningful process.
- Improvements in training and development opportunities were evident and staff told us about them.
- Where patients received care from a range of different staff, teams or services this was effectively coordinated.
- Staff were confident in their understanding of the principles for patient consent and the Mental Capacity Act 2005 and they followed them.

Summary of findings

Evidence based care and treatment

- National Institute for Health and Care Excellence (NICE) guidelines and Joint Royal Colleges Ambulance Liaison Committee (JRCALC) clinical practice guidelines were available to staff.
- Clinical policies and procedures, based on evidence based practice were adhered to and appropriately reviewed.
- Emergency operations centre staff used the advanced medical priority despatch system (AMPDS) to assess and prioritise emergency calls.
- Clinical advice and support, based on current guidance and best practice was available from the clinical assessment team (CAT) in the emergency operations centre (EOC). Clinical updates were sent to clinicians via email, included in the trust's eNews letter and they were also displayed on notice boards in ambulance stations. However, several staff told us they received so much information it was difficult to read every document. Senior staff confirmed there was no trust procedure to record which staff had received, read and understood clinical or procedural updates.
- EMAS were involved in local and national pre hospital research. Research participation during the previous 12 months included a national study on the clinical and cost effectiveness of different equipment used to manage patient airways. Airways are used when patients were unable to breathe for themselves. In September 2016 the trust reported over a third of EMAS clinicians were involved in research.

Patient outcomes

- Patient clinical outcomes were monitored as part of the NHS England's Ambulance Quality Indicators. Data was provided by all eleven NHS ambulance services. The trust's clinical audit department collected and analysed patient data and submitted a bi-monthly board report on patient outcomes for three specific treatment pathways.
- The most recent data available was for the period January to September 2016. During this period the trust performance was in line with, and for the majority of the time better than, the England average for providing initial care for patients suffering a stroke or heart attack.
- Between January and September 2016 the trust cared for 251 patients who had been witnessed to have collapsed and required resuscitation. Of these patients 111 (44.2%) had their

circulation restored by the resuscitation they had received at the time they were admitted to hospital. This performance was worse than the average performance of 51.2% across all 11 ambulance trusts during the same period.
- The percentage of emergency calls resolved by telephone advice and support (hear and treat) was more than ten percent better than the England average.
- From August 2015 to November 2016, the proportion of patients who re-contacted the service following treatment and discharge at the scene, within 24 hours was consistently better than the England average. From January to August 2016 the trust's performance showed a trend of improvement. However in November 2016 there was a sharp increase in the trust's re-contact rate, although this still remained better than the England average.
- The trust had recently undertaken a pilot in Lincolnshire for paramedics to treat sepsis before hospital admission. The acute sector hospital trained the paramedics how to take blood cultures and to identify sepsis patients. They were then immediately treated with an intravenous antibiotic for sepsis. Sepsis is a severe infection, which spreads in the bloodstream. The evaluation of this pilot had not been completed at the time of our inspection but initial indications showed positive outcomes for patients and the trust hoped to take this forward across other counties.
- There was a planned programme of service monitoring and clinical audit and patient outcome data was used to inform service improvements.

Competent staff

- At our last inspection we found staff had not always received an annual appraisal. The trust had improved the appraisal process, which staff recognised and appreciated. Appraisal completion rates were improved although slightly below the number required to reach the target of 95% in all areas by the end of March 2017. The NHS staff survey results for 2016 reflected the staff view that the quality of appraisal had improved.
- At our last inspection we were not assured that staff were receiving appropriate clinical supervision. Staff reported an improvement in clinical supervision with clinical team mentors and team leaders providing effective clinical supervision for frontline staff.
- At our last inspection we found staff did not always receive appropriate non-mandatory training to enable them to carry

out the duties they were employed for. Access to training had improved and all staff told us training was now given a much higher priority. The investment in training and development opportunities for staff was evident and they told us about it.

- No formal training was provided for staff prior to them being placed in the position of hospital ambulance liaison officer (HALO) and this was where less experienced staff relied on their colleagues for support. Staff working in this role explained they learnt on the job. A HALO worked with ambulance crews and hospital staff to facilitate the timely and safe handover of patients to the hospital staff. Given the delays to handover patients were experiencing in some acute hospital emergency departments the need for staff to have appropriate training to significantly and consistently impact improvement was evident.

Response times

- At our last inspection we found the trust did not ensure response times met the needs of patients by reaching national target times. During this follow up inspection we found there had not been significant improvement in the response times to life threatening emergency calls or to the response of providing a vehicle equipped to convey a patient to hospital. From August to December 2015 and from August to December 2016 the trust did not meet the national response targets for Red 1, Red 2 or A19 calls. Red 1 calls are the most time critical calls for patients in cardiac arrest and other severe conditions such as major bleeding. Red 2 calls are serious but less time critical and include a response for a patient suffering a stroke or having a fit. The national standard for ambulance services is to send an emergency response within eight minutes to 75% of Red 1 and Red 2 calls. The A19 standard requires a fully equipped ambulance, capable of conveying a patient to be sent to 95% of Red 1 and Red 2 calls within 19 minutes of a request being made for a vehicle to convey a patient to hospital.
- From August 2016 to December 2016, 6,578 patients required a Red 1, eight minute response from EMAS, 4,563 patients (69.4%) received an eight minute response. Compared to the same five month period in 2015 this showed a very slight improvement on the percentage (68.2%) of Red 1 calls responded to within eight minutes. However, the number of patients requiring a Red 1 response had increased in 2016. This meant 1,801 patients did not receive an eight minute response between August to December 2015 and 2,015 patients did not receive an eight minute response during the same five month period in 2016. The Red 1 national response target of 75% of calls responded to within eight minutes was met by two divisions in August 2016.

In all months other than this no divisions met the Red 1 response target. The overall trust compliance with the national response time target for Red1 calls in January 2017 was 65.3%. This did not meet the national response time target of 75%. The performance data for the month of February 2017 showed an improved compliance of 71.3%.

- From August 2016 to December 2016, 136,702 patients required a Red 2 eight minute response from EMAS, 78,237 patients (57.2%) received an eight minute response. Compared to the same five month period in 2015 this showed deterioration in the percentage (60.8%) of Red 2 calls responded to within eight minutes. As the number of patients requiring a Red 2 response had increased in 2016, this meant 46,773 patients had not received an eight minute response between August to December in 2015 and 58,472 Red 2 calls did not receive an eight minute response during the same five month period in 2016. From April to December 2016 no division met the national response targets for Red 2 calls. The overall trust compliance with the national response time target for Red 2 calls in January 2017 was 54.5%. This did not meet the national response target of 75%. The performance data for the month of February 2017 showed an improved compliance of 58.71%.
- All senior leaders consistently told our inspection team that there were challenges in meeting target response times because of the increasing number of calls categorised as Red 1 and Red 2, the increasing acuity of patients and the time lost to hospital handover delays.
- From August 2016 to December 2016 142,926 patients required an A19, 19 minute response from EMAS, 120,060 patients (84%) received a 19 minute response. Compared to the same five month period in 2015 this showed deterioration in the percentage (87.2%) of A19 calls responded to within 19 minutes. As the number of patients requiring a resource to convey had increased in 2016 this meant 15,745 patients had not received a 19 minute response between August and December in 2015 and 22,866 patients had not received the 19 minute response in the same period in 2016.

Multidisciplinary working

- Staff in emergency departments and other areas of acute hospitals, community services and care homes were all positive about working practices and coordination of care with EMAS staff.

- There was a joint governance agreement between the police, fire and ambulance services across the east midlands. EMAS led on clinical governance and were part of the joint emergency services interoperability programme (JESSIP).
- In the Nottingham city area EMAS were part of an emergency falls response team that responded to emergency calls where patients had fallen. A paramedic worked alongside an assistant practitioner who was a specialist in falls prevention and mobility and this provided multidisciplinary approach to the falls service.
- There was a multidisciplinary approach to managing handover delays at emergency departments. There was on going and regular communication between EMAS and the acute trusts both at board level and operational level. Senior EMAS staff had been involved in the development of the acute trust's standard operating procedures for the safe management of patients during handover delays.
- The operating procedures set out a multidisciplinary approach to managing the delays, with nursing and medical staff from the acute trusts working with EMAS clinicians.
- EMAS executives attended the accident and emergency delivery board meetings. This was to ensure the impact of handover delays was clearly understood and to work with other providers to implement actions to minimise the number and impact of delays. There was close monitoring of handover delays with daily reports being produced; this enabled the trust to see emergency departments where there were sustained periods of significant delays. Monthly meetings were taking place with acute trusts.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- The trust policy for capacity to consent was available to staff who demonstrated a good understanding of the requirements for patient consent to care and treatment.
- At our last inspection we found there was not a jointly agreed local policy governing all aspects of the use of Section 135 and Section 136 of the Mental Health Act 2005. The trust had established protocols which had been approved by the national ambulance mental health group and we observed staff using the protocols appropriately.
- We reviewed trust response times to section 136 requests. Section 136 requests are requests made by the police for the conveyance of patients who are suffering from mental disorder and are in immediate need of care or control. The national ambulance mental health group, Section 136 protocol states

Summary of findings

the local ambulance service will respond within 30 minutes (dependent on operational demand). Between January 2016 and January 2017 the trust received 359 section 136 requests. All calls (with one exception) were classed as green two calls, requiring an ambulance response within 30 minutes. The average response time across this period was 41 minutes. In the months of October 2016 and November 2016 response times averaged over one-hour. This meant the trust did not always provide timely responses to section 136 requests.

Are services at this trust caring?

Are services at this trust responsive?

Are services at this trust well-led?

Requires improvement

We rated well-led as requires improvement because

- There was a lack of consistency in the management of risk and risk registers.
- Some staff groups were not aware of the incident management system. There was a lack of consistency in the quality of incident investigation, and learning identified from incidents and complaints was not effectively shared with all staff.
- Whilst the trust had a clear vision and strategy, frontline staff were not aware of these.
- We found pockets of concern about the potential bullying and harassment of staff who were not confident to report this.
- We found instances where policies and procedures relating to staff wellbeing were not followed in practice.
- The trust were not compliant with the requirements of the Fit and Proper Persons Regulation.

However:

- There was a high level of confidence in and respect for the leadership of the acting chief executive.
- There was increased confidence in the effectiveness of the board and frontline leaders were better equipped with skills and knowledge.
- The culture of the trust from board to frontline staff was overwhelmingly patient focussed. Our inspection team observed caring, professional staff delivering compassionate, patient focussed care in circumstances that were challenging due to the continued demand placed on the service.
- Staff engagement and satisfaction had improved since our last inspection.

Summary of findings

- There was a governance framework able to support the delivery of safe, high quality care.
- The trust were trialling an initiative to provide pre-hospital care for patients with sepsis.

Vision and strategy

- The trust's vision was to deliver outstanding sustainable emergency and urgent care services across the communities of the east midlands. Trust key priorities for the period 2017 to 2019 were summarised on one page under the five headings of; our performance, our people, our development, our quality and our money. All executive and non-executive directors we spoke with were clear about the vision and strategy for the trust; however frontline staff were not familiar with the priorities despite some information being on display in trust locations.
- Since our last inspection the commissioners of the emergency and urgent care service had contracted a pricing review which had reported. The trust had been able to use this review to informed contract negotiations for 2017/18, ensuring the provision of a financially sustainable service.
- The trust's commissioners had agreed to commission an independent review of demand and capacity in early 2016. Significant delays in the contracting of this work meant the report was due for publication shortly after our inspection of February 2017. The review was intended to provide an independent report to inform the commissioners in relation to funding required for the service to remain viable. The findings of this review were anticipated by the trust and senior leaders were sighted on the possible changes in strategy and efficiencies which may be required as a result.

Governance, risk management and quality measurement

- We had some concerns about the management of risk at the trust. We asked to see copies of the trust risk registers. We received copies of risk registers for the divisions but did not receive any register representing corporate risks. A senior manager told us strategic risks were recorded on the board assurance framework. Following our inspection the trust told us other risks were reported on their clinical and quality risk register which they had not provided as part of the standard information request. The registers were presented in different formats with inconsistent scoring of the same risks across different divisions, although the trust told us this was because

the scoring reflected the significance of the risk for that division. Actions were not always detailed and attributed to owners and where they were some expiry dates had passed with no updated information.

- At our last inspection we found that staff did not report all appropriate incidents and incident investigation was inconsistent. There was a lack of evidence of learning from incidents, investigations and complaints and learning identified was not consistently shared with all staff. During this inspection we found an improved understanding amongst emergency and urgent care staff around incident reporting, however 14 out of 15 staff questioned in the emergency operations centre did not understand what constituted an incident or how to report it. Serious incident investigations continued to be inconsistent. Although the trust had introduced a new lessons learnt group, replacing the learning review group which reported into the clinical governance group the minutes of these minutes did not identify how learning was effectively shared with all staff. We were not assured that learning consistently took place or that it was shared widely within the trust. Furthermore we could not gain evidence that recommendations had always been acted upon.
- The trust board had a governance framework to support the delivery of safe, high quality care. There were a number of sub committees including quality and governance, audit, workforce, finance and performance. These sub committees also received reports from sub groups for example the clinical governance group was a sub group of the quality and governance committee. These groups were attended by non-executive directors who provided challenge and scrutiny. We looked at the minutes of the quality and governance committee and saw there had been challenge and scrutiny.
- The trust's 'Quality Everyday' audit programme was designed to give assurance of everyday quality. This programme included audits of medicine management, vehicles, stations, staff and infection prevention control. A central team visited divisions monthly to carry out quality assurance visits. All stations were audited three times per year, every vehicle twice a year and all staff once per year. The results were reported to the trust board.
- All directors and non-executive directors made two formal quality visits to frontline areas per year. Whilst the trust had a procedure setting out expectations and documentation required for these visits, the descriptions of the process given to us by executive and non-executive directors were inconsistent

and we did not see evidence that standard documentation was completed for these visits. Following the inspection, the trust provided us with evidence of standardised documentation for these visits.

- The trust had recently introduced divisional emergency and urgent care performance reviews where local managers accounted for local performance across a range of topics. Meetings had been held quarterly and attendees included executive team members and representatives from other functional teams such as quality, finance and safety. We requested the terms of reference for and minutes for these meetings but the trust told us there were none but actions were recorded. We reviewed records of the actions from the meetings which allocated responsibilities and identified completed actions in some but not all cases.
- The trust subcontracted emergency ambulance services to third party providers. We saw evidence of annual governance audits, carried out to check the quality of service delivery. However, one memorandum of understanding with a volunteer ambulance provider was unsigned and out of date.
- At our last inspection we found there were gaps in the trust's local security management processes, especially in relation to a lack of auditing of the security management of medicines. At this inspection we found overall medicine management storage had improved with better systems in place. We asked to see local security management audits but the trust advised us they did not undertake separate security management audits. Divisional audits were conducted via the quality everyday process and the consultant paramedic carried out medicines management audits.

Leadership of the trust

- There was a high level of confidence in and respect for the acting interim chief executive amongst the trust board. Many staff told us he was less visible than the previous chief executive and they would like to see him out and about in their services. However they also told us they were confident that he was leading improvements.
- There was a highly effective professional relationship between the chair and the chief executive which supported the trust to focus on external stakeholder engagement and continuous improvement.
- Senior and middle managers told us improvements had been possible because of consistency in the leadership of the trust over the previous 12 months and they hoped this would continue. A large proportion of senior and middle managers

also told us the trust board had worked more effectively in the previous 12 months and were focussed on quality. All leaders we spoke with stressed the need for certainty around the ongoing leadership of the trust to provide a platform for improvement.

- At our last inspection we found frontline leadership lacked capacity to lead effectively and on occasions lacked the experience or knowledge to do so. The need to develop leaders had not been actioned because of operational pressures. During this inspection we found the trust had begun a review of the operational management team and were in the process of restructuring following a consultation with staff. In addition a number of development initiatives had been introduced to support front line leaders in their roles. From May 2016 leadership training courses had been available for managers. Staff told us they were experiencing increasing levels of support from their line managers.

Culture within the trust

- There was a patient focus at board level and throughout the trust. All staff we spoke with were committed to their jobs and to ensuring high quality patient care.
- All NHS trusts and NHS foundation trusts are required by the NHS contract (2016/17) to nominate a Freedom to Speak Up Guardian. This appointment should be in place by the end of March 2017 with trusts expected to have plans in place from September 2016. We found a lack of clarity about the role and plans to appoint to it during our inspection with a number of senior staff giving different interpretations of the plans. Following our inspection the trust confirmed a Freedom to Speak up Guardian would be in place from 1 April 2017.
- At our last inspection we found staff satisfaction was mixed. Staff had not always felt respected or valued and sometimes they had felt bullied or harassed. Some teams were working in silos and not working consistently. Generally most staff told us things had improved although a small number of staff in specific areas raised concerns with us during this inspection in relation to bullying and harassment by middle managers. We escalated this and the trust began immediate action to address the concerns
- During a period of change and restructure many staff at all levels were keen to ensure there was a clear understanding of the differences between being managed and being bullied or harassed. The trust's chaplain and the equality and diversity manager told us the trust was working effectively on matters of bullying and harassment. We saw that a professional behaviour

course was being delivered by the equality and diversity manager to all staff. At the time of our inspection 36% of managers had completed this course. This addressed how to recognise professional behaviour and bullying and harassment at work.

- The trust's director of workforce told us 43% of staff reported not feeling confident to report bullying and harassment in the NHS staff survey and that this figure had not changed in the previous five years. We spoke with union representatives who also confirmed some concerns about a bullying culture with some staff not feeling confident to report.
- We identified concerns about the way human resources business partners worked with their operational colleagues. At times we identified policies and procedures were not followed or decisions were over-ruled, especially in relation to sickness absence and return to work procedures.
- The trust had peer to peer and pastoral care worker schemes in place for providing support to staff who had experience traumatic events or increased levels of stress. However, despite the trust providing evidence of staff being stood down to receive support, a significant number of staff told us they had not received welfare calls or been given the support identified in these programmes. We were not assured that the processes in place were effectively implemented for staff.

Fit and Proper Persons

- The trust did not meet the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensures that directors of NHS providers are fit and proper to carry out this important role. We reviewed the records for five executive directors and one non-executive director. We found references from latest employers were missing in five out of six of the files, right to work checks had not been carried out and photographic proof of identity checks were missing from two files. Disclosure and barring (DBS) checks were held on files when they should be destroyed once recorded, relevant checks of qualifications, skills and experience had not been consistently carried out and two files did not include a health self-declaration form.

Public and staff engagement

Summary of findings

- The trust hosted two patient voice groups and a patient experience forum which was chaired by the director of nursing and quality. We saw the trust board considered had heard a patient story at two out of five meetings between May 2016 and January 2017.
- The trust's public website enabled patients and the public to give feedback, compliments or make a complaint and the trust used social media to share information about the service with the public.
- The trust's staff engagement score for 2016 had improved on the 2015 score and was marginally better than the average for ambulance trusts in England. The score for staff recommending the trust as a place to work or receive treatment had improved from 3.31 to 3.40 against an average for ambulance trusts of 3.46. Results overall in comparison with other ambulance trusts were improved with the majority of indicators showing improvement and results which were comparable with or better than those of other ambulance trusts. There was a widespread view amongst staff we spoke with that the organisation had improved in the past year.
- Since our last inspection the trust had introduced an electronic newsletter for all their staff which was circulated via email.
- Sickness absence rates were remaining around six percent from September 2016 onwards despite having fallen to slightly below the England average in May and June of 2016 at less than five percent.

Innovation, improvement and sustainability

- At our last inspection we issued the trust with a warning notice requiring them to make significant improvement in the quality of health care they provided. This was because we found they did not have sufficient staff with the appropriate skill mix to provide safe care and treatment. We also found insufficient numbers of staff had received statutory and mandatory training and appraisals. The trust had created a quality improvement plan and engaged with staff, stakeholders and partners to successfully address all of these issues.
- The trust's improvement plan, developed after our last inspection had led to a number of improvements in the safety and effectiveness of services including but not limited to an increase in vehicle numbers, improved compliance with the checking and cleaning of vehicles and equipment, and improved access to training for staff involved in major incidents.

Summary of findings

- There had been a continuous improvement in the proportion of patients who contacted the service again (following discharge of care by telephone) within 24 hours. The trust performed significantly better than the England average.
- The trust's hear and treat rates (emergency calls resolved over the telephone) were better than the England average.
- The trust had extended the provision of a mental health triage car in Lincolnshire and also to include patients in Derbyshire increasing the provision of appropriate care and treatment for patients with mental health conditions.
- At our last inspection we highlighted the trust should consider training for staff in the management of patients with a mental health condition and in the mental capacity act (MCA). In September 2016 the trust began rolling out a mental health training programme and had exceeded their target training completion rates in February 2017.
- The trust's senior leadership team had engaged extensively with local acute trusts to find ways to improve hospital handover delays at emergency departments and to ensure the safety of patients waiting.
- The trust were trialling an initiative in North and North East Lincolnshire. Where patients presented with the symptoms of sepsis, blood cultures were taken and a pre-hospital dose of intravenous antibiotic therapy administered to the patient. This saved valuable time and provided prompt lifesaving treatment. Sepsis is a severe infection, which spreads in the bloodstream. The results of the study had not been published at the time of our inspection but were showing positive patient outcomes. The trust was the only ambulance trust in England providing pre-hospital care to this group of patients.
- The trust's commissioners had agreed to commission an independent review of demand and capacity in early 2016. Significant delays in the contracting of this work meant the report was due for publication shortly after our inspection of February 2017. The review was intended to provide an independent report to inform the commissioners in relation to funding required for the service to remain viable.

Overview of ratings

	Safe	Effective	Caring	Responsive	Well-led	Overall

Our ratings for East Midlands Ambulance Service NHS Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Requires improvement	Requires improvement	N/A	N/A	Requires improvement	Requires improvement

Outstanding practice and areas for improvement

Outstanding practice

- The trust had run a highly effective recruitment campaign and received a national award for equality and diversity in recruitment.
- The trust were trialling a pre-hospital sepsis treatment in North and North East Lincolnshire. Where patients presented with the symptoms of sepsis, blood cultures were taken and a pre-hospital dose of intravenous antibiotic therapy administered to the patient. This saved valuable time and provided prompt lifesaving treatment. The results of the study had not been published at the time of our inspection but early indications showed positive outcomes for patients. The trust was the only ambulance trust in England providing pre-hospital care to this group of patients.
- The trust had extended the provision of a mental health triage car in Lincolnshire and also to include patients in Derbyshire increasing the provision of appropriate care and treatment for patients with mental health conditions.
- We observed caring, professional staff delivering compassionate, patient focussed care in circumstances that were challenging due to the continued demand placed on the service.

Areas for improvement

Action the trust MUST take to improve

- The trust must ensure patients receive care and treatment in a safe way by meeting national and locally contracted response time targets for Red1, Red2 and A19 categorised calls.
- The trust must take steps to improve EOC call taking response times therefore reducing the number of calls abandoned and the length of time callers are waiting on the phone.
- The trust must ensure all staff know how to report incidents. The trust must ensure serious incidents are appropriately and consistently investigated with lessons learnt acted upon and shared widely.
- The trust must ensure all staff understand the Duty of Candour Regulation and their responsibilities under it.
- The trust must ensure all staff access and attend mandatory training with particular focus on compliance rates for equality and diversity and risk management training.
- The trust must ensure all staff are fitted for and trained in the use of a filtered face piece mask to protect them from air borne infections.
- The trust must increase the percentage of frequent callers who have a specific plan of care.
- The trust should ensure there are systems in place to ensure staff have received, read and understand information when there are updates to trust policies, procedures or clinical practice.
- The trust must ensure they comply with the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014).

Please refer to the location reports for details of areas where the trust SHOULD make improvements.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 5 HSCA (RA) Regulations 2014 Fit and proper persons: directors 5 (5) (a) (b) Information must be available to be supplied to the Commission in relation to each individual who holds an office or position as a director of the service provider. **How the regulation was not being met:** The provider did not hold the information specified in Schedule 3 in relation to executive and non-executive director appointments.

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes must enable the provider to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. **How the regulation was not being met:** Some staff did not know how to report incidents using the trust incident reporting process. Serious incidents were not always appropriately and consistently investigated. Methods used to share feedback and learning from incidents did not ensure changes were made to improve practice to prevent future incidents. The trust did not have systems in place to ensure staff had received, read and understood information when there were updates to trust policies, procedures or clinical practice. Not all qualifying staff were fitted for and trained in the use of a filtered face piece mask (FFP3).

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment must be provided in a safe way for service users. **How the regulation was not being met:** The trust were not meeting national or locally contracted response time targets for Red1, Red2 and A19 categorised calls. The trust were not meeting response time targets for call answering, green three (telephone response in 20 minutes) and demonstrated deteriorating performance in call abandonment. Only 10% of frequent callers had a specific plan of care.

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour A health service body must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity. **How the regulation was not being met:** Not all staff were aware of their legal responsibilities under the Duty of Candour Regulation.

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Persons employed must receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. **How the regulations was not being met:** Not all staff had received mandatory and statutory training. Compliance rates for equality and diversity and risk management training were particularly low.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment must be provided in a safe way for service users. **How the regulation was not being met:** The trust were not meeting national or locally contracted response time targets for Red1, Red2 and A19 categorised calls.