CareQuality Commission

East Midlands Ambulance Service NHS Trust

East Midlands Ambulance Service NHS Trust

Quality Report

1 Horizon Place,
Mellors Way,
Nottingham Business Park,
Nottingham,
NG8 6PY
Tel: 0333 012 4216
Website: www.emas.nhs.uk

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

Ratings

Overall rating for this ambulance location	Requires improvement	🟠
Emergency and urgent care services	**Requires improvement**	🟠
Patient transport services (PTS)	**Requires improvement**	🟠
Emergency operations centre	**Good**	🟢
Are acute services at this trust safe?	**Inadequate**	🔴
Are acute services at this trust effective?	**Requires improvement**	🟠
Are acute services at this trust caring?	**Good**	🟢
Are acute services at this trust responsive?	**Good**	🟢

Summary of findings

Are acute services at this trust well-led?	Requires improvement	🟠

Letter from the Chief Inspector of Hospitals

The East Midlands Ambulance Service NHS Trust (EMAS) is one of 10 ambulance trusts in England providing emergency medical services to Derbyshire, Nottinghamshire, Lincolnshire, Leicestershire, Rutland and Northamptonshire, an area which has a population of around 4.8 million people. The trust employs around 2,900 staff who are based at more than 70 locations including ambulance stations, an air ambulance station, emergency operations centres (EOCS) and support offices across the East Midlands.

The main role of EMAS is to respond to emergency 999 calls, 24 hours a day, 365 days a year. 999 calls are received by the emergency operation centres (EOC), where clinical advice is provided and emergency vehicles are dispatched if required. Other services provided by EMAS include patient transport services (PTS) for non-emergency patients between community provider locations or their home address and resilience services which includes the Hazardous Area Response Team (HART).

Every day EMAS receives around 2,000 calls from members of the public dialling 999. In 2014-15 they provided a face to face response to 649, 625 emergency calls. The service provided by EMAS is commissioned by 22 separate Clinical Commissioning Groups with one of these taking the role as co-ordinating commissioner.

Our announced inspection of EMAS took place between 16 to 20 November 2015 with unannounced inspections on 3 December 2015. We carried out this inspection as part of the CQC's comprehensive inspection programme.

We inspected three core services:

• Emergency Operations Centres

• Urgent and Emergency Care including the Hazardous Area Response Team (HART) and the air ambulance.

• Patient Transport Services

Overall, the trust was rated as requires improvement. Caring and Responsive were rated as good. Effective and Well Led were rated as requires improvement and Safety as inadequate. We have taken enforcement action against the provider in this respect.

Our key findings were as follows:

• The trust was working hard to improve response times for emergency calls but these were consistently below the national target.

• There were insufficient staff and a lack of appropriate skill mix to meet the needs of patients in a timely manner.

• Standards of cleanliness and infection control, although inconsistent in some trust buildings were generally good on ambulances.

• All staff, especially those at the frontline were passionate about and committed to providing high quality, safe care for patients. At the same time they were open and honest about the challenges they were facing.

• Whilst the trust were working hard to recruit staff, they were finding it a challenge to retain staff and overall numbers were only increasing minimally.

• Staff morale was low and they often did not feel valued. There was an unrelenting demand for emergency services combined with a lack of staff and resources to meet the need.

• Frontline leaders did not have the capacity or in some cases the skills to support teams and individuals and fulfil the requirements of their roles.

• Many staff were not receiving performance development reviews (appraisals), clinical supervision (where appropriate) or mandatory training.

• There was a clear statement of vision and values driven by quality and safety. The trust board functioned effectively.

Summary of findings

- Without exception the Chief Executive was held in high regard by staff for her visible, open approach.

We saw several areas of outstanding practice including:

- We observed many examples of non-clinical staff supporting patients and saving lives in what were extremely difficult and stressful situations. Staff remained calm and gave callers confidence to deliver life-saving treatment.

- The trust had introduced 'change Wednesdays' in the emergency operations centre (EOC) to avoid daily contact with staff about minor changes to policies and systems. Staff were confident any changes to policies or procedures would take place on the same day every week.

- The trust were the best performing ambulance trust in England for the number of calls abandoned before answered.

- A mental health triage car was available in Lincolnshire between 4pm and midnight, staffed by a paramedic and a registered mental health nurse from a mental health trust. They could assess the needs of the patient and provide appropriate care which in some cases avoided hospital admission or the use of a Section 136 detention under the Mental Health Act 1983.

- The trust had a joint ambulance conveyance project working with six fire and rescue services in their region. This was the first service of its kind for an ambulance service nationally.

- The trust, in partnership with six fire and rescue services across the region, had introduced a regional emergency first responder (EFR) scheme. This was the first regional service of its kind of an ambulance service nationally.

- A project was in place to improve treatment for patients in acute heart failure. Crews had been issued with continuous positive airway pressure (CPAP) machines. The CPAP machine improves oxygen saturation levels in these patients.

- Staff in patient transport services (PTS) had direct access to electronic information held by community services including GPs. This meant they could access up to date information about patients including their current medication.

- The patient advice and liaison service had recruited existing patients to report to them about their planned journeys and experiences of patient transport services (PTS). They called this a 'secret shopper' programme.

- Staff name badges included their name in braille to assist patients with visual impairment. Guide dogs were allowed to accompany visually impaired patients.

- The Chief Executive was praised by all staff for her visible, open approach and her commitment to engaging staff face to face.

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

Importantly, the trust must:

- Ensure staff report all appropriate incidents which are then appropriately and consistently investigated.

- Ensure learning from incidents, investigations and complaints is shared with all staff.

- Ensure all staff receive statutory and mandatory training.

- Ensure all domestic, clinical and hazardous materials are managed in line with current legislation and guidance.

- Ensure vehicle and equipment checks are carried out to the determined frequency.

- Ensure there are sufficient emergency vehicles to safely meet demand.

- Ensure medicines, including controlled drugs are stored and managed safely.

- Ensure paper patient report forms are stored appropriately and securely in trust premises and in such a way on trust vehicles as to maintain patient confidentiality

Summary of findings

- Ensure there are sufficient numbers of staff with an appropriate skill mix to meet safety standards and national response targets.

- Ensure arrangements to respond to emergencies and major incidents are practised and reviewed in line with current guidance and legislation.

- Ensure response times meet the needs of patients by reaching national target times.

- Ensure all staff receive appropriate non-mandatory training to enable them to carry out the duties they are employed for.

- Ensure all staff receive an annual appraisal.

- Ensure service level agreements are in place to monitor the quality of taxi service provision for patient transport services.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Emergency and urgent care services	**Requires improvement** ●	Overall we rated emergency and urgent care services as requiring improvement. East Midlands Ambulance Service NHS Trust needed to improve several aspects of their services including frontline staffing, numbers of vehicles available for responding to emergencies, vehicle and equipment checks, infection control, medicines management, response times and training. Current staffing numbers and skill mix was sometimes below acceptable levels, although it is acknowledged staff were committed and worked long hours with many experiencing low morale, high levels of stress and work overload. On occasions there were no frontline staff to respond to emergencies as all available staff were busy. The proportion of Red 1 and Red 2 calls attaining national targets was similar to the England NHS ambulance trust average. In the previous 19 months the trust had only reached the national target of 75% for Red 1 calls for four months. Red 1 calls are those which are immediately life-threatening such as cardiac arrest. Red 2 calls are those which are serious but not the most life threatening for example unconsciousness or chest pain. We found variable standards of cleanliness, infection prevention and control and a lack of regular vehicle and equipment checks due to lack of staff time. There were insufficient numbers of appropriately trained staff to provide the necessary skill-mix but ambulance crews always demonstrated care and compassion to patients. A minority of staff felt bullied and harassed by their managers but we found team leaders had insufficient time to manage their staff because of operational pressures. The Chief Executive Officer was widely respected by staff who demonstrated the trust's values through their own working

Summary of findings

practices. We found some systems and processes across the divisions differed and were not trust-wide, therefore leading to fragmentation.

Patient transport services (PTS)

Requires improvement ⬤

The patient transport service (PTS) serving north and north east Lincolnshire and the emergency department (ED) in Nottingham was considered to be good for effective, caring and responsive, and requires improvement for safe and well led.

The PTS ambulance and control teams worked well together to provide an effective and responsive patient transport service to meet the needs of the population it served. The service was supported by a team of 42 volunteer drivers. Volunteer drivers' used their own vehicles to transport patients. Vehicle documentation for MOTs and insurance had not been consistently checked and recorded. Communication between the control staff and drivers demonstrated an embedded respect for each other and good working relationships.

Staff demonstrated safety awareness and ensured each patient journey was as safe and comfortable as possible. This was reflected in the positive comments received from patients, carers and staff from local hospitals and care homes.

Staff knew how to report incidents and understood their responsibility to submit reports in a timely way. However, there was little evidence of sharing and learning and staff were unable to identify changes made following a reported patient safety incident.

Staff attended a comprehensive induction when joining the service but attendance to mandatory training did not meet the trust target of 95% with some key topics such as resuscitation and moving and handling showing minimal attendance.

Staff did not consistently receive annual appraisals to monitor competency and support professional development. Dates for appraisals were set for all staff but frequently cancelled at short notice.

Summary of findings

Emergency operations centre

Good ●

The emergency operations centre (EOC) was considered to be good for effective, caring, responsive and well-led, and requires improvement for safe.
There were processes to enable staff to safeguard children and vulnerable adults. Staff followed guidance on providing medicines advice to patients, and records were appropriately stored on an electronic system.
Staff used evidence-based systems to provide care, advice and treatment to patients. Clinicians worked to national guidance and standards when providing advice over the phone. The trust took part in national audits and we saw actions and learning were evident.
There was effective working between EOC's and with other emergency services. There were additional training opportunities for staff and opportunities for professional development. The service had systems and processes for clinicians to advise patients how to manage their own health as well as to provide information about alternative patient pathways.
Staff were compassionate and caring towards patients. We observed excellent examples of staff treating patients and callers with dignity, respect, and were supported by staff at the end of the phone.
The service had processes and systems to cope with different levels of demand. There were different ways for patients to access the service, and interpreting services were available for patients whose first language was not English. The service had systems and processes to manage and work with high volume service users and children with complex needs.
There was learning from complaints and concerns and staff told us they received learning through feedback from managers.
The service managed risk appropriately and quality was measured through monthly staff audits, management meetings, and reports to the board.

Summary of findings

However, we also found some members of staff were not aware of what constituted a reportable incident. Staff did not always report incidents in a timely manner. Mandatory training completion rates fell short of the trust target of 95%. There were staff vacancies; staffing levels at times impacted adversely on the performance of EOC. Despite data from the trust showing the majority of staff had received appraisals, we found that half of staff did not have a documented appraisal in their staff file.

There were delays in sending emergency response vehicles to emergencies due to hospital handover delays. Data also showed that the trust were one of the worst performing trusts in the time it took to answer emergency calls.

We found that staff morale in Nottingham was very low and there were communication concerns between management and staff there. There was nowhere for staff to go following a distressing call.

Care Quality Commission

Overall rating:

East Midlands Ambulance Service NHS Trust

Detailed findings

Requires improvement 🟠

Services we looked at

Emergency and urgent care; Patient transport services (PTS); Emergency operations centre (EOC)

Detailed findings

Contents

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 square miles. The trust employs around 2,000 WTE staff.

East Midlands Ambulance Service provides an emergency service to respond to 999 calls; a small patient transport service (PTS) in North and North East Lincolnshire and for one hospital in Nottingham, for non-emergency patients between community provider locations or their home address and emergency operation centres (EOC), where 999 calls were received, clinical advice is provided and emergency vehicles dispatched if needed. There is also a Hazardous Area Response Team (HART).

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 inspected East Midlands Ambulance Service as part of our announced comprehensive inspection programme. The trust is not a Foundation Trust and this inspection has not considered any application for Foundation Trust status.

As part of our inspection we visited trust premises including offices, training areas, fleet workshops, an air ambulance base, specialist units such as Hazardous Area Response Team (HART), ambulance stations and emergency operations centres. We also visited hospital 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:

Head of Hospital Inspection: Carolyn Jenkinson, Care Quality Commission

Inspection Manager: Helen Vine, Care Quality Commission

East Midlands Ambulance Service was visited by a team of 55 people including CQC inspectors, inspection managers, national professional advisor, pharmacist inspector, inspection planners and a variety of specialists.

Detailed findings

The team of specialists comprised of paramedics, consultant paramedics, urgent care practitioners, operational managers, a GP, Mental Health Act reviewers and call handlers.

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 Operations Centres

• Urgent and Emergency Care including Hazardous Area Response Team (HART) and air ambulance

• Patient Transport Services

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), the Trust Development Authority, NHS England, and local Healthwatch organisations.

We held interviews, focus groups and drop-in sessions 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 and observed how they were being cared for. We also talked with carers and/or family members and reviewed patients' treatment records.

We carried out the announced inspection visit between 16 and 20 November 2015 with unannounced inspections on 3 December 2015.

Facts and data about East Midlands Ambulance Service NHS Trust

The East Midlands Ambulance Service is one of 10 ambulance trusts in England providing emergency medical services, urgent care and patient transport services to Derbyshire, Nottinghamshire, Leicestershire and Rutland, Northamptonshire and Lincolnshire (including north and north east Lincolnshire). The trust employs over 2,800 staff who are based at ambulance stations and trust premises across the region.

Their main role is to respond to emergency 999 calls, 24 hours a day, 365 days a year. This response could be 'hear and treat', 'see and treat', 'see, treat and convey'. Their patient transport services provide care and transport to patients attending hospital, day care and outpatient appointments in parts of Nottinghamshire and North Lincolnshire.

East Midlands Ambulance Service works closely with other emergency services including the police and fire and rescue services to provide emergency services during major events and in response to major incidents.

Activity between April 2014 and March 2015:

The emergency and urgent care service made around 643,115 vehicle responses to incidents.

The emergency operations centre received over 2,000 999 calls every day which averages one call every 43 seconds.

The patient transport services made around 98,742 journeys transporting patients.

Financial Performance April 2014 to March 2015:

Annual turnover: £154 million

Income: £154,796,000

Detailed findings

Costs: £154,731,000

Surplus: £65,000

Currently the trust has around 70 ambulance stations organised into five geographical divisions matching the county borders of Derbyshire, Nottinghamshire, Leicestershire and Rutland, Northamptonshire and Lincolnshire.

Our ratings for this trust

Our ratings for this trust are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	Inadequate	Requires improvement	Good	Good	Requires improvement	Requires improvement
Patient transport services	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Emergency operations centre	Requires improvement	Good	Good	Good	Good	Good
Overall	Inadequate	Requires improvement	Good	Good	Requires improvement	Requires improvement

Notes

Emergency and urgent care services

Safe	**Inadequate** 🔴
Effective	**Requires improvement** 🟠
Caring	**Good** 🟢
Responsive	**Good** 🟢
Well-led	**Requires improvement** 🟠
Overall	**Requires improvement** 🟠

Information about the service

The main role of emergency and urgent care services is to respond to emergency 999 calls, 24 hours a day, 365 days a year. East Midlands Ambulance Service NHS Trust (EMAS) provides an emergency and urgent care service to a population of 4.8 million people across the East Midlands, which covers the counties of Derbyshire, Leicestershire and Rutland, Lincolnshire (including North and North East), Northamptonshire and Nottinghamshire.

Each area is referred to by EMAS as a 'division', with Lincolnshire being the largest with 2,687 square miles. The service covers a total area of 6,425 square miles and has over 70 ambulance stations across the divisions and two operation centres in Nottingham and Lincoln. EMAS works closely with other emergency services, including the police, fire service and coastguard to provide emergency services during major incidents. It also provides paramedic services for the local air ambulance charity based at RAF Waddington in Lincolnshire. The trust has approximately 2,000 frontline staff and over 530 vehicles including rapid response vehicles (RRVs).

On average EMAS responds to a 999 call every 43 seconds, amounting to an average of 2,300 calls per day. This can increase to 3,000 calls per day during certain times of the year such as New Year's Eve and other significant events. EMAS supports the work of voluntary community and emergency first responders across the region who give basic lifesaving interventions prior to the arrival of the ambulance crew; this is co-ordinated by EMAS.

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

During the inspection we visited a number of ambulance stations across all five divisions, in both towns and rural areas, and we spoke with over 200 staff in various roles including paramedics, trainee paramedics, ambulance technicians, emergency care assistants, team leaders, location quality managers, senior managers and members of first responder groups. In addition, we spoke with support staff including cleaners and those who deep cleaned ambulances. We observed ambulance crews treating patients. We spoke with over 60 patients, where appropriate to do so, and their relatives. These patients had used the service in their own homes or for conveyance to emergency departments.

We inspected ambulances and reviewed patient report forms. We visited hospitals in each division where we observed the interaction between ambulance and emergency department staff. We spoke with staff in the emergency departments and other areas of hospitals including maternity, children's' wards and surgical and medicine admission units about their experience of working with EMAS.

Emergency and urgent care services

Summary of findings

Overall we rated emergency and urgent care services as requiring improvement.

East Midlands Ambulance Service NHS Trust needed to improve several aspects of their services including frontline staffing, numbers of vehicles available for responding to emergencies, vehicle and equipment checks, infection control, medicines management, response times and training.

Current staffing numbers and skill mix was sometimes below acceptable levels, although it is acknowledged staff were committed and worked long hours with many experiencing low morale, high levels of stress and work overload. On occasions there were no frontline staff to respond to emergencies as all available staff were busy. The proportion of Red 1 and Red 2 calls attaining national targets was similar to the England NHS ambulance trust average. In the previous 19 months the trust had only reached the national target of 75% for Red 1 calls for two months. Red 1 calls are those which are immediately life-threatening such as cardiac arrest. Red 2 calls are those which are serious but not the most life threatening for example unconsciousness or chest pain. Data for November 2015 showed the trust as the second worst performing ambulance trust in England with responses within target at 65.6%. This indicated a deteriorating position.

We found variable standards of cleanliness, infection prevention and control and a lack of regular vehicle and equipment checks due to lack of staff time. There were insufficient numbers of appropriately trained staff to provide the necessary skill-mix but ambulance crews always demonstrated care and compassion to patients. A minority of staff felt bullied and harassed by their managers but we found team leaders had insufficient time to manage their staff because of operational pressures.

The Chief Executive Officer was widely respected by staff who demonstrated the trust's values through their own working practices. We found some systems and processes across the divisions differed and were not trust-wide, therefore leading to fragmentation.

Are emergency and urgent care services safe?

Inadequate 🔴

We rated the safety of emergency and urgent care services as inadequate.

- There were insufficient numbers of appropriately trained staff available with the necessary skill-mix. We had previously raised this concern following our inspections in 2013 and again in 2014.
- Excessively long hand-over times at some acute hospitals were exacerbating the trust's resource ability to respond to and meet demand.
- Staff were dedicated and without exception, every member of staff we spoke with reported regularly working more hours than their shift allocation which was having a detrimental effect on their work-life balance and they were frustrated and tired. Staff essential education or mandatory training, was not always undertaken because of operational pressures.
- Daily vehicle and equipment checks were not always being undertaken because of operational pressures and requested back up vehicles for conveyance of patients were not always available in a timely manner because of lack of resources.
- Without an effective solution to the safety issues there was a risk more staff would leave and the service would become unsustainable.
- Staff knew how to report incidents but did not always receive feedback, although practice had changed as a result of some incidents raised. Root cause analysis of serious incidents was found to be robust, although there was no audit system in place to ensure staff had read clinical updates.
- Standards of cleanliness, infection prevention and control were variable. Policies and processes were in place but not always observed.
- Medicines were not always stored safely or audited effectively.
- The majority of patient records had been completed correctly but paper records were not always stored securely.
- Although processes were in place for responding to major incidents, many staff had not received training.

However, we also found that:

- Staff were aware of safeguarding processes and reported appropriately.
- Policies were in place for deep cleaning processes for ambulances,
- Staff used the Joint Royal Colleges Ambulance Liaison Committee's guidance (JRCALC) to assess patients and responded appropriately to risk.

Incidents

- There was an effective policy and process for the reporting of incidents and near misses. Staff were encouraged to report incidents involving patients or staff and knew how to do so.
- A small number of staff from across the divisions informed us they could not always get a response from the designated telephone line.
- Staff told us they did not consistently receive feedback about incidents. We saw some evidence that feedback was displayed and incidents categorised in ambulance stations.
- According to trust policy serious incidents (SIs) were investigated by a local quality manager and clinical incidents by a senior paramedic.
- We viewed five serious incident reports and found the root cause analysis was robust with thorough investigations having been completed. Although action plans were identified there was no evidence of deadlines being met and the actions completed. We reviewed one incident from 2014 relating to the death of a patient. The outcome from the investigation stated there was insufficient scope to effectively log a Mental Capacity Act 2005 (MCA) assessment check within the electronic patient report form (ePRF) and action was due in March 2015. However, we saw there was still no space to log MCA assessments on the paper PRF or the ePRF in November 2015. This meant lessons were not always being learned from incidents and actions taken to reduce risks.
- Between August 2014 and August 2015, of the 54 SIs reported six were recorded as lack of available resources or delayed response times which could potentially have contributed to patient deaths. The trust had expanded their clinical assessment team to make welfare telephone calls to patients who had experienced a delay in response times and support them to manage their condition until an ambulance arrived. However, delays

and the resulting risk continued. In October 2015 HM Coroner wrote a Prevention of Future Deaths letter to the trust raising concerns that a delayed response to an emergency call was a contributory factor in the death of a patient.

- Some staff were able to tell us about changes in practice as a result of incident investigation. For example, there had been changes to drug storage following an incident involving a missing drug.
- The Duty of Candour Regulation under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires health service bodies to act in an open and transparent way with people when things go wrong. Not all staff were aware of the Duty of Candour Regulation when we spoke with them. However, we reviewed seven incidents relating to Duty of Candour that we received from the trust. We found the trust had investigated the incidents and been open with patients or their relatives about them.

Mandatory training

- Mandatory training for emergency and urgent care staff at EMAS was called essential education. The training included resuscitation, safeguarding adults and children and infection prevention and control (IPC). Timescales for completion of the elements varied between one and three years on an on-going basis. Essential education for staff in non-frontline services included moving and handling, fire safety, resuscitation and infection prevention and control. Completion rates of essential training varied across the divisions between 68% for emergency and urgent care staff in Lincolnshire to 81% in Leicestershire for the same group of staff. The trust's target was 95%.
- In May 2015 the trust extended the essential education programme for 2014/15 to cover the two year period ending 31 March 2016. The trust informed us this enabled initial training courses to be prioritised including essential training for newly appointed ambulance technicians. We were therefore not assured all staff had received the required essential education to deliver safe care to patients.
- Filtered face pieces are face masks used to protect staff when treating patients with a transmissible respiratory infection. It is a Health and Safety Executive requirement for all staff to be fitted for and trained in the use of these masks. Trust compliance with this requirement was 39%. This meant a large proportion of staff would be at

risk when caring for patients in this category. The lead for IPC told us they were aware of the risk but faced difficulties in training staff because they could not be released from front line duties because of operational pressures.

- Prior to our inspection we received information from the trust which indicated the Hazardous Area Response Team (HART) completion rate for essential education was 70%. Following our inspection the trust informed us the evidence they had supplied was not up to date and provided further information indicating the training completion rate was 95%.

- A report had been produced in May 2015 relating to the HART team and had been prepared for EMAS by a company dealing with business psychology. It stated there was a medium risk because of a skills deficit and the learning of safety issues for members of the HART team. They advised an action plan be produced. We asked the trust for the action plan which indicated actions had been taken to mitigate this risk including the secondment of a HART specialist trainer and the introduction of staff competency sign off books.

- Emergency ambulance crew attended a three week compulsory emergency driving training course when recruited in order to achieve the D1 and D2 courses. D1 is a week long course for all non-emergency crews. D2 is two weeks long and is the response advanced driving course which trains crews to drive on blue lights. If any member of staff had an accident they were required to undertake further driver training by a local manager who was qualified to do this.

- EMAS had recently introduced driver refresher training. In one county this consisted of an assessment by a trainer, who was also a paramedic, accompanying a member of frontline staff on shift and was tailored to situations the driver dealt with during the period of observation. It also included an eye test.

Safeguarding

- There were comprehensive policies for safeguarding children, young people and vulnerable adults and the majority of staff were aware of these policies and knew when and how to raise safeguarding concerns. Staff told us about this and we saw them doing so appropriately.

- Safeguarding contact numbers and bulletins were displayed on some of the ambulance station notice boards and during a visit to one ambulance station we saw posters highlighting awareness of female genital mutilation (FGM) to members of staff.

- Safeguarding essential education should be repeated every three years according to trust policy. From 2015 this training had been delivered via 'conversation cards'. Conversation cards were a way for line manager to discuss training topics with their staff.

- Information received from the trust indicated that 97% of staff had received safeguarding training at level one or two for both adults and children by October 2015 which exceeded the trust's target of 95%. This was evidenced from 83 staff we spoke with, for example in Derbyshire, who had all received their safeguarding training. Newly appointed staff received their training during induction and contact telephone numbers for reporting safeguarding issues were given

- A safeguarding forum was held every three months attended by divisional local quality managers, the trust's safeguarding lead and the head of safeguarding. We reviewed the minutes of the forum from July 2015. They reported that the number of safeguarding referrals had continued to increase and in total there had been 11,413 referrals raised in the previous year.

- In Nottinghamshire, we reviewed 20 patient report forms (PRFs). For three of the patients, it was clear that a safeguarding referral had been required. However, we were not able to see whether a referral had been made as there was no space on the form for this to be recorded.

- Staff told us when they needed to raise a safeguarding issue they could ring a designated number in their control rooms. The telephone line was manned by the same team who answered the telephone line for reporting incidents. Demand could sometimes exceed capacity of the team to respond immediately. This meant if two separate issues required referring at approximately the same time by two separate staff, one number would not be responded to. If there was no response to a call, either a message had to be left or a member of staff had to ring from home after their shift finished.

- On some occasions staff had received an automated message when they had rung the number stating that the line was not available owing to reduced numbers of

staff. Under these circumstances, staff could refer through the clinical assessment team. We were informed the trust had just recruited further staff to mitigate the risk of issues going unreported.

Cleanliness, infection control and hygiene

- We found variable standards and some inappropriate practices of cleanliness, infection prevention and control at the ambulance stations we visited. These included occasions where clinical waste bins were not always locked, the correct bags were not always used and waste was not always appropriately separated for disposal. Some sluice areas did not have pedal operated bins. We saw manual handling equipment being air dried following use and after cleaning, some in open garages where they could become contaminated. The trust told us equipment could be cleaned with a disinfectant or detergent wipe. If heavily soiled a solution of Sodium Hyper Chloride was used. Clean linen was not always stored appropriately and protected from contamination risks. The trust had recently purchased disposable mop heads for use in all the ambulance stations. We saw these during our visit although some stations were not using them and some of the mop buckets were contaminated with dust and debris.

- Trust ambulances were deep cleaned every 42 days or sooner if heavily contaminated. This was done by a dedicated 'make ready' team. Cleaning of vehicles between patient use was the responsibility of the ambulance crew. Although we observed staff cleaning appropriately many told us they did not always have time to do so because of operational pressures.

- Ambulance crews were in visibly clean uniforms and adhering to the uniform policy of the trust. Staff were responsible for ensuring their uniforms were clean.

- We observed ambulance crews washing their hands where possible and using hand gel between patients. Results for hand hygiene audits for July to September 2015 varied between 89% and 95% against a target of 95%.

- Personal protective equipment was available for staff on all ambulances we viewed. For example, aprons and gloves. Patients told us and we observed ambulance crews wore gloves appropriately when providing treatment.

- Sterile equipment was stored appropriately in ambulances in clean containers and off the floor.

- Crews were made aware of specific know infection control matters. Emergency medical dispatch (EMD) staff in the emergency operations centre asked callers if they knew of any known infections or contagious diseases affecting a patient. Staff recorded details and recorded on the patient's electronic record if the answer was 'yes'. The information was then visible to the dispatch officer who would pass it to the ambulance crew attending the scene.

- As part of their essential education elements, emergency and urgent care staff should receive annual refresher training on infection prevention and control (IPC). Data from the trust showed the percentage of staff receiving IPC training in the year 1 February 2015 to 31 January 2016 varied between 42% in Lincolnshire to 75% in Northamptonshire. Seventy four percent of the Hazardous Area Response Team (HART) staff had received their IPC training.

- We observed poor infection prevention and control practices in all divisions. For example, lack of secure clinical waste storage, poor cleaning processes of manual handling belts and lack of designated sluice areas in some ambulance stations.

- The trust's policy on the management of medical devices showed a certificate was issued when pieces of equipment had been decontaminated. Decontamination was carried out in accordance with the manufacturer's instructions.

Environment and equipment

- Replenishment of vehicle equipment and supplies was carried out at ambulance stations or at local acute hospital trusts in between patient calls.

- Staff we spoke with knew how to report faulty equipment. As part of our inspection we spot-checked equipment on vehicles in all of the divisions. We found some 10 ambulances we checked were not fully equipped.

- Servicing of equipment was variable with some lifesaving items being overdue for service, for example a charging unit for defibrillator batteries. We also found three battery chargers and a compressor in one ambulance station had been due to be serviced in January, February and July 2015; none of these had been undertaken. In Lincolnshire and Northamptonshire we found vehicles that were not equipped to care safely for bariatric patients and children. For example on two vehicles a child restraint and child chair for conveyance

were not available and on other vehicles bariatric blood pressure cuffs were not available. We were therefore not assured that sufficient equipment was available at all times to treat patients safely.

- Staff told us and we observed occasions where replacement equipment was not available and had to be taken from vehicles which were off the road for repairs to enable a road worthy vehicle to be deployed fully equipped.

- Vehicle maintenance was carried out at three EMAS fleet services workshops and some vehicles in Lincolnshire were serviced by independent garages. Vehicles were serviced every 12 weeks or after 10,000 miles. MOTs were carried out for all vehicles. The fleet services team kept comprehensive records for vehicles off the road (VOR) and the reasons why. However, we observed three emergency ambulances being used despite faults having been reported. For example one had a broken fog light, which had been taped up with surgical tape. We reported this to the station manager and the vehicle was immediately put out of service. We saw another ambulance which had its service light flashing and a third ambulance where a fault on the door had been reported. The trust informed us there was system in place where minor defects on vehicles could be booked for receiving attention at the next workshop visit or planned service; this may have been the reason for vehicles being used despite faults having been reported.

- Many vehicles observed during our inspection had completed over 300,000 miles in service. Whilst there is currently no guidance on when ambulances should be replaced according to age or mileage, staff told us older vehicles broke down more regularly. The trust's fleet services strategy, dated January 2015, acknowledged that a number of Double Crewed Ambulances (DCAs) and Rapid Response Vehicles (RRVs) were in excess of nine and ten years of age. The result of this was having a negative effect upon reliability, VOR or downtime and increased operating costs.

- The fleet strategy also showed the trust had lower levels of spare capacity of DCAs and RRVs compared to two other similar trusts. Twenty four percent of the trust's DCAs were identified as spare capacity compared to 33% and 39%. For RRVs the trust's spare capacity was identified as 29% compared to 40% and 41% with the

other trusts. Spare capacity ensures availability of vehicles at all times to meet patient needs. The lack of spare emergency vehicles had been identified as high risk on the trust's risk register.

- During our last inspection of the service in January and February 2014, we told EMAS there were insufficient vehicles in order to ensure the safety of patients and meet their needs. Despite an additional 35 new vehicles being purchased since then and because of an increase in staff numbers, the situation had not improved. Forty nine percent of rapid response vehicles were over five years old; this was projected to be 89% by 2018. For ambulances, 12% were over five years old and this was projected to be 40% by 2018.

- The trust's safer ambulance checklist had been introduced in July 2014, outlining the Standard Operating Procedure (SOP) for checking vehicles including road worthiness, clinical equipment and minimum essential equipment checks that must be undertaken at the start of each shift. Each vehicle contained a vehicle inspection form booklet where daily checks prior to shifts should be recorded. In each division we found a number of examples where daily service checks had not been completed. Ambulance staff told us they regularly did not have the opportunity to undertake these checks before responding to a call at the beginning of their shift. This meant that staff could not always follow the SOP laid down by the trust to ensure the safety of vehicles. Crews had 30 minutes from the time they arrived at hospital to the time they left. This comprised of 15 minutes from arrival to handover to hospital staff and 15 minutes from handover to being able to respond for another call. The second period of 15 minutes included cleaning and checking the ambulance. Staff told us they were often not able to maintain the 15 minute down-time for cleaning and preparing the vehicle again because they had to respond to patients.

- The trust's fleet services strategy stated that smaller vehicles in use by the Hazardous Area Response Team (HART) in Nottinghamshire had been due for replacement in 2015. This had not occurred; due to the relatively low utilisation and mileage, it had been decided more financially responsible to retain those for a longer period with an expected and realistic service life of seven to 10 years. The trust planned to reduce this to seven years as a maximum over the next three years.

Emergency and urgent care services

- Since 2013, the funding for HART vehicles had been included in the trust's expenditure which was funded by commissioners of the service; prior to this it had been the responsibility of the Department of Health. The purchase of HART vehicles is undertaken by a national buying framework coordinated by the National Ambulance Resilience Unit (NARU). The trust confirmed that NARU had undertaken a tender process.
- A report had been produced in May 2015 relating to the HART team and had been prepared for EMAS by a company dealing with business psychology. It stated there was a medium risk because of equipment faults and inadequate kit for members of the HART team and advised an action plan be produced. We asked the trust for the action plan which showed some mitigating actions and liaison with NARU for support to resolve the issues.
- Equipment for HART vehicles was seen to be in good supply with a dedicated staff member being responsible for its upkeep and maintenance.

Medicines

- Medicines were stored securely at a central resource centre. Staff there obtained, stored and delivered medicines for the trust. There was appropriate security at the resource centre which included security alarms, CCTV and robust staff security checks.
- A new medicine system had recently been introduced to ensure medicines were available for clinical staff across the trust. This was co-ordinated and controlled by the team at the central resource centre and we found staff had either had face-to-face training on the new practice or been updated by documentation circulated by the trust. Staff we spoke with knew about the new system.
- Checks were made on the expiry dates of medicines which ensured that medicines were safe to use. Information on how to use the new medicine system was clearly displayed in medicine storage areas within ambulance stations.
- The trust provided an agreed list of medicines that could be administered by ambulance staff; this detailed which grade of staff were trained to use each of them. We saw clinical staff carried a pocket book, the UK Ambulance Service Clinical Practice Guidelines 2013, which gave information on the correct dose and type of medicine to be used.
- Any updates on medicines were also circulated to staff via the clinical bulletins which we saw displayed on training noticeboards in ambulance stations. For example, we saw recent information about the treatment of pain which included the introduction of a new pain management medicine. Clinical staff we spoke with also told us staff meetings took place to discuss medicine management, e-mails were also sent out and they received support from a team of consultant paramedics.
- Staff were administering medicines to patients with the legal authority to do so. The trust had Patient Group Directives (PGDs) in place to cover the administration of a list of authorised medicines. A PGD is a written instruction for the administration of medicines to a group of patients.
- A drug was being introduced by EMAS for intravenous use (into the vein) for pain. The information had been communicated to staff via the trust's magazine.
- Medicines were not always stored safely. We found variations in how medicines were stored at different locations across the trust. For example, we saw poor medicine cupboard security, padlock access codes not changed on a regular basis, master keys for medicine cupboards held by staff, access codes for medicine storage rooms written on a noticeboard and medicine storage rooms not locked.
- Some ambulance stations had separate Emergency Care Practitioner's (ECP) medicine cupboards. Medicines access for ECP cupboards was restricted to the authorised ECP who held the key for their medicine cupboard. However, there were no arrangements in place to check or audit the medicines available in the ECP cupboards or to check they were safe to use. There was no spare key access in the event that the key was lost or the ECP was not available. We were unable to check medicine storage for two ECP medicine cupboards because the key was not available.
- We found examples of drugs missing and of the 20 documented drug incidents at the trust in October and November 2015 18 related to missing drugs. Actions relating to these had been taken. Following our inspection the trust informed us the missing drugs related to low risk medication.
- At the Lincolnshire and Nottinghamshire air ambulance base we found out of date drugs for return to the trust were not audited effectively and this could lead to missing drugs going unnoticed.
- We found the 25 controlled drug registers across the divisions that we checked for stock balances were

accurate. No incidents had been reported with controlled drug records. However, the management and control of access to controlled drugs was not always managed safely or followed good practice. Controlled Drugs (CDs) as defined in the Misuse of Drugs Regulations (2001) and its amendments are medicines that should be stored with additional security and recording arrangements in place. We found the system of using a single key system to access controlled drug safes on ambulances meant it was difficult to follow a robust audit trail for individual paramedic access to the controlled drugs. We were told by the Medical Director, who was also the accountable officer, that this had been identified by the trust and was on the Clinical Governance Group agenda to be discussed. Various options for the security of CDs were being investigated.

- Across the divisions we found CD records on ambulances and within particular ambulance stations were not always countersigned by a witness. It is recognised that when clinical staff work alone obtaining a witness every time is not always possible. However, the trust's drug policy recommends that a counter signature should be obtained at the next available opportunity. This is also seen as good practice by NHS Protect in order to ensure a robust audit trail of controlled drugs. NHS Protect leads on work to identify and tackle crime across the health service. Paramedics we spoke with recognised that it was important to obtain a second witness to ensure accurate controlled drug records but agreed that it did not always happen.

- We observed the administration of controlled drugs to patients and saw staff following safe and correct procedures. Staff were aware of the correct procedures to follow if any were missing. During an observation in Northamptonshire, we saw drugs being administered for someone who had breathing difficulties. Records were completed to document the administration and the paramedic discussed the use of it to the patient. We also observed the patient's own medicines being transported with the patient to hospital in the designated green medicine bag issued for that purpose.

- Storage of medical gases (oxygen and Entonox) varied across the divisions. At some stations it was stored according to trust policy but not in others. In one station we found empty cylinders stored with full ones and there was no evidence of records being kept

appropriately: paperwork relating to the gases had been placed on a shelf. The trust's policy relating to the storage of medical gases, dated 22 May 2015 stated that full and empty gas cylinders must be segregated.

Records

- East Midlands Ambulance Service had two forms of patient report forms (PRFs); an electronic version (EPRF) and paper (PRF). The format of the forms followed Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidance.

- A copy of the PRF was provided to the receiving hospital and a copy retained by the ambulance crew. EPRFs could be sent electronically to emergency care practitioners in acute trusts if they were referring patients to them or downloaded on arrival at the hospital. If a patient was treated and discharged at the scene or at home, a copy of the paper PRF was left with the patient. If the crew used an EPRF this was not possible.

- We reviewed a sample of 26 paper PRFs and found the majority were clear and legible. An audit of PRFs in Quarter two of 2015 to 2016 (July to September) showed of the 5,954 report forms submitted across the divisions, 5479 had been completed appropriately. Percentages of completion for divisions varied from 87% in Nottinghamshire to 95% in Lincolnshire. The average across all divisions was 92%. In the previous quarter the trust average had been 94%. Actions had been placed in the audit document to implement improvements which included a coordinated programme of work to be developed and implemented by clinical leads in each division.

- PRFs were not always stored securely on ambulances or in ambulance stations. We found completed paper PRF records were kept in different places before being transferred for storage at ambulance stations. We found some of them tucked in the sun visor and left on dashboards in ambulances. On one ambulance confidential information about a patient was visible to passers-by as it was left on the dashboard. This meant people's individual care records were not always stored securely. This was not safe practice and a breach of confidentiality as these ambulances were regularly left open and unlocked outside hospitals. In ambulance stations we found PRFs stored in unlocked rooms, unsecured confidential waste bags or in open filing cabinets.

Emergency and urgent care services

- Staff in the emergency operations centre (EOC) could sometimes access information about end of life care preferences for patients such as do not attempt cardio pulmonary resuscitation decisions (DNACPRs). They would advise ambulance crews where these decisions were in place. Where information was not available in advance ambulance crews had clear guidance to follow should they be presented with or told of a DNACPR decision.

- Some patients had special notes attached to their record. Special notes were electronic, available to EOC staff and contained information relevant to the patient. These were shared with ambulance crews when available. We observed handovers where relevant patient information, including any special patient notes were explained in detail to hospital staff.

Assessing and responding to patient risk

- Staff in the two operations centres in EMAS used the Advanced Medical Priority Dispatch System (AMPDS) to assess and prioritise emergency calls. AMPDS prioritised and coded calls based on responses to questions asked by emergency medical dispatchers (EMD) in the operation centres. The priority, or coding of the call, determined the risk to the patient and therefore the type of ambulance crew sent by dispatchers to the patient.

- Staff had a copy of the Joint Royal Colleges Ambulance Liaison Committee assessment and triage guidance available to refer to. Ambulance crews used the national early warning score (NEWS) to evaluate a patient's condition. The NEWS score is based on a simple scoring system in which a score is allocated to six physiological measurements including pulse and respiration rates. Vital signs such as respiration and pulse rates, blood pressure, heart rate monitoring and the patient's condition were recorded on the Patient Report Form (PRF) or on the electronic PRF (EPRF). Any changes or deterioration in a patient's condition informed the clinical decision making process and urgency of the situation.

- Paramedics used the 'Pathfinder' guide to determine which pathway they should use for patients depending on their presenting symptoms. The Pathfinder is a clinically safe triage system to enable accurate face-face

assessment of patient needs and to identify the most appropriate care pathway for that patient. It has been adopted by several Ambulance Trusts increasing safe care for patients closer to home.

- The service had clear pathways for ambulance crews to follow when responding to life threatening conditions. We spoke with staff who demonstrated knowledge of how to treat and manage sick and deteriorating patients. We observed ambulance crews monitoring patient's conditions regularly and reassessing after the administration of medicines. Paramedics had a range of drugs they could use with deteriorating or seriously ill patients.

- In the event of a patient's condition changing or deteriorating, systems were in place for staff to seek clinical advice from the clinical assessment teams (CAT) based at the Emergency Operation Centres (EOCs). The CAT teams were available 24 hours a day and included paramedics, nurses, midwives and GPs. However, some ambulance crews told us it was sometimes difficult to get the advice they needed. Staffing of the CAT teams had been difficult and staffing levels of the team were reduced at weekends and at night.

- Community first responders (CFRs) are volunteers who respond to life threatening emergencies in their own communities while an emergency ambulance is travelling to the patient. When we spoke with some of them they told us they had often waited extended periods of time for an EMAS vehicle to arrive but the support they received from the crews was good. They used the clinical assessment team in the operations centres to seek approval to upgrade a call if the patient deteriorated. They had found the team were very helpful.

- Data provided by the trust showed that from April 2015 to November 2015 the number of delays in excess of 30 minutes when CFR's or lone workers had requested back-up conveyance by an ambulance varied between 3,978 in April 2015 to 5,072 in October 2015. This meant patients were being delayed in reaching a hospital. In one county for example, on six separate occasions between May 2015 and September 2015 we saw incidents relating to poor outcomes for patients because of delays in back up. One patient who was very ill had to wait 45 minutes for additional intravenous fluids to arrive. On another occasion a lone working paramedic requested back-up on two separate

occasions for two patients and had to wait for between 90 minutes and 2 hours. In another case five patients were carried on one ambulance because there were insufficient resources available to send other vehicles.

- Support was provided by the police where required for patients having a mental health crisis although it is acknowledged this is not always appropriate. In Lincolnshire the service had access to a mental health triage car which was jointly funded with the local mental health trust and manned by a paramedic and a mental health nurse each evening between 4pm and midnight.
- The trust had policies and procedures in place to manage disturbed or unacceptable behaviour from members of the public; this included protecting staff who were lone workers.

Staffing

- During our inspection of the trust in January and February 2014 we found the trust did not always have enough suitably qualified, skilled and experienced staff to meet the needs of people who used the service in a timely way. Vacancy rates varied between 21% in Northamptonshire and 5% in Lincolnshire.
- The trust were unable to recruit sufficient paramedics because of a national shortage. As a result they had taken the decision to recruit technicians and to offer development opportunities to emergency care assistants (ECAs). The trust's vision was to reach a skill mix of 70% qualified staff to 30% unqualified. At the time of our inspection the mix was 74% qualified to 26% unqualified.
- The trust had been successful in recruiting 59 paramedics in the previous 12 months but we were concerned that 39 paramedics had left the trust and the overall increase was only 18. Data provided by the trust showed that although there were 241 staff of all grades recruited in the period April 2014 to March 2015 this had only resulted in an increased overall staffing of 13. This showed a concern about staff retention in all services and conversations with staff and managers confirmed this was a challenge.
- Team leader to staff ratios at the time of our inspection were 1 to 22 and clinical team mentors (CTMs) 1 to 86. At our last inspection we were concerned about the availability of CTMs to support staff. This was still an

issue for staff and CTMs because of the high ratios and because CTMs were required to work operationally most of the time to respond to high demand and support response times.

- Staff at the trust and in acute hospital settings raised concerns about the high usage of double crewed ambulances (DCAs) crewed with two ECAs. The skill mix of a double ECA crew meant they should be restricted to GP urgent calls rather than emergencies. However, lack of resources meant these crews were sent to emergency calls and then had to wait with the patient for a solo paramedic with appropriate skills to attend and treat or accompany the transfer of the patient. Between August 2015 and October 2015 between 15% and 18% of the double crewed vehicles were without a paramedic.
- Information supplied by the trust showed that during October 2015 they required 272.436 rostered staff hours to cover all emergency shifts for all divisions. The amount of hours filled by trust staff for that month was 237,676 leaving a shortfall of 34,759 hours. Whilst some of these hours were covered by third party providers there was still a shortfall of 7% for October 2015. This meant there were insufficient emergency ambulance staff to provide a safe and timely response to patients.
- We saw many staff finished their shift late to complete their work with a specific patient. Some also were not able to take their assigned meal breaks because of high numbers of emergency calls. Data from the trust showed monthly additional hours worked because of late shift finishes were 17,178 in November 2015. Where staff finished late they often had to delay the start to their next shift because they were required by law to have an 11 hour break between shifts. This impacted on the numbers of staff available to respond to calls on subsequent shifts. Information from one ambulance station evidenced that in November 2015, in 87% of 648 occasions staff had no break at all or a late break followed by a late finish time.
- Staffing numbers and skill mix in the divisions were monitored on a daily basis to ensure the quality of the service provided and to mitigate the risk to patients. Additional crews were rostered on Friday and Saturday nights in some divisions to meet increased demand. However, the majority of ambulance crew staff we spoke with stated that there were often poor skill mixes because of insufficient numbers of appropriately trained staff with the required skills, to ensure that patients were safe and received the right level of care at all times.

Emergency and urgent care services

- Staff with 'rostered shifts' generally had their rota completed for twelve months in advance on the basis of annualised hours.The trust had an additional time off (ATO) policy which allowed staff to take additional leave and repay the hours by working additional shifts at a later date. The trust informed us 73,141 ATO hours were granted to staff between 1 January and 31 December 2015. The trust also informed us staff were able to have time off in lieu of additional hours worked (TOIL). 18,952 TOIL hours were granted to staff between 1 January and 31 December 2015. However, booking annual leave was seen as a problem for most members of staff especially if the request was made for a particular unplanned issue. For example illness of a family member. This had created distress for a number of staff.

- Sickness amongst ambulance staff within emergency and urgent care services had varied a lot by division between March 2014 and July 2015. The rates reached over 10% three times during the time period. The higher levels of sickness were in Northamptonshire division (August 2014), Derbyshire division (October 2014) and Nottinghamshire division (January 2015). Average sickness levels had been higher than all East Midlands NHS trusts average; 5.5% compared to 4.0%. However, sickness levels had been falling from a high of 7.5% in January 2015 to 5.5% in May 2015.

- We asked the trust for details of sickness levels. The information they provided showed that the four most common causes of sickness in descending order related to gastrointestinal problems; coughs colds and flu; back problems, anxiety/stress and depression.

- The Resource Management Centre (RMC) of EMAS in Nottingham was responsible for approving all staff requests for annual leave; no-one in individual divisions, including the general managers, had any authority or autonomy about this issue. This led to considerable frustration by all members of staff.

- EMAS was supported to respond to acutely unwell patients within target response times, by approximately 1774 trained community first responders, volunteers and co-responders. These individuals were trained to attend emergency calls and provided care until the ambulance arrived. EMAS monitored its own CFR volunteers but co-responders recruited by third party organisations were monitored by those organisations.

- The Lincolnshire and Nottinghamshire Air Ambulance crew had a total of five paramedics on the team which included two operation managers. The team worked in pairs at all times and sometimes used a doctor who could provide roadside anaesthesia and enhanced skillset.

Anticipated resource and capacity risks

- The trust used the national indicator resourcing escalatory action plan (REAP). This is an indicator of pressure in ambulance services,which can be used to trigger specific actions when a trust is operating with significant and sustained levels of increased activity. The levels of REAP range from one (normal service) to six (potential service failure). We saw REAP levels displayed at ambulance stations, the Lincolnshire and Nottinghamshire air ambulance centre and Hazardous Area Response Team (HART) during our inspection. However we noted these were not always consistent. For example, on 18 November 2015 during our inspection, Beechdale ambulance station was at REAP level four (severe) and at the HART base it was stated as being at level three (moderate). Both venues are in Nottinghamshire.

- Business continuity management is a management led process which identifies and mitigates risks and disruptions that could affect the performance of an organisation. The trust had a comprehensive business continuity response and recovery plan in place, issued in November 2015 and included action plans for loss of staff, vehicles and premises. Staff we spoke with knew contingency plans were available for issues such as bad weather and gave us an example of 4x4 vehicles being available to collect staff.

- A winter operational plan had been produced for 2015/2016; the document was dated 4 November 2015. It was comprehensive in content and included maximising resources and efficiency of call handling as well as working with key stakeholders and commissioners. Administration of influenza vaccines to staff was part of the plan; 49% of frontline staff had received this at the time of our inspection.

- However, we saw issues on divisional risk registers that would impact on the ability of the trust to meet demand over the winter period. For example, hand over times for patients to hospital staff at one acute trust was highlighted as a 'red' risk as well as staff vacancies and sickness levels. The risks were underpinned by controls and assurances but were not clear on actions to be

taken. During our inspection we visited the hospital and saw how ambulance staff were unable to hand over patients in a timely manner so they could respond to other calls.

- We were informed by staff about a redesign to rostering, which was to ensure the staffing resources were able to be deployed to effectively meet demand. Staff raised concerns about it but we saw the trust had sent out a consultation document about this and staff were going to be voting on it.

Response to major incidents

- A major incident is any emergency that requires the implementation of special arrangements by one or all of the emergency services and will generally include the involvement, either directly or indirectly, of large numbers of people. EMAS had a major incident plan. The review date was March 2015. The plan was comprehensive and identified types of major incidents as detailed in the NHS Commissioning Board Emergency Preparedness Framework 2013.
- Plans for major public events across the divisions, included processes to respond appropriately to a major incident at any of these.
- Paramedics working within the Lincolnshire and Nottinghamshire Air Ambulance were aware of their involvement in any declared major incident. This included patient transport or speedy movement of medical personnel when required.
- Some staff we spoke with were aware of the EMAS major incident procedures and how such incidents were escalated.
- However, front line staff in some divisions had not received any training.
- Between 1 January 2015 and 30 November 2015 there had been 17 live major accident scenarios as well as 44 table-top incidents. The numbers of staff involved had varied but always included managers. On four occasions the Special Operations Response Team (SORT) had been involved and on six occasions the Hazardous Area Response Team (HART) had taken part.
- Senior managers had on-going major incident training in combination with the police and fire service. However, there had been limited capacity to release frontline staff to attend major incident training because of increased demand for the service. For example, in one division we spoke with a paramedic who had received no training in involvement of major incidents.

An emergency care assistant (ECA) told us there was no major incident training for ECAs and no learning had been shared from any of the training sessions attended by other staff.

- All of the current Gold Commanders in the trust had attended the Multi Agency Gold Incident Command course. This meant the trust had suitably trained personnel to undertake a lead role in a major incident involving multi-agencies such as the police and fire service. Silver and Bronze Commanders were also available in the trust. We spoke with one member of staff who had been designated a Bronze Commander when they were required to do so. They told us they had received no formal training for the role.
- If hospitals were temporarily unable to receive ambulances because of capacity issues, they were sometimes diverted to other hospitals. The information was sent to ambulance crews by the Emergency Operation Centres.

Are emergency and urgent care services effective?
(for example, treatment is effective)

Requires improvement ●

We rated the effectiveness of the trust's emergency and urgent care services as requiring improvement.

- For EMAS, the proportion of Red 1 and Red 2 calls attaining national targets was similar to the England NHS ambulance trust average. Red 1 calls are those which are immediately life threatening such as cardiac arrest. Red 2 calls are those which are serious but not the most life threatening for example unconsciousness or chest pain. In the previous 19 months the trust had only reached the national target of 75% for Red 1 calls in April 2014 and April, May and July 2015 and had not attained the national target of 75% for Red 2 calls since April 2014. However, data for November 2015 showed the trust as the second worst performing ambulance service in England with responses within target at 65.6% for Red 1 calls and 56.9% for Red 2 calls. This indicated a deteriorating performance.

Emergency and urgent care services

- Prolonged delays at some acute hospital's emergency departments reduced the capacity of front line staff to respond to patient's needs.
- The proportion of A19 calls responded to within 19 minutes was fractionally less than the England average at 94%; the target being 95%. However, data for November 2015 showed the trust as the worst performing ambulance service in England with responses within target at 85.3% for A19 calls. This figure was almost 5% below any other ambulance service in England.
- Some outcomes for people using the service were below expectations and others above compared with other similar services.
- Alternative care pathways for patients not requiring conveyance to hospital were challenging owing to the number of different providers involved across the East Midlands.
- The number of 'see and treat' patients equated to between 25% and 32% of the total patients treated across all divisions compared with an England average of 37%.
- We were not assured sufficient training was in place to support staff or that meaningful appraisals were undertaken.
- Career progression opportunities for paramedics were limited.
- Staff were not supported to undertake mental capacity assessments.

However we also found that:

- EMAS followed both National Institute for Health and Care Excellence (NICE) and Joint Royal Colleges Ambulance Liaison Committee (JRCALC) clinical practice guidelines and had access to a clinical advice team when necessary although this was sometimes not available in a timely manner.
- Front line staff worked effectively with other healthcare providers.
- Good multidisciplinary working was in place and in Lincolnshire the number of mental health patients being conveyed to emergency departments had reduced owing to a joint initiative with a local mental health trust. The trust's research team was involved in national projects to improve patient care across all ambulance services in England.
- Consent was obtained from patients prior to treatment

Evidence-based care and treatment

- Staff carried a copy of the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidance and referred to it in their assessment and documentation of patient care. In some vehicles care-bundle or pathway information was displayed which outlined the accepted steps to be taken for patients who were experiencing for example, a stroke, heart attack or asthma.
- One paramedic we spoke with was able to give a detailed account of the stroke care pathway and how they communicated with the local Stroke Unit. All the care described was within the EMAS stroke policy which was in line with the JRALC guidelines and the National Institute of Health and Care (NICE) guidance.
- Two more paramedics were able to fully explain the care bundles or pathways for specific conditions and discuss the rationale for them. They knew how to get advice if the patient needed care and treatment from a specialist hospital outside their own area.
- Because of clothing restrictions and lack of space in the helicopter, air ambulance paramedics kept laminated emergency cards in their flight suit pockets for use as an aide memoir to refer to when required. This included information relating to for example, burns assessments, cardiac pacing and major trauma triage tools. They told us the information was useful and easy to use.
- Clinical updates were sent to clinicians via email. We saw some of these on notice boards in ambulance stations although there was no audit trail in place to notify the trust which clinicians had read these. Therefore there was no assurance all clinicians had read or understood them.
- There was evidence of self-care pathways for issues such as falls, epilepsy, hypoglycaemia (low blood sugar), head or neck injuries.
- We did not see any pathways for patients experiencing mental health issues. Staff informed us this was a particular problem out of hours. However one paramedic in Nottinghamshire spoke confidently about the transfer of patients and could provide us with examples.
- The EMAS research team were involved in national projects to improve patient care across all NHS ambulance trusts in England and had links with many large universities. Forty percent of paramedics across the EMAS divisions were included in the research projects. At the time of our inspection two projects were

underway including one related to airway management; paramedics in four divisions had signed up to be part of the project. Reports from the team had included clinical performance indicators for mental health, asthma and falls in the elderly with clinical practice changing as a result. All reports were sent to the trust board for information and a decision on any actions the trust needed to take. 'EMAS Air' was a quarterly information document sent to clinicians via email and included research studies and education items.

Assessment and planning of care

- Ambulance crews followed medical protocols in assessing patients and planning their care. They made effective use of protocols, supporting guidance and pathways in their assessment of patients.

- Eleven care pathways were in place in the Northamptonshire division which were used to redirect appropriate patients with a variety of conditions. For example, minor ailments and injuries, older patients with a history of falls and children with a fever and respiratory illness.

- In Leicestershire, a Smartphone project was being piloted with the issuing of five phones which had been uploaded with an application linked to a mobile directory of services. The plan was to roll this out to all staff in Leicester, Leicestershire and Rutland in 2016. Access to alternative care pathways and the paramedic pathfinder pocket book would be included. This will give frontline staff instant access to information.

- EMAS had a policy in place relating to the treatment of patients who had experienced a cerebro-vascular accident (stroke). The trust's policy directed staff to transport patients to one of nine hyper-acute stroke units in the five divisions across the East Midlands to ensure they received appropriate care quickly. Hyper-acute stroke units deliver emergency care to patients for the first 72 hours following their stroke.

- All ambulance crews were required to take patients to the nearest appropriate hospital for their needs. For example, pregnant women were conveyed to the nearest maternity unit if they were unwell or there was a risk to the unborn baby. However, if there was no medical emergency they would, where practicable, be conveyed to their booked unit.

- During our inspection we observed a patient being conveyed to an emergency department who had suffered major trauma. The department was a major

trauma unit and not a trauma centre but because they were in a critical condition the crew made the decision to take them to the nearest hospital where they could be stabilised. This meant staff acted appropriately and in line with the trust's guidance.

- Paramedics who had received the training used the Pathfinder pocketbook when signposting patients to an alternative health provider if they had been assessed as not requiring the ambulance service. It was used in conjunction with the National Early Warning Score (NEWS). The NEWS score is based on a simple scoring system in which a score is allocated to six physiological measurements including pulse and respiration rates.

- We observed ambulance staff following their own assessment process and documenting their findings. The staff we spoke with demonstrated a clear understanding of the use of alternative care pathways. However, it had been recognised that arranging alternative pathways was challenging owing to the number of organisations involved in the different divisions.

- Clinical support and advice was available from the Clinical Assessment Team (CAT) in the emergency operations centres but this did not always function efficiently for front-line staff. For example an ambulance technician rang for support over a 30 minute period but received no response. The Capacity Management Plan (CMP) was an operating procedure that changed how staff worked in the operations centres depending on demand. This meant at times staff in the CAT team were used to undertake welfare calls and to review all emergency calls. Therefore front-line staff may wait longer for a response.

- Ambulance crews were treating an increasing number of patients at home or on scene without the need to convey them to hospital for further care. This is known as see and treat. Figures supplied by the trust showed between 1 November 2014 and 31 October 2015, ambulance crews across all divisions saw and treated 189,288 patients. The greatest increase in see and treat episodes was in Lincolnshire with an increase of 3% on the previous year's figures. The number of see and treat patients equated to between 25% and 32% of the total patients treated across all divisions.

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- Procedures were in place for dealing with High Volume Service Users. These are individuals who are aged 18 or over and have made five or more emergency calls related to individual episodes of care in one month, or twelve or more calls in three months.
- The trust had a Pain Management Standard Operating Procedure in place dated September 2014. For conscious adults with mental capacity staff used a numerical rating score of 1-10. For adults who could not communicate verbally or for children different systems were in place such as the FLACC score (Face, Legs, Activity, Cry, Consolability) or PAINAD (Pain Assessment in Advanced Dementia) score.
- During our observations with ambulance crews we saw patients were assessed for pain appropriately and relief was provided in accordance with the NICE guidance for example using Entonox and Morphine. Patients were informed about the medicines and their effect before they were administered.
- When inserting cannulas to administer medicines or give fluids via a vein, crews used anaesthetic gel to prevent any discomfort. Patients we spoke with who required this told us pain relief had been administered quickly.

Response times

- Calls to EMAS which were immediately life-threatening such as cardiac arrest and termed Red 1 required a response within eight minutes. The trust's response was similar to the England NHS ambulance trust average and followed the national trend throughout April 2014 to July 2015. For Red 1 calls, the trust only reached the national target of 75% in April 2014 and April, May and June 2015. The lowest response rate was 65% in December 2014; however data for November 2015 showed the trust as the second worst performing ambulance service in England with responses within target at 65.6%. This indicated a deteriorating performance.
- Calls which were serious but not the most life-threatening such as chest pain and termed Red 2 required a response within eight minutes. The trust's response was similar to the England national average from April 2014 to June 2015 and had not met the 75% target since April 2014. Data for November 2015 shows the trust as the worst performing ambulance service in England with responses within target at 56.9% for Red 2 calls. This also indicated a deteriorating performance.

- If Red 1 or Red 2 calls were initially attended by a single clinician in a Rapid Response Vehicle (RRV) and onward conveyancing of the patient was required by a double crewed ambulance (DCA), the national target states an ambulance should arrive on the scene within 19 minutes in 95% of cases. These are referred to as A19 calls. For EMAS, the proportion of A19 calls responded to with transport within that target was fractionally worse than the England NHS ambulance trust average of 94% for the period April 2014 to June 2015. However, data for November 2015 showed the trust as the worst performing ambulance service in England with responses within target at 85.3% for A19 calls. This figure was almost 5% below any other ambulance service in England.
- 'Green calls' are divided into four categories. Green 1 is a serious clinical need but not life threatening and Green 4 a non-emergency, such as feeling sick or unwell. The Green response times are recommendations and not nationally agreed targets. A Green 1 call should be responded to in 20 minutes and a green 2 in 30 minutes. Green 3 and 4 calls are those requiring a telephone assessment and or advice given prior to conveying the patient. Green 3 should be responded to in 20 minutes and Green 4 within an hour. Some Green 3 and 4 calls had the potential to be upgraded to Red calls depending upon patient symptoms and condition. The trust's data for Green calls showed that response times had fallen for Green 1 and Green 2 between April 2015 and December 2015 and the target of 85% had not been achieved in any month. Percentages for Green 1 response times varied between 84% in May 2015 and 65% in November 2015. For Green 2 calls this varied between 84% in April 2015 and 67% in October 2015. The trust had exceeded their target of 85% for Green 3 and Green 4 calls between April 2015 and November 2015. Data provided to us showed percentages were between 87% and 99% for the timespan.
- Professionally requested transport is transport requested by hospitals or other health professionals including end of life care transfers. The trust had a policy in place for inter facility transfers (IFT) of patients. These included transfers for extracorporeal membrane oxygenation for both adults and children. Extracorporeal membrane oxygenation is used for patients with severe heart (cardiac) or lung (respiratory) failure. IFT also included transfers of babies or children to paediatric intensive care units (PICU) but did not

Emergency and urgent care services

include transferring patients from outside the East Midlands region to another hospital outside the region. The trust also provided transfers for patients to an intensive care unit within the region from NHS and private sector hospitals. The response times to requests depended upon their priority. This varied between eight minutes and up to eight hours, based on clinical need of the patient. Data for expected response times from April 2015 to November 2015 varied across the divisions. On average, for Red 1 calls the trust achieved 80% which was above the target of 75%. Red 2 calls achieved 99%; above the target of 75%. However, Red 19 and 'urgent' calls (those booked by a GP or other health professional) were below target. Red 19 calls achieved 74%, below the target of 95% and 'urgent' calls achieved 76%, below the target of 90%.

- Response times were affected byt the prolonged delays at some acute hospital's emergency departments taking receipt of patients from EMAS staff. This is referred to as patient handover delays. These delays reduced the capacity of front line staff to respond to patient's needs. This was because ambulance staff needed to stay with their patients to deliver care and support until they were handed over to hospital staff.

- Nationally the number of calls for life-threatening emergencies had risen by almost 14% over the previous three years and total calls had increased by 5%.

- Ambulance staff were frustrated by the failure to reach national response targets. Information received from local Healthwatch groups showed patients had raised concerns regarding delayed response times. Response times were affected by patient handover delays at acute trust emergency departments. In some cases these delays extended over several hours. This meant staff were unable to respond to emergency calls in the community as they were caring for patients awaiting transfer to the care of hospital staff for on-going care. The trust deployed staff from neighbouring divisions to support areas experiencing handover delays but this impacted on the capacity of that division to respond to calls. Ambulances held at acute hospitals awaiting handover were not available to support solo responders and community first responder volunteers who were waiting in the community with patients who required transport. We saw that trust had repeatedly asked their partners for support and action in relation to handover delays. There had been meetings with commissioners

and other stakeholders and the trust deployed their own staff as Hospital Ambulance Liaison Officers (HALOs) to support teams in processing patients and managing risk.

Patient outcomes

- The trust routinely collected and monitored information about people's care and treatment. Ambulance Clinical Quality Indicators measure the overall quality of care and end-results for patients following care and treatment.

- Heart attack or ST segment elevation myocardial infarction (STEMI) is caused by a prolonged period of blocked blood supply within the coronary arteries. Reductions in STEMI mortality and morbidity is influenced by those patients who received the appropriate care bundle, those who have timely delivery to the cardiac catheter lab for intervention, and those who have timely thrombolysis or clot busting medicines. Between April 2014 and April 2015 the proportion of patients receiving angioplasty (unblocking of a coronary artery) within 150 minutes was better than the England average; 93% as opposed to 85%. For the number of patients who achieved an appropriate care bundle for angioplasty, EMAS was better than the England average during this period although this was not always the case. The England average saw a downward trend ranging from 83% to 76% during the period. EMAS ranged from 70% in December 2014 and April 2015 to 87% in September 2014 and 86% in February 2015.

- The number of 'see and treat' patients equated to between 25% and 32% of the total patients treated across all divisions. The England average was 37%.

- Following a cardiac arrest, the return of spontaneous circulation (ROSC) (for example, signs of breathing, coughing, or movement and a palpable pulse or a measurable blood pressure) is a main objective for all out-of-hospital cardiac arrests, and can be achieved through immediate and effective treatment at the scene. Although EMAS results for ROSC had improved between April 2014 and April 2015, when compared to the England average EMAS was worse; 23% compared to 28%. The rate for the Utstein comparator group provides a more comparable and specific measure of the management of cardiac arrests for the subset of patients where timely and effective emergency care can particularly improve survival. For example, 999 calls

where the cardiac arrest was not witnessed, and the patient may have gone into cardiac arrest several hours before the 999 call, are included in the figures for all patients, but are excluded from the Utstein comparator group figure. Using the Utstein comparator group, at the time of arrival at hospital following cardiac arrest the trust on the majority of occasions was worse than the England average of 53%. However, three times in this 13 month period they were slightly above the England average, peaking in April 2015 at 61%. EMAS achieved between 2% and 8% for the proportion of patients with coronary heart disease (CHD), discharged from hospital alive (all patients) following cardiac arrest (April 2014 to April 2015), which was below the England average of 9%.

- As set out in the National Institute for Health and Care Excellence (NICE) national quality standard, the health outcomes of patients can be improved by recognising the symptoms of a stroke or transient ischaemic attack (TIA), making a diagnosis quickly, and early transport of a patient to a stroke centre capable of conducting further definitive care including brain scans and thrombolysis. The proportion of EMAS stroke patients receiving thrombolysis within 60 minutes (April 2014 to April 2015) was similar to the England average, ranging from 63% in April 2015 to 53% in November 2014 and March 2015. The proportion of suspected stroke patients assessed face to face who received an appropriate care bundle (April 2014 to April 2015) was better than the England average on all but one occasion in December 2014. Rates ranged from 99% in June 2014 to 96% in December 2014. The national average was 97%.

- The trust was involved with the Myocardial Ischaemia National Audit Project (MINAP). MINAP is a national clinical audit of the management of heart attacks. EMAS provided information to hospitals on request and were unable to supply any data to us relating to this as they informed us it was an on-going database and not set against any standards.

- A project was in place to improve the treatment for patients in acute heart failure. This involved issuing crews with continuous positive airway pressure (CPAP) machines (the machines are often used for patients with sleep apnoea). The CPAP machine improves oxygen saturation levels in these patients.

- The trust's care of asthma patients in the previous twelve months showed the use of the asthma care bundle was better than the trust target of 90% for three months but worse for nine months. For asthma patients

the trust recorded results better than their own target level of 95% for arterial oxygen saturation levels for three months and worse at between 84%-94% for nine months.

- The proportion of patients who re-contacted EMAS following treatment and discharge at the scene, within 24 hours was 4% to 4.5% which was better than the England average of between 5% to 6%

Competent staff

- Appraisal completion rates for April 2014 to March 2015 ranged from 63% in one division to 100% in another. Frontline staff and team leaders told us appraisals were difficult to organise because of operational pressures which meant staff could not be taken off the road and because of high team leader to staff ratios. Trust data indicated 63% of frontline managers had received training in how to conduct appraisals within the previous three year period. We found evidence of appraisals which had not been completed despite staff receiving letters confirming they had. Although the recorded completion rates had improved since our previous inspection there were still too many staff who had not received a meaningful performance development review.

- At the time of our inspection the trust had three training schools located in Lincoln, Derby and Leicester. Derby has subsequently closed and relocated to Nottinghamshire. Plans were in place to combine the Leicester and Derby training centres into one but a five year extension to the Leicester lease has been agreed. We visited the Lincoln training centre and found tutors were enthusiastic about their role and passionate about what they did. However, they acknowledged that training was difficult in a climate of operational pressures. Staff training was via e-learning on computers and face to face modules in the classroom, but operational staff found it difficult to access computers during work time. Training rooms and e-learning facilities were available at some but not all stations. Where training aids were available and ready for use they included Joint Royal Colleges Ambulance Liaison Committee (JRCALC) and NICE guidance.

- There were driver training facilities in both Lincoln and Nottingham. Funding for four full time equivalent driving instructors had been gained in 2014. This was supplemented by outside agencies. Emergency and urgent care staff who had undertaken emergency

driving training within the past five years varied between 21% in Derbyshire and 48% in Northamptonshire. We did not have details of how many of these staff were new employees and therefore were required to undertake a course before driving an ambulance or rapid response vehicle in emergency conditions. Staff we spoke with had only attended emergency driver training once since joining the service. This was prior to legislation coming into force to require reassessment of emergency driving be undertaken at least every five years. There was no legislation in place for refresher training at the time of our inspection.

- Paramedics delivering a service with the Lincolnshire and Nottinghamshire Air Ambulance had access to a well-equipped training room and we saw evidence of regular on-going training for all the paramedics who worked there. Every call they attended was placed on a database where the clinical skills used could be analysed. Where skills were not used on a regular basis, for example, intubation (the insertion of a tube into the airway to aid breathing), staff undertook a competency test to ensure they maintained their skills in order to be able to practice effectively. All five paramedics in the team had received investment from the charity that ran the air ambulance service to enhance their clinical skills; two had been enrolled on a post-graduate Masters certificate in critical care.

- Concerns were raised by a number of staff with regard to the lack of training for using a defibrillator. Posters had been placed in ambulance stations but there was no audit or control mechanism to identify who had read the posters and knew of the changes. An ambulance technician in one division had been sent to a patient with chest pain without any formal training on how to interpret electrocardiograph (ECG) readings.

- We saw data from the trust indicating how many staff had received training for dealing with patients who had a learning disability or a dementia. Percentages varied for each of the divisions. For example, 70% of staff in Northamptonshire had received training in learning disabilities but only 36% in Lincolnshire. For dementia, 28% of staff had received training in Northamptonshire but only 18% in Derbyshire.

- Basic induction for new staff was one week of formal training which included conflict resolution as well as moving and handling of patients and an introduction to caring for people living with dementia. A local induction was undertaken at their designated base ambulance station.

- Trainee technicians attended a nine week long induction training course with weekly tutorials. Accredited paramedic mentors supported frontline staff in training. The ratio of one mentor to seven trainees was achieved across the trust with the exception of one division where it was one to eight.

- Paramedics are required to re-register with the Health and Care Professions Council (HCPC) every two years which is the responsibility of the individual. As part of that process, they are required to undertake continuous professional development (CPD) and receive clinical supervision. This can include self-reflection and reading journals. Paramedics we spoke with across all divisions told us because of operational pressures on the service, insufficient time was given to support them in this process and training sessions, including mandatory training, had been cancelled. As a result some paramedics were struggling to undertake CPD for re-registration.

- Community paramedics received an additional week of training on clinical examination.

- Although the trust had access to NHS management training courses most of the newly appointed managers, such as those in seconded posts we spoke with, told us they learned their role 'on the job' and from shadowing other managers.

- The competency of staff was assessed by clinical team mentors accompanying ambulance crews during their normal duties. We saw evidence of this in one division during the inspection.

- Paramedics raised concerns with us about the lack of career progression opportunities. We spoke with a number of paramedics who had Masters Degrees. For example, a Masters in advanced clinical practice in pre-hospital critical care but had no opportunity to progress to a consultant paramedic. However, the trust was considering[DS8] developing that role. Some of the paramedics we spoke with told us pay scales within EMAS were lower in comparison to other services and some told us of the inability to access courses they wished to attend.

- All staff we spoke with told us training in dealing with patients experiencing mental health issues was not adequate. We saw a copy of the trust's training booklet

entitled 'Introduction into Understanding Mental Health Conditions'. It was comprehensive in content and covered such issues as depression and suicide. An evaluation form was included in the back of the booklet and the opportunity to comment on future learning needs relating to mental health.

- The trust had protocols for section 136 and transporting patients to and from places of safety. The National Ambulance Mental Health Group had approved the trust's protocol. However, staff told us they needed training in mental health, the Mental Capacity Act 1983 and the Mental Health Act with a special emphasis on transporting patients under Section 136 of the Act. Section 136 of the Mental Health Act 1983 allows a police officer to remove a person they think is mentally disordered and "in immediate need of care or control" from a public place to a place of safety.

- The trust had a Hazardous Area Response Teams (HART), based in Nottinghamshire comprising of six or seven staff in each of the seven sub teams. At HART's operational base we saw a dedicated training room containing an information technological scenario based system for training staff. At the time of our visit staff were unable to demonstrate the system because they didn't know how to use it. The trust informed us this was because the system was still under development and only one technician was trained in its use.

- In addition at the HART operational base there were dedicated training rigs for working at heights and in confined spaces so staff could practice these procedures. Training cars were also available for staff to practise patient care following road traffic collisions. The training equipment available mirrored live equipment to ensure staff were familiar with it and its use. Operational HART teams received one week of protected training in every seven which included practical exercises. Feedback regarding this was generally positive although some staff commented that it was not always planned and they had to make it up themselves. Training included marauding terrorist firearms attack, use of breathing apparatus and specialist rescue team training.However, we saw the trust had developed and introduced personal HART operatives training record manuals covering all competencies that each staff member had to complete and sign in order to ensure they were capable of operational duties

Coordination with other providers

- Processes were in place to monitor the effectiveness of contracts with independent ambulance service providers. EMAS had a quality governance framework (dated September 2015) for independent ambulance providers they commissioned services with. This included comprehensive minimum quality standards that were expected of those providers with evidence of established internal policies and clinical update training.

- Regular contact was made with commissioned independent ambulance providers to ensure quality of care to patients. For example, of the three commissioned independent ambulance providers used by the trust, we saw each of those had received contacts between three and five times between February 2015 and September 2015. EMAS had undertaken a visit to one provider when an inspection had taken place. Any complaints received about the provider were also investigated and any actions required were monitored by EMAS. EMAS informed us that visits to independent ambulance providers included staff leads in, for example, human resources, operations and infection control as well as a clinical lead.

- The care and transportation of patients with mental health illnesses outside of working hours (9am to 5pm) was a cause for concern to EMAS staff. Despite the fact that emergency departments are not the most appropriate place for patients with mental health issues, patients were more likely to be taken to the emergency department as other appropriate services were closed. In Lincolnshire, a rapid response vehicle (RRV) had been made available from 4pm until midnight manned by a paramedic or emergency medical technician (EMT) and a mental health nurse from the local mental health trust: the service was commissioned by the local mental health trust. Based in Lincoln, the RRV could respond to any mental health crisis in the community. The project had been a success and was applauded by the acute trust and police force. It had reduced the number of double crewed ambulances attending such patients and the number of patients admitted to an emergency department. At the time of our visit the paramedics manning the RRV were doing this on an overtime basis as the funding had not been approved to recruit to the post on a substantive basis. A senior manager stated three more RRV's were required to cover the large

county of Lincolnshire in addition to rolling the system out across all EMAS divisions. The service had employed a person to act as strategic lead for mental health issues.

- EMAS operational managers met with other NHS trusts on a regular basis to discuss concerns and issues that involved their trusts including delayed handover times.

- The trust's coordination with other NHS and emergency services had enabled them to pilot and introduce services together to benefit the public living within the divisions. These had included the Joint Ambulance Conveyance Project with Lincolnshire Fire Service, an emergency first responder scheme with all of the East Midlands fire services and an increase in the number of Polamb (police and ambulance) vehicles within Leicestershire. Polamb vehicles allow police and ambulance staff to respond to incidents together. The vehicles were designed in response to increasing numbers of alcohol-related incidents.

- The trust had a clear future operating model in place involving a more streamlined approach in the provision of care to patients. This would involve a multidisciplinary team operating 24 hours a day and better transference of care to core services such as acute hospitals, mental health services, social care and community services. The paper for the model was agreed by the EMAS trust board in August 2015 with the goal of being an excellent consistently high performing provider of emergency and urgent healthcare working and an integral part of the wider health community.

- EMAS was part of the national memorandum of understanding concerning the provision of mutual aid. This is a framework through which NHS Ambulance Trusts jointly agree to provide mutual assistance on a national scale in the event of a major incident.

- Six ambulance personnel crew in Nottinghamshire provided an urgent care ambulance response service with regard to the transfer of patients between home and primary and secondary care sites. The service operated from Monday to Saturday 10:00 hrs until 22:00 hrs and on Sundays from 12:00 hrs until 20:00 hrs. They also provided support for an emergency care practitioner, provision of manual handling support, falls service support and conveyance for patients registered with a Nottinghamshire GP practice, and non-registered patients resident within Newark and Sherwood boundaries. It was a key part of the local Newark and Sherwood infrastructure for unplanned care, working on

behalf of primary care practices and with other provider partners. This ensured the best care was delivered for patients. The service was funded by a Clinical Commissioning Group (CCG).

- From April 2015 the Emergency Fire Responding Project had provided 24 cars funded by the six fire services within the EMAS region. This was a joint initiative with EMAS providing the equipment for the vehicles and the training the staff required. Fire service staff were deployed via the trust's operations centres who in turn contacted the fire service control to request attendance to assist patients.

- Senior members of each division regularly attended meetings with stakeholders such as clinical commissioning groups (CCG's) and their local acute trusts to discuss delay in handover times for patients and ways of avoiding admissions to an acute setting for certain patient groups. In Northamptonshire the trust was working with one provider to facilitate a direct admission for patients as an alternative to taking patients to the emergency department of an acute hospital.

Multidisciplinary working

- From observations we saw staff worked effectively with other organisations, such as the emergency departments in the hospitals. We saw several well-structured and competent handovers where information relevant to the patient, including any special notes, was explained in detail to the receiving emergency department staff and a copy of the PRF was left with the staff for their records.

- One senior manager in an acute trust spoke of the good relationship with EMAS and emergency department staff we spoke with confirmed this; they had never witnessed any poor or concerning practice by ambulance staff.

- An emergency department consultant informed us they respected the skills of EMAS staff and felt they could have an informed conversation with crews on arrival of a patient in the department.

- Nursing staff in all divisions commented that EMAS frontline staff were "wonderful." In one division they told us they had a "very good" relationship with them.

- In the Derbyshire division a joint police/ambulance response car was deployed for events and times of expected peak demand. For example payday weekends. A 'falls' car worked in North Derbyshire and was crewed by a physiotherapist as well as a paramedic. The crew

responded to patients who had had a fall and where physiotherapy input was required to aid with mobilisation. Holistic care-planning was used and the crew could refer the patient on to specialist services and undertake reviews.

- A community paramedic scheme in Derbyshire had been set up to work with GPs, but this had not been successful. The vehicle was now being used to respond to emergency calls.
- We identified excessive delays in hospital staff being able to receive patients from EMAS staff at two acute trusts. EMAS managers were working with senior managers at both trusts to reduce the time to the fifteen minute target set for acute trusts to receive patients from the ambulance service once they had arrived at the emergency department.

Access to information

- A variety of information was available to all emergency and urgent care ambulance staff. Policies and procedures were available on the trust's intranet system. Some were available on ambulance station notice boards. However, staff informed us they did not always have time to look at them as they were busy responding to emergency calls. Clinical updates or changes in procedures were generally emailed to staff but there were no systems in place to ensure staff had read and understood the information they were sent. Staff could access the trust's intranet from home via a log-in through the public website.
- All paramedics had access to the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) Ambulance guidelines (2013) on expert clinical advice. We saw two newly appointed paramedics who had been given a pocket version of the guidelines with laminated inserts for additional medicines either carried by or due to be carried by ambulance staff. For example, intravenous paracetamol.
- The Chief Executive of EMAS sent a bulletin to staff on a regular basis. The bulletins dated 27 October and 17 November 2015, included details about the forthcoming CQC inspection, an article about global antibiotic awareness week and learning from incidents.
- A new publication entitled 'In Focus' was launched in August 2015 for staff to receive clinical and quality updates. This contained direct links to EMAS policies.
- Paramedics had access to the Pathfinder pocket book. In addition, if ambulance staff used the e-version of the

patient report form (PRF) it was available on their Toughbook. Staff using the Toughbook had access to a system for identifying poisons, incident reporting and staff rotas.

- Staff could not leave a copy of the electronic PRF with patients who had received a 'see and treat' visit from a member of EMAS staff. Therefore, if the patient had needed to ring for another ambulance there was no paper record in the patient's home to refer to for past treatment. However, ePRF reports gave instant access to information if it was required at a later date. For example, by the police or a coroner's enquiry. Paper PRFs took longer to access.
- Staff were able to access a team in their control rooms for advice on the directory of services and alternative pathways for patients.
- Where ambulance staff worked with GP's, they were experiencing difficulty in gaining access to patient records both before and after visiting a patient. This was because the two different electronic systems in use by EMAS and the GP practices were incompatible.
- Ambulance crews reported problems accessing information for patients with a 'Do Not Attempt Cardio-Pulmonary Resuscitation' (DNACPR) in place. We were informed they would always attempt CPR unless they had sight of a current, fully completed and original DNACPR document or a certified copy.
- In Derbyshire patients who were identified as having complex care needs or those requiring palliative or end of life care were often supported by a specific care plan document. This included details of their resuscitation status, and the action to be taken in the event of an acute emergency. The information was available electronically and in paper format. However, ambulance crews reported the care plans were not always accessible and they were unable to access the electronic version. This sometimes led to unnecessary admissions to the emergency departments in the division.
- Performance information was available on each vehicle and was conveyed to crews when they logged onto the vehicles each day
- Ambulance crews were informed by their operations centre if a patient had been 'flagged'. This included a risk of violence to staff.
- In one ambulance station we saw clinical notices in a bowl on the kitchen table for staff to look through; they were not filed appropriately.

Emergency and urgent care services

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Ambulance crews were aware of the importance of obtaining consent from patients who were conscious and able to do so before giving any form of care and treatment. For patients on their own and who were unconscious, staff acted in the patient's best interest in a lifesaving situation.
- During our observations we saw staff gaining verbal consent prior to treatment being given.
- Staff told us they involved family and carers where possible if they had not been able to obtain the consent of the patient.
- In some ambulance stations we saw flow chart diagrams informing staff how to undertake a mental capacity assessment, although not all staff were aware of this. Staff knowledge varied when we spoke with them about the Mental Capacity Act (MCA) 2005, and they recognised they would benefit from further training on the subject.
- We spoke with one staff member who was able to give a recent example of when they had undertaken an MCA assessment. Another member of staff, who told us they did not feel confident in MCA assessment, explained the process extremely well. However, we saw no evidence of how staff were supported if they had to undertake an MCA assessment and there was nowhere to record the outcome of such an assessment in the patients report form (PRF) or the electronic version of the form. We were therefore not assured MCA assessments were being undertaken correctly or appropriately.
- We were informed by ambulance staff the trust had made training on the MCA a priority during 2015. Information we received from the trust showed the number of staff who had received training in 2015 was low and varied from 12% in Lincolnshire to 37% in Northamptonshire. This included information about patients with learning disabilities and living with a dementia as part of its annual update programme three years ago.
- Some ambulance staff we spoke with were aware of the Deprivation of Liberty Safeguards (DoLS). DoLS are part of the Mental Capacity Act 2005 and staff received awareness of this as part of their safeguarding training. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. We were told by staff in Derbyshire a local policy was in place to ensure the police attended any death of a patient who was subject to a DoLS. When we asked the trust about this we were informed there was no specific policy in place but the ambulance crew in attendance contacted the police to report it; the police determined whether they would attend or not. The crew always reported there was a DoLS in place on the 'Fact of Death' pro-forma.
- For crews attending a patient with mental health needs, staff risk assessed the situation and asked for police assistance if a patient was or may become aggressive. Observations during our inspection showed an ambulance crew treating a patient with a severe mental health illness in a calm and respectful manner evidencing good people skills. They understood the legal powers in relation to transporting patients experiencing a mental health crisis.

Are emergency and urgent care services caring?

Good ●

We rated caring in the emergency and urgent care services as good.

- Feedback from people who used the service and those who were close to them about the approach of staff was very positive. Frontline staff treated patients with compassion and respect.
- Ambulance crews explained treatment and care options in a way that patients understood and involved them and their relatives in decisions about whether it was appropriate to take them to hospital or not. .
- Staff afforded patients dignity and privacy at all times and respected their confidentiality.
- When appropriate, patients were supported to manage their own health by using non-emergency services such as their GP or local urgent care centre.
- Patients, their relatives and other people important to them received emotional and practical support from ambulance crews.

Compassionate care

Emergency and urgent care services

- During our observation of care delivery by front-line EMAS staff in all divisions, we observed compassionate care to patients in ambulances, patients' homes and in the emergency departments of hospitals.

- During our periods of observation, patients and relatives across all the divisions in EMAS told us they were very happy with the treatment and care they received from ambulance crews.

- We observed patients being treated with respect by ambulance staff throughout our inspection. Patients conveyed to hospital were covered in a blanket to maintain their modesty and keep them warm whilst on a stretcher or in a wheelchair. Ambulance doors were shut after loading patients to ensure they were kept warm and their privacy maintained. Ambulance crews maintained the dignity of patients when transferring them from a stretcher to a hospital trolley or bed.

- We observed a paramedic ensuring a patient was dressed before getting them out of bed and on another occasion ensuring a patient had warm clothes and slippers on before moving them onto the ambulance.

- Staff showed patience and sensitivity to the needs of patients. Ambulance crews asked how patients wanted to be addressed and introduced themselves.

- All the interactions we observed demonstrated that staff respected patients and relatives as individuals, including those from particularly vulnerable groups such as frail elderly and those requiring emotional support.

- We observed genuine caring and compassionate responses by all EMAS staff during our periods of observation. They included speaking with a member of the public with a problem outside an emergency department and supporting a patient with specific needs who was then able to calm and treat them.

- On one occasion an ambulance crew waited for a relative to arrive before they took the patient to hospital; the relative was able to give the crew useful information about the patient.

- We observed ambulance staff speaking to patients in a kind and supportive manner while treating them. We also heard crews interacting with patients on a personal level and speaking in a reassuring way.

- Staff showed show respect towards relatives and carers that travelled with patients and were aware of their needs when attending their loved ones at home and when conveyed to hospital.

- Patients told us ambulance crews were professional and had a warm and understanding manner which reassured them. One patient told us they felt confident about the service and another described it as, "The best service ever."

- All the interactions we observed were non-judgmental and staff treated each patient as an individual whatever their circumstances were.

- Because of delays in ambulance crews being able to hand patients over to hospital staff, at one emergency department, the crew were able to obtain coffee and water in order to keep patients hydrated when this was appropriate. Crews also managed to obtain food for some patients from a ward, although there was no formal process for this and no prompts for crews to look at hydration or food during the delays.

- The Family and Friends test (FFT) was created to help service providers and commissioners understand whether patients were happy with the service provided, or where improvements are needed. It is a quick and anonymous way to give views after receiving care or treatment across the NHS. It asks one question, 'Would you recommend this service to friends and family?' Data for the EMAS FFT showed response rates were similar to the England average, but scores were often better.

- During our observations staff ensured they were positioned so that they were not overlooked when completing patient report forms (PRFs) or electronic PRFs (ePRFs). EPRFs were not left unattended at any time.

- Hospital handovers were conducted as privately as possible and staff tried to ensure that no-one apart from receiving staff could overhear confidential information about patients.

- Ambulance data screens automatically went blank when ambulance crews booked in attendance at jobs. Crews reactivated screens to check details and blanked them again before leaving their vehicles. This meant no-one else could see details on the screen when vehicles were left unattended.

Understanding and involvement of patients and those close to them

- We observed patients being involved in their care and treatment throughout our inspection. Ambulance crews

explained what they were going to do and why before treatment was given and ensured the patient understood them. If further explanations were required by the patient the ambulance crew gave these.

- Staff explained their findings, following their examination of the patient, to both patient and relatives or carers that were present and their reasons why conveying the patient was necessary. Agreement and consent was obtained if they had capacity to give this.
- If patients refused to be treated or conveyed to hospital ambulance crews respected this even if they thought the decision unwise.
- We observed during handover from ambulance to emergency department staff that patients were engaged in the conversation and were encouraged to ask questions and raise any concerns they had as part of the handover process.
- Carers were asked to help with assessments and were also permitted to accompany the patient if they were taken to hospital.
- Carers attending patients experiencing a mental health crisis were involved in their care and were invited to accompany their loved ones.

Emotional support

- Ambulance crews consistently reassured patients and provided emotional support whilst they were in their care. We observed an ambulance crew member crouch down to the eye level of a patient who was distressed and in a lot of pain to talk to them and give reassurance, whilst another held their hand. One patient told us how they had appreciated the ambulance crew member talking with them throughout the journey to the emergency department at their local hospital.
- We observed ambulance crews being very respectful, calm and supportive to distressed patients and their relatives.
- We saw an ambulance crew offering reassurance to a patient who was having difficulty breathing; this helped them relax and they became less anxious.
- We observed relatives being supported whilst treatment was being administered by ambulance crew members to their family member. They were included in discussions about the patient's medical history and current condition.

- Ambulance crews made sure relatives understood what was happening to their loved ones which helped them make informed choices about accompanying them to hospital.
- We observed an ambulance crew making arrangements for a relative of a patient to stay with another relative as they were mindful of their emotional wellbeing.
- Calm supportive treatment and non-confrontational advice was given to patients who were experiencing emotional trauma.
- Staff informed us they would support relatives as much as they could during or just after a death of a patient whilst in their care.

Supporting people to manage their own health

- In Northamptonshire a randomised trial was underway for staff to use for patients with diabetes who had recovered from an episode of hypoglycaemia (low blood sugar) following EMAS attendance. This was aimed at reducing the number of 999 calls. The randomised control trial would see a group of patients referred to a specialist diabetes nurse or advised to seek their own follow up with their GP. The number of patients who agreed to this and outcomes for patients were to be measured throughout the trial.
- In the previous twelve months between 3% and 7% of calls across the divisions had been classed as 'repeat callers' that is people who telephone the service on a regular basis. The majority of those had been in Nottinghamshire. Repeat callers were identified as such by trust staff in the operations centres and ambulance crews informed before they attended. The trust had several alternative pathways across the region but ambulance staff in attendance at a job made decisions on whether or not to follow the pathways. However, the clinical assessment teams in the operations centres advised crews if necessary on alternative and the most appropriate pathways for patients. This meant patients were not taken to hospital unnecessarily.

Emergency and urgent care services

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

Good ●

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

- The trust worked with local Healthwatch groups to facilitate a better service for local people.
- A number of different specialist clinical services had been designed to meet the needs of local people.
- A frail elderly liaison officer (FELO) was in post working with care homes with the aim of reducing inappropriate calls to the service.
- New EMAS ambulances were able to convey bariatric patients.
- Staff wore ID badges in braille as well as the written word for patients with a visual impairment and a telephone translation service was available to staff when required.
- A 4 x 4 vehicle was in use in Derbyshire to aid retrieval of patients in the Peak District who could not be accessed by an ordinary ambulance because of the terrain.
- People in the East Midlands region had access to an air ambulance service with a team of EMAS paramedics attending incidents that required a rapid response time.
- The trust had a replacement programme in place for vehicle tracker devices.
- The number of compliments had outweighed the number of complaints from November 2014 to October 2015.

However, we also found that:

- Communication cards for people with complex needs were not available on all ambulances and training on dementia had not been delivered since 2011/2012
- Frontline staff were not always available to respond to patients because all staff were attending other emergencies.
- Tracker devices on some vehicles did not function which sometimes delayed response times for patients.
- Prolonged delays at some acute hospital's emergency departments reduced the capacity of front line staff to respond to patient's needs.

- Information about the Patient Advice and Liaison Service PALS) was not always available on ambulances.

Service planning and delivery to meet the needs of local people

- In order to facilitate a better service to local people, a quarterly meeting of the Healthwatch group across the East Midlands was held with EMAS and local meetings had taken place with the chief executive, directors, divisional operations teams and the community responder's managers. Healthwatch is the independent consumer champion in health and care, working to gather and represent the views of people who use health and care services. The Healthwatch network is made of up of local Healthwatch groups across each of the 152 local authority areas and, at a national level, Healthwatch England.
- There were a number of different specialist clinical services designed to meet the needs of the local population. The trust had emergency and community first responder schemes to respond to life threatening emergencies in rural areas where ambulances might take longer to arrive.
- The trust was supported by the East Midlands Immediate Care Scheme (EMICS), which the Emergency Operations Centres (EOCs) deployed to provide pre-hospital urgent care. The EMICS were doctors in rapid response vehicles (RRV). They could provide support to crews or act as a first response. Dispatchers in EOC could deploy community first responders (CFRs) to road traffic collisions, cardiac arrests and work place incidents. They had direct radio contact with the EOC.
- Three ambulances had been purchased by Lincolnshire Fire and Rescue Service with the same specification as EMAS ambulances. The vehicles were based in Woodhall Spa, Stamford and Long Sutton. Emergency Co-Responders (ECRs) manning the vehicles had received further training in diagnostic techniques from EMAS staff but were not trained in further clinical practice. Such vehicles attending an emergency were backed up by a paramedic in a RRV from EMAS. If a patient required admission to hospital the paramedic would accompany the patient in the ambulance.
- In their own time members of staff were able to be on-call as Medical First Responders (MFRs) in the communities where they lived. They acted in a similar way to CFRs in that they responded in their own cars, but were able to take more equipment with them.

Emergency and urgent care services

- Vehicles and crews in each division and area were deployed as far as possible to reflect high and low populated areas and seasonal variations. For example, along the east coast in Lincolnshire the population increased dramatically during the summer months and procedures had been put in place to support the increase in ambulance calls. This had involved placing EMAS staff in two locations along the coast on a daily basis (one in a holiday camp) to triage and treat patients and/or signpost them to other healthcare providers where necessary. Another member of staff had been placed in the seaside resort of Skegness to undertake the same duties. This showed the trust was responding to local demand.

- As a result of Midlands and East specialised commissioning group a number of centres had been commissioned to provide specialist services across the region. When required, EMAS staff were used to transport patients from incidents and hospitals to regional centres for care. For example, the major trauma centre and neurosurgery centre at Queen's Medical Centre Hospital in Nottingham. In addition ambulances could also be required to transport sick babies to specialist centres within the region.

- Members of the Hazardous Area Response Team (HART) team based in Nottinghamshire told us that up to one year prior to our inspection the trust monitored when the HART team were deployed to undertake other duties and were not available. However, more recently they had been told not to record the information. When we asked the trust about the results of their monitoring of this they told us they were not aware this occurred. The trust informed us four members of the HART team were always available on base to respond immediately, in line with the 2015 HART specification. If the need for a HART capability was subsequently confirmed, the trust ensured an additional two HART members must be deployed within 15 minutes. The incident command desk (ICD) made arrangements to release the HART cars if they were committed to 999 calls.This meant there could be a delay in response to a serious incident if members of the HART team were not available. During our inspection HART crews were deployed appropriately. HART teams are based in each of England's 10 Ambulance Trusts (in some cases with more than one unit in each trust). This means they are able to cover the whole of England and in some cases work together on some incidents.

- The trust had a 'hear and treat' service. The clinical assessment team (CAT) could assess and triage patients that required medical help without sending an ambulance. This meant more patients could be treated and assessed in their home without being conveyed to hospital and ambulances were deployed more appropriately to serious incidents.

- The trust had developed a mental health steering group at the beginning of 2015. The steering group met once a month and senior managers attended. The group aimed to improve the service provided to patients with a mental health illness. Managers sent information to staff from the steering group.

- Paramedics working with the Lincolnshire/Nottinghamshire Air Ambulance facility based at RAF Waddington near Lincoln could respond to a call within the EMAS region within 15 minutes, ensuring patients could receive responsive, quality care in a life threatening situation.

- In the Derbyshire division a four-wheel drive ambulance had been donated by an individual to be used off-road when responding to calls with the Peak District Mountain Rescue team. This meant staff could attend patients where access by ordinary ambulances was difficult because of the terrain.

- EMAS ambulances and Rapid response vehicles (RRVs) were equipped with tracking devices. Tracking devices enabled staff in the Emergency Operations Centre (EOC) to see where vehicles were, so appropriate emergencies could be allocated to the vehicle. However, tracking devices did not work in some of the vehicles across all divisions. This meant dispatchers in the EOC needed to track manually where vehicles were in order to send them to appropriate calls which delayed response times to incidents. We saw 14 vehicles during our inspection with trackers not working. Staff in EOC were not recording and escalating the tracking issues on a regular basis. We raised the issue of trackers with managers who said they were aware of the problem and trackers were on the corporate risk register with a replacement programme underway.

- Data supplied by the trust showed there had been four separate serious incidents recorded relating to delayed response times in the period between September 2014 and September 2015. Three of those had resulted in patient deaths.

- 'Drift loss' was a phrase EMAS used to explain the number of resource hours individual divisions spent

supporting other divisions of EMAS. For example, when crews in Leicestershire supported those in Nottinghamshire. Data supplied by the trust showed Leicestershire had received a difference of 1232 hours from other divisions, and more than any other division, between June and November 2015. The majority of those hours (1495) came from Derbyshire. Lincolnshire had sent a difference of 1236 hours in the same period.

Meeting people's individual needs

- For patients whose first language was not English EMAS used two translation services, one of which was a telephone system. Data obtained from the trust showed the service was used 699 times in quarter two (July 2015 to September 2015). Staff said they used this when necessary; we did not see these in use during our inspection.
- Communication aid cards were available on some ambulances for staff to use with patients. However, these were not available on all vehicles.
- The EMAS community engagement officer met with hard to reach groups of people from ethnic backgrounds in order to ensure the service was meeting their needs.
- Staff identification badges were also in braille. This helped patients who had a visual impairment to identify staff who were caring for them.
- The Mental Health Act (MHA) Code of Practice (Parts 17.3 to 17.6) states that consideration should be given to the most appropriate method of transport for mental health patients. In Lincolnshire, if the mental health car was not available (outside the hours of 4pm and midnight), a Red call (the most urgent) was put out. In the other four divisions this always occurred unless, for example in Leicestershire, the police mental health car was available.
- In Northamptonshire we observed care given to a patient with a mental health concern and a deteriorating physical condition. The staff member delivered care in a calm and unhurried manner and worked very closely with the mental health multidisciplinary team. The crew concerned were able to accommodate additional patient escorts that were required for the safety and wellbeing of the patient and staff.
- A clinical nurse specialist in mental health had been appointed in August 2015 to develop skills and processes for patients presenting with mental health issues.

- The trust had a Frail Elderly Liaison Officer (FELO) in post who was undertaking a root cause analysis on emergency calls from care homes. The work was to determine more details surrounding the calls with the aim of reducing inappropriate calls. The number of calls amounted to 20% of all calls received. The FELO was developing a close working relationship with care homes to take this work forward
- Ambulance staff were aware of the patient passport system, which some patients with specific conditions such as renal conditions and cancer used. The passport indicated the specific hospital and ward to attend if presenting with certain symptoms. This meant patients received care in the most appropriate place for their needs in a timely manner. Staff were also aware of the passport system for people with learning disabilities; the system made sure any healthcare professionals caring for those patients would have a better understanding of their needs.
- The service had three vehicles across the region equipped with specialist equipment for moving and handling bariatric patients, although the vehicles did not transport patients. Bariatric patients are those with excessive body weight which is dangerous to health. For most people in this group, the first crew on the scene would provide immediate support for the patient's physical needs and request support. In Lincolnshire, the fire service were usually summoned to give assistance in moving patients and the majority of new vehicles and stretchers in the trust's fleet were able to transport patients up to 50 stone or 318 kilograms. There was a flagging system for addressing a number of issues. For example, where specialist equipment had been used in the past for a patient.
- Community responders were especially important in rural areas when crews were not always in the vicinity. Of the 586,380 emergency calls the trust had received between November 2014 and October 2015, community first responders (CFRs) had been first on scene in 3% of them. Organisations and charities trained the volunteers who received regular updates to ensure they retained their competencies. EMAS staff were aware of their support to the trust. The EMAS CommunityResponse Managersand Community Resuscitation Trainers (CRTs) provided support during the process of setting up community schemes as well as ongoing support.
- There was no coordinated training for staff in dementia awareness. The trust had not delivered a dementia

education module to staff since 2011/12. This meant services delivered might not take account of the needs of patients and callers living with dementia although some staff we spoke with could give us examples of how they would communicate with patients living with dementia.

- The trust held a programme of awareness raising and education for learning disabilities, which they delivered to relevant staff. This was one off training and was not part of the essential education programme. This included recognition of learning disabilities, assessment of mental capacity and the importance of making reasonable adjustments for individuals with learning disabilities. The trust developed easy read information for patients, which they could find on the trust website. The trust had produced a CD ROM and accompanying workbook in easy read format entitled "The Ambulance Service and Me". The aim of the workbook was to assist people with learning disabilities to access the ambulance service and to reduce their anxiety when using the service.

- Staff always ensured there were chaperones for patients with learning disabilities who called needing transport. In the case of 999 emergency calls staff remained on the telephone with the patient or their carer until a frontline member of staff arrived. Staff attempted to identify a family member or carer to accompany the patient to hospital.

- Only a small number (10%) of people, who rang the service regularly for an ambulance response, had care plans in place to suit their needs. This was because of a lack of capacity in the high volume service user team.

- The emergency operations centres had information on their systems on receiving calls for children with complex needs. They included plans for taking children to specific hospital wards rather than an emergency department. However, if ambulance staff judged the child should be taken to an emergency department, they would be.

- EMAS provided a number of specialist services across the East Midlands. Northamptonshire, Nottinghamshire and North Derbyshire provided a falls team who responded to elderly patients to assess their needs and provide support in order to reduce further falls. The services were delivered mainly in partnership with other organisations and funded by Clinical Commissioning Groups (CCGs) and other bodies.

- The Newark Emergency Care Practitioner Scheme was in place to attend patients via a 999 call or an urgent call for patients at home or in a care home when requested to do so by a GP or other healthcare professional.

- The Newark NG24 Urgent Crew scheme was based in Newark and Sherwood and provided an urgent care ambulance response service and transfer of patients between home and primary and secondary care sites. It worked on behalf of primary care practices (GPs).

- During Bank Holiday weekends and other peak times the trust worked with partners to run City Centre Triage units. These units provided initial assessment and some treatments for patients who would otherwise needed to attend a hospital emergency department.

- Two Lincolnshire Clinical Assessment Cars were in operation in the south of the county and which were funded by a local clinical commissioning group (CCG). Initial indications were that over 50% of patients seen were referred to alternative pathways other than A&E or treated on scene with no further action required. The hours of operation were between 8 am and 8 pm seven days per week.

- The Lincolnshire Mental Health car operated between 4pm and midnight every day to respond to patients with a mental health crisis. A paramedic and trained mental health nurse could travel anywhere within the county. This has reduced the number of patients with a mental health problem needing conveyance to an emergency department.

- Northamptonshire Frail Elderly Liaison Officer (FELO) provided a review of patients taken into hospital by EMAS staff from either a care home or secure housing. They provided support and advice to those establishments with the aim of reducing the number of repeat calls for their services.

- In one division concerns were raised by staff that they were not meeting needs of patients. They told us on night duty in particular there were insufficient vehicles and crew to respond to emergency calls if the only available crew were sent out of area. We saw a book where such issues were being logged.

Access and flow

- Dependent upon the symptoms described in the call made to the emergency operations centre (EOC) at EMAS, this determined how quickly an ambulance was dispatched.

Emergency and urgent care services

- Response times of emergency vehicles were monitored by the two EOCs for EMAS in Nottingham and Lincoln. Frontline staff said that sometimes no vehicles were available to attend a 'red' call in a specific area, especially rural areas. This frequently happened when crews were responding to other calls and were delayed in handing over patients to emergency department staff in acute hospitals. In such circumstances, a call would go out to all available crews in the area to assist. The trust used senior members of staff to attempt to alleviate the situation when ambulances were held up outside emergency departments waiting to hand over their patients to hospital staff. In Northamptonshire we saw the Fast Intervention Team respond when seven ambulances were held up at one emergency department in the county. This prompted a duty team leader to visit the ED and assess the situation; the situation was resolved without any intervention.

- At an acute hospital in Northampton a new system was in place to assess patients on arrival in the emergency department. We saw this was delaying patient's progress who were transported into the department by EMAS staff. As a result ambulance crews were waiting longer to hand over patients. In addition there had been the introduction of computer terminals in the emergency departments of two acute hospitals in the division. The ambulance arrival screen on the system displayed a mutually agreed handover time. Screens in use at the time of the inspection showed expected arrival and actual arrival times of ambulances.

- During an afternoon observation in a large acute emergency department in Northamptonshire we tracked five ambulance arrival times. One sick patient was taken straight into resuscitation for care and treatment. The other four patients with their EMAS crews queued for times ranging between 10 and 12 minutes. Staff in the department told us the average waiting time for handover form ambulance crews was between 20 and 30 minutes which exceeded the national target set for acute trusts of 15 minutes.

- Shortage of ambulance crews was a limiting factor in the responsiveness of the service. Overtime was offered to front line staff prepared to work it in order to increase the number of staff on the road. Staff were also encouraged to join the staff bank to work additional hours when and if they wanted to.

Learning from complaints and concerns

- Information about the Patient Advice and Liaison Service (PALS) was not always available to patients or relatives on vehicles. However, staff informed us they would always give people who wanted to complain the phone number for EMAS headquarters.

- The trust had consistently achieved their 100% target for acknowledging complaints and concerns raised through the Patient Advice and Liaison Service (PALS). The PALS team was contactable through the trust website; it offered an email address, telephone contact number and an address where contact could be made to EMAS. In addition, the process of how complaints were handled and the role of the Parliamentary and Health Service Ombudsman (PHSO) were also explained. The trust had had one complaint upheld by the PHSO during the last year.

- The trust board had approved the centralisation of the PALS process. Recruitment for the posts within this service had been completed and induction of staff was in progress.

- The compliment-complaint ratio for 2014/15 was over 9:1, with a total of 1083 compliments compared to 117 complaints. This represents an improvement on the ratio of just over 2:1 with 464 compliments and 177 complaints achieved in 2013/14.

- The number of complaints received fell from 177 in 2013/14 to 117 in 2014/15. This represented a decrease of 34%. In 2012/13, the number of complaints was 229. The trend of continuous fall in complaints, in conjunction with a 133% increase in compliments, could indicate continuous improvement in patient experience for patients, their families and carers.

- The main theme of complaints in the time period 1 November 2014 to 31 October 2015 was delayed response times in four of the five divisions. The trust had implemented actions to rectify the complaints which included recruitment of additional staff.

- The investigation of complaints had been made more robust and rigorous through the setting up of a dedicated team of investigators and the trust had introduced an independent peer review of formal complaints by another NHS ambulance trust.

- The trust's comprehensive complaints policy stated that all complaints should be concluded within 30 days with resolution meetings being offered. Between 1 November 2014 and 30 October 2015, 52 complaints

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had been responded to within this timescale. A further 28 had taken between 35 days and 60 days and another three over 60 days. Advocacy services were offered to complainants if required.

- The percentage of compliment letters acknowledged within the trust's five day target was increasing, with 99% achieved in 2014/15 compared to 95% in 2013/14 I and 84% in 2012/13.
- In some ambulance stations information about complaints was displayed on notice boards. For example, in Northamptonshire the top three themes from complaints was visible although the majority of staff we spoke with were not aware of the information.
- Information received from the trust showed the learning from complaints that had taken place; this was in the form of recommendations.
- When a complaint was made about a member of staff relating to them or the care they gave, experiences differed about whether they received on-going information. A member of staff recalled they were updated on the outcome of an investigation. However, another member of staff stated they received no information regarding complaints and told us of an incident which occurred in the summer of 2015 for which they had not been updated about the outcome.
- Performance management was undertaken for staff members in some cases where complaints were made. Performance of the staff members was then monitored to ensure improvement had been made.
- The trust had implemented the Friends and Family Test (FFT) comment card for 'See and Treat' patients, that is patients who had been attended by EMAS staff, treated and left at home because there was no need to transport them elsewhere.
- The trust had improved communication with patients and their families through the development and implementation of a calling card which was being left at the address of a patient being taken to hospital for the patient, their relatives or carers to complete. We were informed that staff in Northamptonshire had raised a concern that the cards did not have the name of the division on them so comments or concerns could not be attributed to the correct division. The trust was also using questionnaires for complainants and electronic software for online feedback.
- The trust had included patient experience within their quality everyday programme. Audits undertaken helped

raise awareness among clinicians and other staff about the Patient Advice and Liaison Service (PALS), complaints and the importance of good customer service.
- Patient stories were a feature of EMAS Board meetings, with patients and/or their carers sharing their stories and making their experiences personal.

Are emergency and urgent care services well-led?

Requires improvement ●

We rated the emergency and urgent care services as requiring improvement for well-led.

- All staff had respect for the Chief Executive Officer and were appreciative of the progress made in the organisation.
- Although staff were not directly engaged with the vision and strategy of the organisation they displayed EMAS values through their own working practices.
- Governance systems were in place and a remedial action plan formulated to improve performance figures.
- In the main, staff were positive about the direct local leadership.
- Public and stakeholder engagement activity took place in many forms.
- 'Listening into Action' had been introduced in the trust to engage staff with change.
- Patient stories had been a feature of the trust's board meetings making the issues raised both personal and vivid.

However, we also found that:

- Staff morale was low with the majority experiencing high levels of stress, work overload and not feeling valued.
- Staff were frustrated at not being able to achieve national targets but were focussed on delivering quality patient care.
- There were no systems in place to record if staff had read communications from senior managers and minimal time for staff to be part of face to face meetings.
- Some systems and processes in use across the divisions differed and were not trust-wide, therefore leading to fragmentation and inconsistency.

- Risk registers were held at divisional level and local teams had no knowledge of the progress made or actions taken to mitigate them.
- Team leaders had insufficient time to manage their staff appropriately because of operational pressures.
- Support mechanisms were in place for staff to access if necessary although some felt unable to use them whilst others stated they did not feel supported.

Vision and strategy for this service

- The majority of the staff we spoke with, including team leaders, were not aware of the trust's vision or strategy for the service despite these being visible in some of the ambulance stations we visited. The trust's board meeting minutes of 28 July 2015 showed the trust's vision and values had been attached to payslips for all staff on 23 July 2015 and had included key messages from the Annual Report.
- Operational staff were aware of the trust's values, 'Respect, Integrity, Contribution, Teamwork and Competence' and in some instances could quote them all.
- Through discussions and observations of service delivery during our inspection the commitment of staff to saving lives displayed their individual values and behaviour which aligned with the trust's vision; 'To play a bigger part in the community through enhanced emergency and urgent care services delivered by proud, respected, highly skilled and compassionate staff.'
- All of the operational staff we spoke with demonstrated their high level of commitment to provide a good quality and safe service although they were frustrated at not being able to always achieve national target times for responses to emergency calls.
- Most communication with staff was via emails. The trust informed us when staff used their personal email addresses for communications, they were able to use a communications direct database to track who received and opened emails. Because of the limited time spent at ambulance stations and varying shift patterns there was little time for face to face meetings.

Governance, risk management and quality measurement

- Performance of attaining national targets for response times was monitored and reported at divisional level, i.e. in each of the five counties that EMAS served. The Chief Executive of the trust attended the divisional

performance review meetings each quarter which meant the Board had a good overview of how performance was being managed in each division. As performance levels were still not attaining national response time targets in July 2015, the trusts' Board meeting minutes reported a Remedial Action Plan (RAP) had been put in place to improve the performance across the divisions.

- Risk registers were kept at divisional level. The numbers of identified risks across the divisions ranged from eight in Northamptonshire to 23 in Leicestershire. The risks were graded according to severity, with performance ratings risked as the most high; staffing issues were also given a high priority. Risk registers showed actions that had been taken to mitigate the risks raised. Some senior managers we spoke with were not aware of what was on the divisional risk register. Premises risks were present for each of the divisions; in total 11 risks in ambulance stations across the divisions had been identified. This included the general poor condition of Coalville resulting in constant infection prevention and control inspection failures. The risk of slips, trips and falls in stations across Lincolnshire owing to the lack of maintenance had been identified and the station doors at Heath in Derbyshire were in a poor state of repair and difficult to use.
- Members of the Hazardous Area Response Team (HART) team based in Nottinghamshire informed us that up to one year prior to our inspection the trust monitored when the HART team were deployed to undertake other duties and were not available. However, more recently they had been told not to record the information. When we asked the trust about the results of their monitoring of this they told us they were not aware this occurred. The trust informed us four members of the HART team were always available on base to respond immediately, in line with the 2015 HART specification. If the need for a HART capability was subsequently confirmed, the trust ensured an additional two HART members must be deployed within 15 minutes. The incident command desk (ICD) made arrangements to release the HART cars if they were committed to 999 calls. HART teams are based in each of England's 10 Ambulance Trusts (in some cases with more than one unit in each trust). This means they are able to cover the whole of England and in some cases work together on some incidents.
- Although incident reporting was centralised via an electronic system, quality team managers in each

division were responsible for grading the incidents in their own division and undertook investigations. This gave them an overview of themes and trends locally and individual staff members received feedback when and where it was appropriate.

- The governance of Community First Responders (CFRs) was monitored by the organisation or charity responsible for their recruitment. (CFRs are volunteers who give their own time to respond to emergency calls made to EMAS in their own community). All responders were required to attend on-going professional development and refresher training which was monitored by their own organisation and records maintained.

- Patient record forms (PRFs) were completed by staff for each patient they attended. These were either in paper format or via an electronic hand-held system. Clinical team leaders sampled and reviewed them against a pre-determined set of criteria. For example, clinical impression, pain score and whether oxygen was administered. Records were available to evidence this was an on-going review process. However, staff in Nottinghamshire stated they did not receive any feedback on the outcome of the audits.

- Systems and processes in use were not always trust-wide in nature. We saw two different systems in place for documenting information relating to coroner's cases.

- Governance systems for the paramedics working with the air ambulance were very robust. They used the same system as the rest of EMAS which fed into an associate operations director and medical director of the trust. Crews attending a patient and using any clinical intervention above what was considered 'normal' completed a 'rationale' pro-forma and discussed the treatment of their patient, anything they had learned and anything they needed to change as a result. The paramedics held a governance day every three months which was attended by all air crew, doctors and pilots plus other interested staff such as clinical mentors. Statistics of cases were discussed and where possible a clinical presentation was given by a doctor and a scenario enacted followed by a de-brief. This enabled the paramedic staff to learn from the jobs they had attended and improve on their expertise.

- Governance systems were in place for third party private and voluntary independent ambulance providers working for EMAS. The trust required evidence from

those providers that demonstrated clinical quality was being appropriately identified and monitored. It included resource levels, code of conduct, regulation of medicines and complaint management. Private providers were expected to comply with a series of quality standards including training and sign off for competencies. Meetings (both face to face and via telephone) were arranged on a monthly basis and inspections were undertaken. This ensured these providers were operating to EMAS standards and expectations.

Leadership of service

- Without exception all the staff we spoke with across the divisions were positive about the Chief Executive. They described her as being approachable, with some staff having met with her during their regular 'tea with the chief' sessions. Staff felt she was supportive and more engaged with them than had previously been the case.

- The visibility of other executive team members was varied but posters had recently been displayed in ambulance stations showing photographs of the senior team. The chair of the trust had carried out observation shifts on vehicles which staff appreciated.

- Each of the five divisions had a general manager responsible for its operational management. Their role included both a corporate and divisional focus. Staff generally felt supported by this level of management. In the Nottinghamshire division the role of station manager had been reinstated in response to feedback from staff in 2014; staff in the division told us they felt more supported because of this.

- [DS1]Locality quality managers (LQMs) were responsible for investigating complaints and serious incidents and sitting on the local adult safeguarding board and trauma network. In addition they dealt with requests for information from coroners as well as supporting staff during coroner's hearings. They informed us they did not receive any formal training for their current role; they shadowed other LQMs and learned from them. The trust informed us training for dealing with coroner's inquests had been offered to LQM's and other staff. This group of managers held daily conference calls with other LQMs across the trust to discuss performance, availability of staffing and sickness levels. It was also a forum for sharing of good practice.

- Team leaders were aware they needed to be accessible and available for staff but current service demands

meant that this was sometimes difficult to achieve as they were required to respond operationally rather than support staff. Team leaders did not manage a dedicated team of staff, but were available to support any member of the frontline team who required support. Some of the staff we spoke with thought local leadership from team leaders at their station was good. They felt there was a good relationship amongst all frontline staff which fostered mutual support and encouragement. We saw this when we attended acute trusts to talk with staff who were waiting to hand over patients to staff in the emergency departments. However, other staff told us they did not see team leaders enough, although were encouraged to call the appropriate staff for clinical support. Staff at some of the more rural stations we visited felt isolated which in turn led to low staff morale. One team leader we spoke with explained it could be difficult to catch up and talk with busy staff.

- At frontline and middle leadership level during our inspection 66 staff were in internal seconded positions. The majority of these were frontline leaders. This meant staff were uncertain about their futures and leadership teams were not stable.

- Support mechanisms were in place for staff. An employee assistance programme was in place for all staff to access counselling. The trust's occupational health provider was also able to provide specialist counselling services such as Cognitive Behavioural Therapy (CBT).

- More informal staff support mechanisms were in place for staff to access. These included Trauma Risk Management (TRiM), P2P (Peer to Peer) and Pastoral Care Workers (PCW) as well as the support of a full-time chaplain and mediation service. However, staff attitude to these services varied. Some thought them worthwhile whilst others were more sceptical and concerned about confidentiality.

- Staff did not always feel they were supported after responding to a traumatic call. We heard examples where staff not given any time to recover or debrief before being sent out again because of operational pressures.

- All staff we spoke with were aware of national targets. They were frustrated that they were not able to achieve targets but were focussed on good clinical care for patients.

- Most communication with staff was via emails. The trust informed us when staff used their personal email

addresses for communications, they were able to use a communications direct database to track who received and opened emails. Because of the limited time spent at ambulance stations and varying shift patterns there was little time for face to face meetings. Some staff told us communication was a problem.

- Most of the staff we spoke with were concerned about working shifts without rest breaks or not being able to finish their shift on time.

Culture within the service

- Staff told us they were proud to work for EMAS and loved their jobs but felt the organisation did not value them. Some staff told us goodwill was being eroded because of this.

- From our observations we saw all staff were committed to ensuring patients received a good service and their behaviours reflected the values of the organisation.

- Five members of staff in two divisions told us they perceived there was a bullying and harassment culture within the local team. Concerns raised included management not listening to concerns, lack of work/life balance, late or no meal breaks, failure to offer support and a mis use of trust policies in order to control staff. Prior to and during our inspection we received a small number of anonymous whistleblowing enquiries related to bullying management styles. We escalated this to the trust and they took action to follow these up.

- We heard negative concerns from some staff about lack of support by the organisation and inconsistent management practices between divisions. We could not be assured that the culture in the service encouraged openness and transparency, although we observed good team work and patient care.

- Results for the trust in the NHS Staff Survey for 2014 showed EMAS was in the top 25% for 28 of 31 questions asked. A total of 86 questions were used in both the 2013 and 2014 surveys. Compared to the 2013 survey, EMAS had a significantly better response to 15 questions including staff feeling satisfied with the quality of work and patient care they were able to deliver and staff recommending the trust as a place to work. The trust showed no significant difference in 67 questions and scored worse in four questions including receiving no training in how to handle violence to staff/patients and not having clear, planned goals and objectives.

Public and staff engagement

Emergency and urgent care services

- Listening into Action (LiA) had been introduced in the trust. This was first discussed and approved at a public Trust Board meeting in EMAS in January 2014. LiA is a scheme designed to engage staff in change within the organisation and has been used in many NHS trusts across the country. LIA was set up with groups in each of the divisions to discuss and take forward issues. For example, in Northamptonshire a group of staff had put together an aide memoir for new starters. This held information for new colleagues about important telephone numbers and addresses for ambulance stations. Other projects included equipment availability for frontline staff and a project looking at improving the service for elderly members of the community, working with residential and care homes who frequently called 999 along with other aspects of community engagement.

- All staff were aware of the Chief Executive's bulletin. This was available in both electronic and paper format. Items included in the bulletin included a focus on individual staff members who had received praise from patients for their care and partnership working between EMAS and Leicestershire and Rutland Fire and Rescue Service.

- In an attempt to improve communication across the Nottinghamshire division, the Nottingham management team had produced 'The Notts Responder' a newsletter designed to ensure information was shared across the county. The locality manager for North Nottinghamshire had commenced informal meetings called 'team talks'; we saw evidence of these planned into the diary and dates of the events displayed on notice boards.

- A quarterly divisional review group was held, with staff representation, promoting excellence in safety and care. We saw evidence of issues raised in the October 2015 meeting including the importance of undertaking daily vehicle checks and completion of documentation when treating patients.

- Staffing rota consultations were held annually, although not all staff felt their views were listened to.

- The trust had a staff award system. Managers kept a record where positive feedback was given about individual staff members; this was used to make decisions about which staff should be nominated for the awards which were made quarterly.

- The community team from the trust regularly hosted and attended events across the divisions. For example, in December 2015 five events had been planned in locations in Northamptonshire, Lincolnshire and Leicestershire. In September 2015 trust staff had attended an event in Leicestershire, 'Pass it on Leicester' where they had been promoting EMAS as part of the campaign to raise an awareness of blood cancer.

- Evidence we gained from ambulance stations showed the general public appreciated and respected the skills of ambulance staff. In many ambulance stations we saw newspaper clippings and 'thank you' cards thanking the crews for their help, care and support to either the patients or members of their families.

- During the year April 2014 to March 2015 patient stories had been a feature of EMAS Board meetings, with patients and/or their carers sharing their stories and making their experiences vivid and personal. The trust recognised that this was a means of highlighting compliments and confronting their challenges. In the Patient Experience Annual Report 2014/15 the trust identified seven issues as a priority for 2015/16. This included widening the options for feedback and developing more opportunities, including face-to-face/ interactive options, for sharing lessons learned from complaints and Patient Advice and Liaison Services (PALS) concerns.

- Electronic software for online feedback from the public was available on the trust's internet site.

- In order to ensure patients with mental health problems were treated by the most appropriate clinicians and in the right setting, regular meetings were held with mental health colleagues at local mental health trusts; the focus of this was Section 136 of the Mental Health Act (MHA). This section of the MHA relates to people who may be at home or in another place and who are deemed to be dangerous to themselves or others and need removing to a place of safety.

Continuous improvement and sustainability

- In Leicestershire a Smartphone project was being piloted with the issuing of five phones which had been uploaded with an application linked to a mobile directory of services. This was currently in the test phase and the plan was to roll out to all staff in Leicester, Leicestershire and Rutland in 2016. Access to alternative care pathways and the paramedic pathfinder pocket book would be included. This would give frontline staff on the road instant access to information.

- In Lincolnshire, a rapid response vehicle (RRV) had been made available from 17:00 hrs until 24:00 hrs manned by a paramedic and a mental health nurse from the local

mental health trust. It was commissioned by the local mental health trust. Based in Lincoln, the RRV could respond to any mental health crisis in the division that was not in a hospital. The acute trust and police force were positive about the initiative which had reduced the number of double crewed ambulances attending such patients and the number of them admitted to an emergency department.

Patient transport services (PTS)

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

Information about the service

Patient transport services (PTS) provide non-emergency transport for adults and children who are unable to use public or other transport due to their medical condition. This includes those attending hospital out-patient clinics, being discharged from hospital wards and those who need treatment such as chemotherapy or renal dialysis.

East Midlands Ambulance Service (EMAS) is commissioned to provide PTS in North and North East Lincolnshire. There are 30 PTS ambulances operating from Grimsby and Scunthorpe ambulance stations. These ambulances serve the two local hospitals, Diana Princess of Wales Hospital and Scunthorpe General Hospital, plus Goole and District Hospital. They also cover six GP surgeries and all care homes and hospices within NHS North Lincolnshire. Forty-two volunteer drivers using their own cars support this service.

In addition, two PTS ambulances based at Nottingham Queens Medical Centre (QMC) provide eligible patients with transport home from the emergency department (ED). These ambulances will also transfer mobile patients from the ED to the City Hospital Nottingham for admission.

The patient transport service recorded 98,742 patient journeys between April 2014 and March 2015.

There are 103 staff employed in the service made up of 58 substantive staff and 45 bank staff. The substantive staff consist of 35 care assistants, 12 control staff, one service manager, three team leaders, six patient transport drivers and one customer service manager.There are also 42 volunteer drivers.

During our inspection, we visited two ambulance stations where we spoke with 14 staff including team leaders, maintenance staff, administration staff and ambulance crew. We spoke with six volunteer drivers and observed six patient transport staff during their shift. Our observations included patient journeys from their home or care home to outpatient departments and a renal dialysis unit.

We spoke with 23 patients using the patient transport service in a variety of settings. This included patients on ambulances and those waiting for collection from the hospitals or the renal dialysis unit. We were also able to speak to four patients who had previous experience of using the service and four carers who were accompanying patients on their journey.

We spent time in the PTS control centre where all aspects of booking and transport is coordinated. This was also the main communication hub between transport planners and PTS crews out in the community.

We also visited Nottingham QMC ED and spoke with two ambulance crew members and ED staff.

Patient transport services (PTS)

Summary of findings

The patient transport service (PTS) serving north and north east Lincolnshire and the emergency department (ED) in Nottingham was considered to be requires improvement for safe and well led and good for effective, caring and responsive.

The PTS ambulance and control teams worked well together to provide an effective and responsive patient transport service to meet the needs of the population it served. The service was supported by a team of 42 volunteer drivers. Volunteer drivers used their own vehicles to transport patients. Vehicle documentation for MOTs and insurance had not been consistently checked and recorded.

Communication between the control staff and drivers demonstrated an embedded respect for each other and good working relationships.

Staff demonstrated safety awareness and ensured each patient journey was as safe and comfortable as possible. This was reflected in the positive comments received from patients, carers and staff from local hospitals and care homes.

Staff knew how to report incidents and understood their responsibility to submit reports in a timely way. However, there was little evidence of sharing and learning and staff were unable to identify changes made following a reported patient safety incident.

Staff attended a comprehensive induction when joining the service but attendance to mandatory training did not meet the trust target of 95% with some key topics such as resuscitation and moving and handling showing minimal attendance.

Staff did not consistently receive annual appraisals to monitor competency and support professional development. Dates for appraisals were set for all staff but frequently cancelled at short notice.

Are patient transport services safe?

Requires improvement ●

Incidents

- The patient transport service (PTS) staff demonstrated an awareness of patient safety. Staff knew how to report an incident and understood their responsibility to raise and report incidents and concerns.

- Incidents were reported in three ways: through the trust's electronic reporting system, by telephone or in paper format. The most frequently used method was by telephone. Staff reported the telephone line was frequently busy resulting in delays of up to 24 hours before an incident was reported. However, for serious incidents, the reporter would contact their line manager immediately who would take details, report the incident electronically and initiate actions if necessary. Staff received an automated email acknowledging receipt of an incident report following submission.

- Incidents were rare within PTS with one serious incident reported by PTS in the year April 2014 to March 2015. This was following a delayed response to a 999 call placed by a volunteer driver for a patient with chest pain. We reviewed the investigation report, which demonstrated a thorough analysis of the incident and a completed action plan. However, there was no recommendation or action for sharing and learning across the organisation to prevent a further recurrence.

- Staff were not familiar with the Duty of Candour Regulation but said they would be open and honest with people if things went wrong. The Duty of Candour Regulation requires healthcare providers to be open and transparent with people about the care they receive when things go wrong.

- There was minimal formal feedback to the PTS teams relating to incidents within PTS or East Midlands Ambulance Service (EMAS) as a whole. We reviewed team leaders' meeting notes and action logs for 2014/15 and found no evidence of sharing and learning from incidents. However, there were notice boards in each

Patient transport services (PTS)

station entitled 'Quality everyday', which included incident descriptions. Staff told us there was limited time in their working day to access information on notice boards or emails.

- We were told important news would be shared in person by their team leader or in written format left in their personal drawer (pigeonhole) at the base station. Staff were not able to give any examples of changes made following a reported incident

Mandatory training

- The statutory and mandatory training requirement was a yearly update for infection prevention, information governance, moving and handling and resuscitation. For fire safety update was bi-annually and three yearly for safeguarding, conflict resolution, equality and diversity and risk management.

- Mandatory training records as provided by the trust identified a low percentage of staff attending subjects requiring annual updates. Of the 52 ambulance staff none had completed resuscitation and only 2% had completed the moving and handling updates since April 2015. Control staff were up to date with mandatory training. Other subjects averaged 73% attendance. The trust target was 95%.

- We reviewed six staff training records and found these to reflect the data presented by the trust. Four had attended training during 2014/15 and two had records dating 2011/12. The trust was in the process of transferring to a computerised training record system and told us some records might be out of date during the transition process.At the time of our visit to the training centre, the computerised system was not working so we were unable to corroborate this.

- Volunteer drivers did not attend mandatory training. Updates were shared with them by letter and through information boards located at the ambulance liaison desks.

Safeguarding

- There were processes in place to safeguard people from abuse. Staff were aware of safeguarding, gave examples of how they identified concerns, and how they would report them through the direct safeguarding telephone number or to their team leader.

- Team leaders, when notified of a safeguarding incident told us they recorded all information available and escalated to the safeguarding team. In severe cases, the police would also be notified.

- The EMAS safeguarding team trained all staff at induction to level two. Updates were three yearly with 79% of staff having completed an update within the required three year period against a trust target of 95%. This was evident in the training records reviewed. Safeguarding has three levels: level one for employees who do not come into direct contact with patients, level two for those who have contact with patients and level three for those who have contact with children and young adults.

- Safeguarding information, including guidance on the mental capacity act, domestic violence and dementia awareness was displayed on notice boards at each station. Clinical team leaders maintained and audited these boards monthly.

Cleanliness, infection control and hygiene

- All PTS vehicles we inspected were uncluttered and visibly clean. Equipment was labelled and stored in the cupboards provided.

- Personal protective equipment (PPE) including gloves and aprons were easily accessible on the vehicles. All disposable items had intact packaging and were within their use by date.

- Cleansing wipes were available and we saw staff cleaning chairs and equipment after each patient. Hand gel was readily available and observed to be used by PTS staff. A crystallised disinfectant was provided for use on spilt body fluids.

- The trust's infection prevention and control (IPC) team audited a sample of vehicles each quarter. We viewed eleven IPC audit forms, which indicated compliance of 86% to 100% with a Trust target of 100%. Non-compliance was generally rectified immediately at the station. The infection control team told us the most common issues were out of date disposable items or damaged trolley strappings. We saw recorded evidence where non-compliance had been rectified and a feedback email to the station leader confirming that the checks were complete.

Patient transport services (PTS)

- Vehicles had a deep clean every six weeks with the next due date displayed in the cab window. There was a dedicated vehicle cleaner at each station who described the deep cleaning process. Cleaning records for each of the vehicles was available.

- Staff had access to the cleaning policy for reference. Staff could describe actions for the disposal of clinical waste and told us they would return to base as soon as possible to facilitate deep cleaning if necessary.

- In line with good practice, staff were bare below the elbow, which meant they could effectively clean their hands and wrists, reducing the potential spread of infection.

- The infection control team informed us that they had recently commenced a programme of visiting each station to discuss premises cleaning.

Environment and equipment

- All the vehicles viewed appeared to be in good condition throughout although some driver floor mats were worn. We brought this to the attention of the station maintenance crew.

- Staff completed a vehicle check at the beginning of each shift, using a checklist booklet, specific to each vehicle. This included checks of electrical equipment for example lights and radios, non-electrical equipment such as patient safety equipment and chair restraints, and medical equipment including oxygen and first aid boxes. We observed this checking process and reviewed the checklist booklets for two vehicles, which were completed.

- Vehicle records indicated they were regularly serviced under manufacturer's warrantee at specialist dealerships. Records indicated that those vehicles requiring an MOT were up to date. There was a five-year replacement programme for vehicles however some had been in service for up to seven years.

- There was a system for reporting defects. These were appropriately assessed and repairs organised in a timely manner.

- Vehicles were fitted with a winch for use when assisting patients in wheelchairs onto a vehicle. We observed staff checking and using this equipment safely.

- Patient equipment such as walking aids could only be carried with prior arrangement due to limited space and the need to secure all items during travel. However, we did see staff showing flexibility when a patient's walking aid was secured and transported despite not being booked.

- There was a variety of equipment on the vehicles to promote the safety of patients. This included standard safety belts, strapping to attach wheelchairs to the vehicle floor and padded supports to ensure wheelchairs were secure during the journey. We witnessed the use of all these restraint systems, which were adjustable according to patient size from bariatric to small adult or child. The service occasionally transported children who were accompanying adult patients.

- Vehicles were fitted with appropriate moving and handling aids, which included slide sheets, banana boards, and lifting belts. Staff were confident in the use of these aids.

Medicines

- PTS vehicles did not carry any medication other than oxygen. Patients or their escorts were responsible for their own medication whilst in transit.

- Oxygen cylinders were available, although patients receiving ongoing oxygen therapy carried their own supply with them.

- Oxygen cylinders on the vehicles had a sticker indicating the delivery regulators had been checked and the oxygen was within date. Staff checked these during the routine morning vehicle checks. We looked at vehicle check books and found that oxygen was checked prior to the start of each shift.

- Replacement oxygen cylinders were stored at the stations and secured with a collar system to prevent them falling.

Records

- Electronic records showed checks of volunteer driver's MOTs and insurance were not up to date. We brought this to the attention of their manager who told us this information was available in paper format waiting to be uploaded onto the electronic system. We looked at a sample, which had been completed. However, despite

Patient transport services (PTS)

assurances about electronic records being updated urgently this had not been completed when we returned for an unannounced visit ten days later. Some electronic records were up to three years out of date. All volunteer drivers had received a letter in the month prior to our inspection requesting them to present driving and vehicle documents for verification.

- PTS drivers received printed work sheets at the start of a shift. These included collection times, addresses and patient specific information such as relevant medical conditions, mobility, and if an escort was travelling with the patient. Information was stored in the driver's cab out of sight, respecting patient confidentiality.

- PTS staff received information via mobile telephones, although staff told us these were unreliable at times due to network coverage and short battery life. Team leaders were assessing this issue although it was not on the risk register. Staff told us this was not a direct risk to patients as information was recorded on the daily job sheet and updates could be received through the radio system. However, they felt the mobile telephone system was better for patient confidentiality.

- Patient medical records were transported in an envelope and handed directly to a nurse or carer on arrival at the destination.

- Do not attempt cardiac pulmonary resuscitation (DNACPR) orders were communicated in advance of journeys to PTS crew. This would be on their job sheet or mobile telephone.

Assessing and responding to patient risk

- Information about patients' needs, collected at point of booking, was communicated to PTS staff on their printed work sheets. Many patients were regular users of the service for whom staff could prepare in advance.

- We observed staff providing appropriate support for a new user to the service who had variable mobility issues.

- Staff told us if a patient became unwell during a journey, they would stop their vehicle as soon as it was safe to do so. Staff were familiar with the guidelines for calling for the assistance of an emergency vehicle.

- Patients with challenging behaviour were generally accompanied by a carer or relative. One PTS staff member recalled a patient displaying unexpected challenging behaviour and having to stop the vehicle and call for assistance, as per policy, by radio.

- Volunteer drivers were provided with instruction about responding to changes in a patient's clinical condition or behaviour within their handbooks. One volunteer driver told us that he had not had to call for assistance but would not hesitate to do so.

- During periods of high activity or difficulties due to adverse weather conditions patients with life threatening conditions were prioritised. This included patientsrequiring renal dialysis or chemotherapy.

Staffing

- Staff vacancies within PTS were low however, turnover was high due to staff choosing to progress their career within the service to work in emergency and urgent care. For this reason, the service had regular recruitment drives.

- Following recent recruitment there were no vacancies in the Nottingham PTS team and the North & North East Lincolnshire team had 3.69 whole time equivalent (WTE) vacancies (5%).

- Bank staff were utilised to fill gaps in the rota when required.

- Staffing levels generally matched planned levels.

- Staff sickness rates fluctuated during 2015; 6.5% in January rising to 6.9% in May then falling to 1.9% in August. The August 2015 rate was the lowest since July 2014. This was following a recent recruitment drive.

Anticipated resource and capacity risks

- The service had a business continuity response and recovery plan, which was aligned to the Business Continuity International Standard ISO 22301 providing a framework for the service to prepare for, respond and recover from service disruptions, whatever the source from bad weather conditions to major incidents. This was a comprehensive document, which was available on each station.

- The trust's major incident plan included the role of PTS in a major emergency. The plan included potential

Patient transport services (PTS)

emergencies locally and nationally. PTS staff were involved in major incident response rehearsals. Staff told us they would seek guidance from their team leader in the event of a major incident.

- PTS drivers ensured vehicles were always left with a full tank of fuel in preparedness for public transport should a major incident occur.

Are patient transport services effective?

Good 🟢

Evidence-based care and treatment

- East Midlands Ambulance Service (EMAS) had policies in place to support evidence based care and treatment. These included the infection prevention and control policy reviewed 2015 and Risk Management Standards for Ambulance Trusts (NHS Litigation Authority; January 2010). These were applicable to the PTS and were accessible through the trust's intranet. Guidelines for the administration of oxygen followed national ambulance pre-hospital and British Thoracic Society recommendations.

- There was a lack of specific PTS policies. We were directed to trust wide documents for guidance, for example, medicines management, oxygen administration and care of a deteriorating patient were available on the trust wide intranet.

- Eligibility for patient transport reflected Department of Health guidelines and was monitored by the control centre staff at point of booking. Patients discharged from hospital had their clinical need for ambulance transport assessed by a qualified nurse.

Assessment and planning of care

- The control centre staff assessed patients' needs at the point of booking. The assessment included relevant information, such as the patient's level of mobility, sight or hearing problems and any need for a relative or carer to accompany them. This enabled control staff to plan appropriate transport to meet individual needs.

- PTS staff received written information, on their daily job sheet, about patients' requirements; this was supported by information sent directly onto their mobile telephone and was updated during the shift. We observed staff receiving and responding to information received.

- PTS staff used the information provided and local knowledge to ensure patients were prioritised appropriately. Staff said they occasionally changed the running order if driving conditions changed, for example unexpected traffic delays, which may affect patient's treatment. This was particularly relevant to patients having renal dialysis or chemotherapy.

- We observed PTS staff assessing patients' needs at the point of pick-up and offering assistance to board the vehicle as appropriate.

Nutrition and hydration

- PTS staff did not routinely provide food or drink for patients during their journey. Staff told us they reminded patients to eat and drink before travelling or to bring some food with them for the journey. We saw a patient with diabetes bring biscuits on the advice of the driver.

- Patients told us they generally came prepared with snacks and money to purchase drinks.

- There was a small supply of drinking water available on the vehicles should it be required.

- There were vending machines or catering facilities in the patient waiting areas adjacent to the ambulance liaison desks.

- Ambulance liaison staff told us they would occasionally make drinks for patients who had been waiting a long time for their transport home or were unable to use the hospital facilities.

Patient outcomes

- There were key performance indicators (KPIs) set by commissioners for the PTS based on national guidance. KPIs are a set of quantifiable measures used to gauge or compare performance in terms of meeting agreed levels of service provision.

- The trust's outcomes for PTS KPIs April to September 2015.were:

Patient transport services (PTS)

- 98% of patients recorded as arriving prior to or up to 30 minutes after an appointment time. This exceeded the KPI target percentage of 95%.

- 92% of patients collected within 60 minutes of the time they were ready following their appointment. This was below the KPI target of 95%.

- 96% of patients were on vehicles for less than 90 minutes. This exceeded the KPI target of 95%

- EMAS were commissioned for PTS within north and north east Lincolnshire and had two ambulances serving the emergency department at Queens Medical Centre Nottingham. PTS provided elsewhere within the east midlands was by non-NHS providers. In comparison to other NHS ambulance providers within England, the PTS achievements against the commissioned KPIs were better than average.

Competent staff

- PTS staff had appropriate skills and knowledge to do their job. All ambulances were staffed by ambulance care assistants who were appropriately trained and supported.

- PTS staff attended a three-week induction at the start of their employment with the service. This included a range of subjects, such as customer service, types of patients, first aid, manual handling, patient positioning, emergencies, basic life support, care of people living with dementia, safeguarding to level two and radio procedures. A qualified driving instructor carried out driving assessments over a one-week period during induction. There were no annual checks of driving skills.

- Information provided by the trust stated 100% of PTS ambulance staff had received an appraisal in the year 2014/15. Completion rates for appraisals for the year April 2015 to the date of inspection was 52%. The trust target was 95%. Staff told us this was because of a lack of flexibility in the working day and limited opportunity to roster time for front line PTS staff to attend. There was no protected time for team leaders to plan and carry out staff appraisals. There was no action plan in place to address this issue and it was not on the risk register for this service. However staff did have provisional dates for their appraisals.

- Control centre staff had all received appraisals.

- We observed new staff working supernumerary within patient transport and at the Lincoln control centre.

- Volunteer drivers underwent comprehensive checks prior to commencing work for the PTS including personal references, disclosure and barring service (DBS), occupational health assessments and check of their car insurance and MOT status. They attended induction and were provided with a comprehensive volunteer car driver's handbook outlining their responsibilities to the patient, themselves and their vehicle.

- Volunteer driver driving skills were checked through observation by the customer service manager on joining the service. This was recorded in their personal files. There were no subsequent checks of driving competency.

- Control centre staff received on the job training with a period of observation and practical application. We observed a new member of staff working alongside experienced control centre staff.

Coordination with other providers

- All PTS bookings were coordinated through the control centre in Lincoln where the most appropriate and available transport was selected for each booking. This could be single or double person crew or a volunteer driver.

- There were established relationships with local health care providers. We observed two-way communications between drivers and staff at their planned destination regarding traffic status, which had the potential to delay a patient's arrival.

- Hospital discharge lounge and day case ward staff told us EMAS PTS staff responded to their requests for transport in a timely way.

- Patients were transported to the renal dialysis unit at Scunthorpe hospital. We observed one patient being taken to this centre. There was co-ordination with the centre staff regarding collection times for patients ready to go home. There was no specialist contract with the renal dialysis unit. Patients were booked through the usual transport booking process.

- Staff in the emergency department (ED) at Queens Medical Centre Nottingham told us PTS staff provided a

Patient transport services (PTS)

reliable and effective service. The PTS staff checked directly with hospital staff or were alerted by telephone of patients who were waiting for transport. Staff in this service occasionally transferred mobile patients from ED to Nottingham City Hospital for admission.

Multidisciplinary working

- We observed PTS and care home staff sharing key information when collecting patients to attend hospital appointments. This was important for the patient's wellbeing and ensured they were prepared and adequately supported for their planned journey.

- We observed good working relationships between drivers and control staff. We felt this was important as the relationship between control staff; drivers and volunteer drivers enabled effective care and promoted good team working.

- The trust had direct access to electronic information held by community services, including GPs. This meant that PTS staff could access up-to-date information about patients, for example, details of current medication.

- PTS staff were in regular contact with clinics and telephoned ahead if a patients was going to be late for an appointment.

Access to information

- PTS staff had two-way communication with the control centre via mobile telephones or radio. This ensured that up to date information was always available, including journey times, patient details, pick up and drop off times.

- The control centre was able to track vehicles to support the forward planning process.

- Information about patients' individual needs such as medical or mobility requirements was readily available on the daily worksheet and updated information was provided through mobile telephones throughout the day.

- Staff had access to organisational information on noticeboards, through the trust intranet, or through written information in their individual drawer at the station.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed staff asking for patients' verbal consent for all interventions, including use of the winch to load wheelchairs and the use of restraints such as seatbelts and chair fixing equipment.

- Staff received information about the mental capacity act (MCA) at induction with updates at training. Information could be found on notice boards at ambulance stations and at hospital liaison desks.

Are patient transport services caring?

Good ●

Patient transport services (PTS) was rated as good for caring.

- Patients and carers consistently informed the inspection team they felt safe, treated with dignity and respect and that their individual needs were met for their journey. PTS staff were observed to respond to and anticipate people's changing needs and demonstrated compassion and empathy at all times.
- Staff responded compassionately when people needed help and support.
- Family and friends test results indicated 82% of patients would recommend the service to others.

Compassionate care

- Throughout our inspection, we observed staff treating patients with dignity, courtesy and respect.
- Patients and carers reported high levels of satisfaction with the PTS. They told us they felt safe and cared for during their journeys.
- Friends and Family test 2013 / 2014 was completed by 104 patients, 64% were regular users of the service. Results indicated that 82% would recommend the service to others and 90% found the booking process easy, staff professional and they were treated with dignity and respect. Seventy per cent of respondents said they were informed of approximate waiting times with 59% being happy with the information provided.
- We observed patients being collected from their own homes, care homes and hospital settings. Every effort was made to ensure that they were comfortable, secure

Patient transport services (PTS)

and warm during the journey. PTS staff requested extra clothing or blankets where indicated. They explained when it was a cold day that the ambulance door may be open whilst picking up other patients.

- Wherever possible vulnerable patients, such as those living with dementia or a disability could have a relative or carer with them, although space on vehicles was limited and this was only possible if booked in advance.
- We observed positive interactions between staff and patients as they prepared for their journey. Staff ensured patients had with them all that was required for the appointment as well as keys to get back into their home on return and snacks if necessary.
- A volunteer driver told us that wherever possible they picked up the same patients attending for regular appointments such as chemotherapy and got to know them well during their period of treatment.

Understanding and involvement of patients and those close to them

- Control staff explained to callers the rules about booking escorts for patients on journeys. We observed staff in the control centre taking time to explain eligibility criteria and service provision. Control staff directed callers to alternative transport if they did not meet the eligibility criteria. They were also able to advise where financial assistance could be sought if required.
- We observed conversations between patients and PTS staff during journeys. Patients were reassured about arrival times for their appointments and kept informed if there were any delays due to traffic conditions.
- Staff we travelled with told us they had not encountered language difficulties and would be informed in advance if a patient did not speak English.
- All patients were accompanied to their destination after leaving the vehicle and assisted with booking-in at reception.

Emotional support

- We observed good rapport between PTS staff, patients and their carers whilst accessing vehicles and during journeys.
- We saw PTS staff giving sensitive support to one patient who was anxious about their hospital appointment and showing empathy towards another patient who had received upsetting information through the post.

Supporting people to manage their own health

- Patients were encouraged wherever possible to use their own mobility aids when entering or leaving the vehicle.
- Patients were asked if they required assistance with sitting or standing.

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

Good 🟢

The patient transport service (PTS) was found to be good for responsive.

- The control centre and PTS crews worked together planning the transport of patients unable to use public or other transport due to their medical condition.
- The service was delivered in a way that met the needs of the local population. The importance of flexibility, choice and care was reflected in comments made by service users.
- There were minimal complaints made against the service with the majority of concerns solved quickly through local resolution.

Service planning and delivery to meet the needs of local people

- Patient transport services (PTS) provided non-emergency transport for patients who were unable to use public or other transport due to their medical condition. This included those attending hospital, outpatient clinics, being discharged from hospital wards or requiring treatment such as chemotherapy or renal dialysis.
- The service was meeting the demand for patient transport locally as reflected in the commissioning requirements.
- Volunteer drivers supported the ambulance service transporting patients who did not need the facilities provided by an ambulance.

Patient transport services (PTS)

- Out of area patient transport that required taxi or independent ambulance transport was subject to CCG approval for funding. This included patients attending specialist medical services for example in Sheffield or London.
- Specialist equipment for bariatric (heavy) patients was available with two specialist wheelchairs and one stretcher for use across the north Lincolnshire area. The control centre planned journeys to ensure the need of this patient group was met. They monitored the whereabouts of equipment, coordinated patient journeys and crew availability as required.

Meeting people's individual needs

- Patients and carers told us that the service was excellent and flexible to meet their individual needs. One patient told us their mobility was variable on a day-to-day basis and the service was able to adapt to their changing needs.
- For patients living with dementia and those with reduced mental capacity their support needs were assessed at point of booking. Escorts could be approved or a two-man crew arranged as required. We observed good relationships with care home staff to ensure the right level of patient support was provided.
- Staff told us guide dogs were allowed to accompany visually impaired patients. Staff name badges included their name in Braille to assist patients with visual impairment.
- An information leaflet entitled 'Keeping the wheels in motion' was available in patient collection areas. This explained the eligibility criteria and offered an opportunity for patients to comment on the service provided.
- People told us they found the booking process easy to follow but expressed some frustration regarding eligibility for transport, which was determined by the commissioner.
- Two carers, escorting patients, explained that they had become frustrated about the rules about escorting patients on journeys. They said the standard questions asked did not account for the personal difficulties some patients had when attending hospital appointments.
- PTS ambulance staff and control staff spoke to patients and carers with respect and gave advice about other transport options if there were eligibility problems.

Access and flow

- Patients or their representatives booked the service by telephone through the control centre. Those asked about the booking process said that they found it easy but that they were asked the same questions every time.
- Recently a system had been installed to record calls made to the control centre. Staff were positive about this and said it helped them in their role and would provide evidence if there was a concern raised.
- If a journey was running late the driver would ring ahead to the destination with an estimated time of arrival and kept the patient informed and reassured.
- The control centre was in constant communication with all PTS and volunteer drivers ensuring that when patients were ready for their return journey the wait was kept to a minimum. Response to calls was monitored and staff could see how many people were waiting.
- PTS and volunteer staff were adaptable and demonstrated a commitment to the patients waiting for transport, swapping and changing scheduled journeys to promote flow.
- Patients were called 24 hours in advance of their planned journey to check they still required transport. Any potential delay was communicated with patients, carers and PTS staff by telephone.

Learning from complaints and concerns

- Patients told us that they would make any complaints to the driver or the control centre. Information leaflets were available on the vehicles about how to complain.
- Complaints, concerns and compliments were managed through the patient advice and liaison service (PALS). There were 63 contacts to PALS between April and November 2015, of which 51 related directly to EMAS patient transport services. The remainder were related to other patient transport providers. Contacts covered a variety of issues including eligibility criteria for transport, standards of patient care and general advice about patient transport. There were no formal complaints regarding PTS.
- All contacts were acknowledged within one working day (trust target was three working days) and all but one closed due to resolution within 20 working days.
- Learning was evident in that a concern raised regarding a lack of seatbelt extensions was acted upon and all PTS ambulances now had these in place.
- The patient information and liaison service (PALS) had recently commenced a 'secret shopper programme'. This had involved recruiting existing patients to report

Patient transport services (PTS)

to PALS about their planned journey and their experience of PTS. There had been positive feedback with one patient telling her story to the trust board. PALS planned to recruit from different patient groups to give a broad view of patient experiences of PTS.

Are patient transport services well-led?

Requires improvement ●

The patient transport service (PTS) was considered requires improvement for well led.

- A governance framework was in place although there was no service level agreement for third party provision such as taxi services.
- The risk register did not include key risks relating to mandatory training or staff appraisals.
- Failure to carry out volunteer driver vehicle safety checks had not been identified as a risk.
- Management and staff within the service were consistently positive about their work and told us they were proud to work for East Midlands Ambulance Service (EMAS) and they saw a positive future for the service.
- Staff felt well supported in their role by their immediate line managers and told us the chief executive had a visible and open approach.
- Staff and patients had participated in surveys, the results of which broadly matched those of similar services within the United Kingdom.

Vision and strategy for this service

- Management and staff were very positive and proud to work for the PTS.
- There was hope and enthusiasm that the service would expand into adjacent counties. The service had recently been selected as a 'preferred bidder' to expand into another county. Managers and staff told us this had given them hope for future expansion of the service.
- The trust had published values of respect, integrity, contribution, teamwork and competence, which were displayed in all departments. Staff were aware of these and told us they understood the purpose of the values for promoting good service.
- The service was demand led with little opportunity for flexibility due to capacity. This resulted in day-to-day leadership rather than long term planning.

Governance, risk management and quality measurement

- There was an effective governance framework with monthly team meetings with monitoring of risk, quality and governance on the agenda. However, risks identified during our inspection were not included on the risk register. These include sharing and learning from incidents, mandatory training, volunteer driver vehicle documentation checks and staff appraisal rates.
- Staff reported to us a risk that the computer systems occasionally froze. We observed this in the control centre. The team leader was informed immediately and the backup paper system was commenced. The problem was resolved quickly without affecting the service.
- There was a systematic programme of audits to monitor safety within the PTS. Examples included infection control and prevention audit and vehicle deep clean audits.
- There were two taxi companies used by PTS, however there was no formal service level agreement in place with taxi companies. This means there is no formal process for monitoring the quality and safety of the service provided.

Leadership of service

- PTS staff told us they felt very well supported by their managers and felt comfortable approaching them about any work related subject or concern. They told us managers generally rectified any problems quickly and effectively.
- Staff were positive about the Chief Executive, saying they had seen a difference in the service with a more visible and open approach. This was supported by regular chief executive bulletins, which were displayed and available at all stations.
- PTS was a relatively small service within EMAS. Staff generally knew, supported each other and worked well together.

Culture within the service

- The EMAS PTS covered a small geographical area across north and north east Lincolnshire and provided support to the emergency department at Nottingham Queen's Medical Centre. Staff told us they felt 'a bit out on a limb' from the main ambulance trust.

Patient transport services (PTS)

- PTS control, ambulance staff and volunteer drivers worked well together to ensure that patient journeys were achieved within target times and were proud of their achievements as a team.
- However, ambulance staff told us there was often no time during a shift to take a break or access drinks. We observed staff negotiating with control to roster in comfort breaks but this was not always possible due to work demand. One member of the control team told us he had shadowed a PTS team for a day and therefore understood the demands and time constraints.
- There was a culture of openness and honesty across all staff groups.

Public and staff engagement

- Staff were invited to give their views about working for the trust through a survey in October 2014. An independent company carried out the survey and 15 out of 64 eligible PTS staff responded, a rate of 23.4% (the overall response rate for the trust was 28.8%). The results were the same or better than average when compared with other staff groups in the trust. None of the results was worse than other staff groups. The questions covered a range of areas, such as personal development, training, management support and health, safety and well-being at work.
- PTS staff did not have protected time to access emails and other communication. This was done in their own time at the end of a shift or from home; there was therefore a risk of essential information not being received by PTS ambulance staff

Innovation, improvement and sustainability

- The PALS secret shopper programme was an innovative method of getting patient feedback.
- There was genuine positivity about the future of the PTS service with a hope that the service would eventually expand. Staff were delighted that the trust was tendering for further PTS contracts in neighbouring counties and felt confident about their future.

Emergency operations centre

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

Information about the service

East Midlands Ambulance Service NHS Trust serves a population of 4.8million across the East Midlands (Derbyshire, Leicestershire and Rutland, North and North East Lincolnshire, Northamptonshire and Nottinghamshire), covering 6,425 square miles. Between April 2014 and March 2015 the emergency operations centre (EOC) responded to and dispatched ambulance clinicians to 643,115 calls. Every day EOC receives approximately 2,155 calls from people dialling 999 including healthcare professionals making urgent transport requests.

The Emergency Operations Centre (EOC) receives and triages 999 calls from members of the public and other emergency services. It provides advice and dispatches ambulances to the scene as appropriate. The EOC provides assessment and treatment advice to callers who do not need an ambulance response, a service known as 'hear and treat'. Staff give callers advice on self-care, making an appointment for a general practitioner (GP) or directs them to other services. The EOC also manages requests by health care professionals to convey people either between hospitals or from the community into hospital.

The trust has two emergency operations centres (EOC). One in Lincoln and a larger EOC at trust headquarters in Nottingham. The two EOC's work as one virtual EOC and all calls are routed to the next available operator across the two centres. Clinicians work at both EOCs triaging lower priority calls and providing clinical advice to patients. The Lincoln EOC manages emergency calls from Health Care Professionals and GP urgent calls for Lincolnshire. In addition, Lincoln EOC responds to the community first responder (CFR) calls for the whole of the East Midlands area. Nottingham EOC responds to calls for the rest of the East Midlands including the air ambulance service. The incident command desk (the coordinated response for major incidents) is in Nottingham.

We inspected both EOC sites during our visit. We spoke to 76 staff across both sites including emergency medical dispatchers (EMD), dispatch officers, clinicians (including paramedics and nurses), team leaders, duty managers and senior managers. We listened to 45 emergency calls and observed how patients were treated and responded to over the phone. We looked at 13 staff records and examined information sent to us by the public and other stakeholders such as Healthwatch.

Emergency operations centre

Summary of findings

Overall, we rated the emergency operations centre (EOC) as good.

There were processes to enable staff to safeguard children and vulnerable adults. Staff followed guidance on providing medicines advice to patients, and records were appropriately stored on an electronic system.

Staff used evidence-based systems to provide care, advice and treatment to patients. Clinicians worked to national guidance and standards when providing advice over the phone. The trust took part in national audits and we saw actions and learning were evident.

There was effective working between EOC's and with other emergency services. There were additional training opportunities for staff and opportunities for professional development. The service had systems and processes for clinicians to advise patients how to manage their own health as well as to provide information about alternative patient pathways.

Staff were compassionate and caring towards patients. We observed excellent examples of staff treating patients and callers with dignity, respect, and were supported by staff at the end of the phone.

The service had processes and systems to cope with different levels of demand. There were different ways for patients to access the service, and interpreting services were available for patients whose first language was not English. The service had systems and processes to manage and work with high volume service users and children with complex needs.

There was learning from complaints and concerns and staff told us they received learning through feedback from managers. The service managed risk appropriately and quality was measured through monthly staff audits, management meetings, and reports to the board.

However, we also found; Some members of staff were not aware of what constituted a reportable incident. Staff did not always report incidents in a timely manner. Mandatory training completion rates fell short of the trust target of 95%.

There were staff vacancies; staffing levels at times impacted adversely on the performance of EOC. Despite data from the trust showing the majority of staff had received appraisals, we found that half of staff did not have a documented appraisal in their staff file.

There were delays in sending emergency response vehicles to emergencies due to hospital handover delays. Data also showed that the trust were one of the worst performing trusts in the time it took to answer emergency calls.

We found that staff morale in Nottingham was very low and there were communication concerns between management and staff there. There was nowhere for staff to go following a distressing call

Emergency operations centre

Is emergency operations centre safe?

Requires improvement ●

Overall, we rated the safety of the EOC service as requiring improvement. We found:

- Some members of staff were not aware of what constituted a reportable incident. Staff did not always report incidents in a timely manner.

- Mandatory training completion rates at 89% fell just below the trust target of 95%.There was nowhere for staff to go to take time out after distressing calls.

- Equipment failure on vehicles continued to impact on responses to emergencies.

- Managers were not able to meet planned staffing levels leading to staff shortages at evenings and weekends.

However, we also found:

- There were processes to enable staff to safeguard children and vulnerable adults.

- The environment was visibly clean and staff could identify potential infection control risks to crews.

- Records were appropriately stored on an electronic system and special notes were available for patients who had specific individual requirements.

- Staff could prioritise and assess emergency calls and resources deployed to respond to major incidents.

Incidents

- The trust reported a similar number of incidents to other ambulance trusts but reported less deaths, severe and moderate incidents and many more no harm incidents. The most frequent incidents reported by EOC staff were ambulance delays. Ambulance delays included treatment and delayed care to patients due to some calls triaged incorrectly at the beginning of a 999 call.

- The service had processes and systems for investigating incidents. The EOC management team reviewed and discussed incidents. We saw detailed reviews of incidents and managers listened to calls where appropriate. Managers conducted a root cause analysis

(RCA) in which learning for both individuals and the organisation was established. Investigations had recommendations and action plans. We saw actions followed up and monitored on a monthly basis. The board received regular updates on incidents as part of the investigation and review process.

- There were four ways for staff to report incidents: paper forms, electronic forms on the trust intranet, a direct telephone line to the safeguarding team or by informing a line manager or team leader. This meant incident reporting was flexible to suit the needs of staff.

- Staff in the EOC told us they knew the incident reporting process and staff demonstrated the different ways of reporting incidents. When staff needed to report an incident, they would first raise this with a team leader or duty manager. This helped to ensure sufficient available staff to take incoming emergency calls while staff dealt with the incident.

- One member of the training team told us they worked closely with line managers to develop actions plans for staff who had been involved in incidents and where they had identified individual learning needs. Supervised practice, attendance at specific training and focused self-learning were examples of actions taken as a result of an incident investigation

- In the Lincoln EOC we saw positive examples of incident investigation and learning. For example, amended questions and prompts used to prioritise health care professional referrals following a delayed response to a patient. The amended scripts included the involvement of the patient's GP in agreeing the response time, or maintaining a safe environment for the patient in the event of a delayed ambulance.

- At both EOCs, staff told us the trust published learning points from incident investigation in the weekly EOC operating instructions and EOC Bulletin. Notice boards displayed feedback from the investigation of incidents in both EOCs. A learning event for staff took place and key stakeholders in May 2015 and the trust had made a commitment for this to be an annual event.

- We found most staff were unaware of what was classed as an incident. This meant staff did not always report incidents. Staff did not report and record abuse of staff as an incident in line with the trust policy. Most staff said they saw taking abuse as part of the job. Abuse of staff

should be recorded as an incident as per the abusive caller standard operating procedure. Managers acknowledged there were gaps in staff knowledge about what was an untoward incident.

- Staff gave examples of not reporting incidents on time. They said they waited to the following shift or when they next returned to work after their rest period. Staff we spoke with said they delayed reporting incidents mainly due to time pressures. Data from trust showed between September 2015 and March 2016 out of 287 incidents reported 231 were reported the same day. The trust incident reporting policy stated staff should report incidents "as soon as possible but at least before the end of their shift and pass this to an appropriate manager". Data from trust showed between September 2015 and March 2016 out of 287 incidents reported 231 were reported the same day. This meant 56 incidents were reported a day or more after the incident occurred.

- The duty of candour is a regulatory duty relating to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.' Serious incident investigations showed that the trust informed and involved patients when things went wrong. Managers knew about the need to be open and transparent with patients.

- Joint reviews of incidents with partner organisations such as other trusts, the police, and fire services took place. We saw four examples of joint incident investigations provided by the trust. In all examples, we saw that there was a lead person and organisation to coordinate the investigation. Investigations were comprehensive with clear actions and learning identified in all cases.

Mandatory training

- Staff knew mandatory training in the trust as essential education. Staff received mandatory delivered on a three-year rolling programme. In year one, staff received all ten modules of essential education which included infection control, conflict resolution, information governance, and safeguarding. In the following two

years, managers chose individual topics depending on need, or the regularity of the delivery of the subject. New members of staff covered all 10 modules during their induction period.

- Despite the majority of staff saying they were up to date with their essential education the overall training completion rate for EOC was 89%, which did not meet the trust target of 95%.

- Managers delivered Mandatory training by using conversation cards. Conversation cards were a set of questions or topics managers discussed with staff in a one-to-one or group situation. There was a conversation card for each of the ten mandatory training categories. This format meant managers could deliver training in an informal and flexible way.

- Managers did not receive any training to deliver essential education topics. One manager said they tried to have their training with their manager before undertaking training with colleagues. Despite managers having the answers available when delivering training to staff, there was no evaluation system to ensure that staff had understood the training.

- The National Ambulance Resilience Unit (NARU) works with ambulance trusts to support the development of properly trained, equipped and prepared ambulance responders to deal with hazardous or difficult situations. Staff received training which met NARU standards. The duty manger on each shift had received NARU approved training so there was at least one manager trained to support staff in dealing with difficult situations. One member of staff showed us their NARU handbook.

Safeguarding

- All staff had safeguarding level two training as part of their induction. A new member of staff told us they received safeguarding training on their induction and knew how to handle a safeguarding call. The trust repeated safeguarding training every three years as part of the essential education programme using conversation cards. Ninety four per cent of staff across both sites had received safeguarding training, slightly under the trust target of 95%. Staff said managers discussed safeguarding at one-to-one meetings and yearly appraisals. Staff knew how to identify concerning situations for example; terminated calls and background noise.

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- The Nottingham based safeguarding team provided a 24-hour direct telephone referral service. We observed staff making safeguarding referrals using a direct line, which followed the safeguarding policy. Staff asked for support from their line manager appropriately. We saw two examples of staff safeguarding children; a child at risk of self-harm and an incident where children were present where an adult required emergency medical treatment. The safeguarding team were available and quick to respond to the member of staff making the referral.

- The Child Protection - Information Sharing (CP-IS) project is a national programme to help protect children and young people, particularly those who are subject to a child protection plan and children in care. This programme allows the sharing of child protection information from local authorities to the NHS with a return message indicating a child had been seen in an unscheduled care setting. The trust had signed up to the project and planned to run a pilot in Nottingham. The trust was awaiting clinical commissioning group contact regarding the next stage of the project.

- Staff in the EOC did not have direct access to child protection registers. Having direct access to child protection registers enables health care providers to check whether children have already been subject to safeguarding procedures. They told us if they had any concerns they would discuss the case with the clinical assessment team or the safeguarding team.

- There were safeguarding reporting arrangements with multiple local authorities across the East Midlands.

Cleanliness, infection control and hygiene

- Both EOCs appeared visibly clean at the time of inspection. There was hand gel available and disinfectant wipes were available at workstations. There were notices and information in the EOC bulletin, the toilets and kitchen providing guidance on infection prevention, control and hand hygiene.

- All staff received infection prevention and control training as part of their induction programme. Infection prevention and control training was repeated every three years. Training included hand hygiene, sourcing infection control information, return to work after illness and use of food and drink. If EOC staff needed further information about infection prevention and control, they could contact the infection prevention and control team.

- The service had processes for identifying and passing on infection control risks to crews and hospitals. We observed emergency medical dispatch (EMD) staff asking callers if they knew of any known infections or contagious diseases affecting the patient. Staff recorded details and recorded on the patient's electronic record if the answer was yes. The information was then visible to the dispatch officer who would pass it to the ambulance staff attending the scene. The clinical assessment team (CAT), a team of clinicians who provided clinical advice and support to staff and patients, could make other health providers aware.

- Notices gave details about flu clinics in EOC including where staff could go to get flu vaccination. Flu vaccinations for staff would contribute to preventing staff from falling ill over the winter months and therefore preventing further staff absences.

- Staff had a toolkit providing guidance on what to do in the event of a suspected infection control incident. The infection prevention and control team at the trust provided telephone advice to frontline staff including EOC. Clinical staff knew where to go to get guidance on infection control issues.

Environment and equipment

- Staff based at Nottingham EOC said there was nowhere quiet to go for 'time-out'. There was a kitchen area with a sofa. However, the kitchen was small and we observed it was a social area for people to talk and have their breaks. This meant staff could not spend quiet time in the kitchen. A quiet space may be important when staff have been dealing with particularly distressing calls. Managers said staff could use the EOC conference room or access to meeting rooms within Horizon Place at all hours of the day or night. However, staff said these rooms were used often and therefore sometimes could not use them.

- Staff had workstation safety assessments completed via a self-assessment questionnaire every year. The majority of staff had received regular workstation

Emergency operations centre

assessments and we saw examples of these. Managers discussed any issues raised on the questionnaire with staff. . We saw specially adapted chairs and moveable desks for staff who required them.

- In the event of workstation equipment failing there were several pre-configured desktop personal computers, which allowed rapid replacement of the faulty equipment. Staff told us they rarely experienced equipment failure. There were systems and procedures to order and replace equipment. There was a capital-funded programme of rolling hardware replacement which provided EOC hardware and replaced information management and technology equipment on a three to five year cycle.

- In the event of equipment and software failure, there were systems and processes to ensure the service could continue to operate. If the computer aided dispatch (CAD) system failed for example, crews would still receive information via telephone and radio. EOC staff performed monthly 'takedowns' without the use of computer systems to ensure the service could still continue. Takedowns were when the service operated without electronic systems to test that back-up systems worked. Staff used fallback papers (job sheets) which contained all the necessary information required for each call.

- Our inspection team reviewed four job sheets and saw each call received was time stamped and again when the dispatcher received the job. This allowed staff to identify any delays in handing over jobs. The job sheets reflected the computer systems so staff could work through them in logical order. The job sheets contained all necessary information crews and dispatchers needed when responding to a job.

- Some dispatchers at Lincoln EOC told us they felt the screens they had were not big enough and they could not see resources at the same time. They said bigger screens would be better. Staff had raised this with managers but told there was not enough funding to purchase new screens. In response to this the trust said Lincoln and Nottingham EOCs had the same size screens. A bigger screen would not allow staff to see more resources and the resource allocation function used by all dispatchers lists the nearest 20 resources to any incident.

- When new updates for computer software were introduced all staff received briefings and training on new equipment and assessment systems, This meant staff could use the latest version of the information systems and equipment they used.

- Dispatchers and emergency medical dispatchers (EMDs) worked to a set of protocols to keep people safe. Managers reviewed and refreshed them on a regular basis. We saw staff had hard copies available to them on their desks and they referred to them when working. In addition, staff used the protocols in the event of an IT systems failure.

- Despite an ongoing replacement programme vehicle trackers continued to be an issue for dispatch staff. Tracking devices enabled staff in the EOC to see where vehicles were. They supported staff to allocate vehicles to appropriate emergencies. We reviewed resources for three dispatchers and saw 14 vehicles had trackers not working. This could lead to delays in reaching the patient if the crew were not where the dispatcher thought they were.

- The service conducted an infection control and prevention audit in April 2015. The overall score for the EOC was 56% against a target of 95%. The audit report identified several areas requiring more thorough cleaning. We saw there were actions and completion dates, for example, dust found to be at an unacceptable level and the microwaves in the kitchen were dirty. The trust reported most actions had been completed but that a re-audit was due on 31 December 2015.

- Staff at both sites had easy access to a water cooler and could get regular drinks whenever they needed them.

Medicines

- Staff in the clinical assessment team (CAT) gave self-medication advice as recommended by the clinical decision support software. The software supported staff to give the right advice because of regular updates.

- We saw staff in the CAT used Joint Royal College Ambulance Liaison Committee (JRCALC) and British National Formulary (BNF) guidelines for medicines advice. Clinical staff told us they would never give medicines advice about medication prescribed by the patient's GP as there was a risk of it adversely affecting the patient's health.

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Records

- All patient records were stored electronically on the Advanced Medical Priority Dispatch System (AMPDS). Computers were password protected.

- Staff received information governance training as part of the induction programme. The trust delivered information governance training every year using conversation cards. By September 2015, 69.3% of staff had attended information governance refresher training which meant this was on target for 95% by the end of March 2016.

- All calls were voice recorded which meant calls could be audited later if further information was needed about a call, for example; for a complaint or incident investigation.

- Staff used the AMPDS to record the priority and response of calls, and the clinical assessment team (CAT) used telephone assessment software (TAS). Both were nationally approved telephone assessment systems and regularly updated to include any evidence-based changes.

- Some patients had special notes attached to their record. Special notes were electronic and contained information relevant to the caller. Special notes assisted EMDs or the CAT in their decision-making about the next course of action for the caller. Special notes could be the code for a key pad to gain entry to a patient's home or complex care instructions such as care pathways for someone with a known and recurring mental health problem. However, because special notes were electronic it meant that they were not available in the event of a system failure.

- The trust safeguarding team used a clinical computer system used by healthcare professionals. It was a centralised system based on a "one patient, one record" model. The system allowed users to access details about patients and their care records.

- Both assessment systems, AMPDS & TAS had the capability to record special information about patients that could enhance and improve their care pathway. Special information might include, end of life care plans, do not attempt cardio pulmonary resuscitation orders (DNACPR), instructions on how to access/enter property i.e. key safe details, care packages for frequent callers or

patients with long-term conditions, and violent patient instructions. The trust was reliant on other health care providers sharing this information. Staff passed special information to operational staff on the road where it existed.

Assessing and responding to patient risk

- EOC staff used the Advanced Medical Priority Dispatch System (AMPDS) to assess and prioritise emergency calls. AMPDS prioritised and coded calls based on responses to questions asked by emergency medical dispatchers (EMD). The priority, or coding, of the call determined the risk to the patient and therefore the response sent by dispatchers.

- The AMPDS had several risk assessment tools including, a breathing tool, pulse taking tool, cardiac arrest tool, contractions (pregnancy) tool and stroke tool. The AMPDS system prompted EMDs to ask the caller about patient alertness and breathing. Use of these tools resulted in a more accurate assessment of patient symptoms and in the case of the cardiac arrest tool allowed the EMD to give CPR advice over the phone until operational staff arrived.

- Some staff (including managers) expressed concerns about the lack of flexibility and coding produced by the AMPDS system. We saw examples of the system used correctly but the coding sometimes produced inappropriate responses based on information provided by callers. Staff said they felt like robots and were not trusted to use common sense. Staff had escalated concerns to managers and managers knew of this issue. The trust responded to this by stating call-takers were not clinicians did not have the necessary clinical knowledge or skills to enable them to make any clinical judgements or decisions. The AMPDS system kept people safe and it was trust policy for staff to stick to the system rigidly for this reason.

- The clinical assessment team (CAT) used Telephone Assessment Software (TAS) to assess lower priority calls. The electronic system automatically transferred calls to the CAT queuing system. The TAS supported the clinician in assessing and deciding on the most appropriate course of action for the caller. This ranged

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from dispatching an emergency ambulance to providing self-care and medication advice. The TAS queue was visible to the CATs in both the Nottingham and Lincoln EOCs.

- The CAT could use their clinical judgement and the TAS to inform what they needed to do and change the level of priority of calls. We saw CAT staff change coding and the priority of calls appropriately after re-assessing the risk to patients. This meant the service had procedures to re-assess risk and ensure an appropriate response to keep the patient safe. .

- During busy periods, the CAT could assess calls without the support of the TAS. More calls could be managed quickly when staff Assessed calls without TAS because it shortened the call. However, staff told us that they were uncomfortable in this situation as they did not have the back-up of the clinical decision support software and made decisions about care purely from their personal clinical expertise and knowledge.

- The CAT conducted welfare calls to check on the condition of the patient while they were waiting for a response during busy periods. We saw an example of staff calling back a patient four times over a six-hour period while waiting for an ambulance.

- Certain identified nursing homes had alerts attached so dispatchers and crews knew there could be a possible do not attempt cardio pulmonary resuscitation (DNACPR) in place for a patient. Staff could identify specific end of life care plans and these included DNACPR orders. If a caller mentioned a patient had a DNACPR, an EMD wrote in the notes to ask the crew to check it. Ambulance clinicians were trained to recognise and act on DNACPR orders

- Staff described to us what they would do if they received multiple calls from the same location. If a member of staff from a residential home rang about residents affected by the same virus, the EMD would ask to assess the worst affected patient first, which would result in an appropriate response. If the response resulted in sending an ambulance, staff would warn the crew there were multiple cases at the same address. A second example would be multiple calls from a crowd affected by the same incident. In this case, staff deployed specialist resources along with other emergency services.

- Dispatchers could see the skill set of each member of operational staff. This meant staff with the appropriate skills deployed to the patient for example; highly skilled paramedics did not need to see elderly patients who had fallen without injury, but were not able to get up themselves.

- Dispatchers and crews used special codes to call for help in the face of challenging behaviour and to keep staff safe. This meant crews could talk discreetly and call for help at the scene.

Staffing

- Managers planned staffing by monitoring call trends. Therefore, managers could predict when their busiest periods were and plan staffing accordingly. We saw rotas varied from day to day to match predicted demand.

- We reviewed staffing rotas for the EOC from 23 October 2015 to 8 November 2015. The rotas showed during this period managers were not able to meet their planned staffing levels for EMD and dispatch on any of these days. Gaps in staffing ranged from 28% to 6% understaffed. Staff told us they were under pressure especially at weekends.

- Staff identified a recent weekend where there were significant staff shortages. We reviewed performance data from the trust for that weekend. There was a large increase of abandoned calls (39 to 432) over that particular weekend and performance on response times dropped from 82% to 59%. This suggested staffing levels affected performance.

- The vacancy rate across the trust between April 2014 and March 2015 was just over five per cent with the rate for both EOC sites at six and a half per cent.

- Managers stated staffing shortages were due to cuts in the staffing budget. The number of EMD staff reduced from 138 to 89 due to a budget restriction earlier in the year. Managers were not able to replace departed staff or recruit to vacant posts. Senior management confirmed the budget for recruitment had not been in place until recently. Recruitment was ongoing at the time of inspection and we saw new members of EMD staff undergoing their induction.

- Staff said a recruitment campaign had taken place to recruit 17 more EMDs for the Lincoln EOC. However,

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there was an advertisement mistake in the recruitment process resulting in all the newly appointed EMDs working from the Nottingham EOC. This did not affect service delivery because of shared call answering between EOCs.

- Three new team leader (whole time equivalent) seconded posts created for Lincoln EOC did not cover the 24-hour period so at times there was not a team leader on duty to support EMD staff. When there was no team leader to consult, staff would refer to the duty manager or other experienced staff in the call centre.

- The trust did not use agency staff because of the specialist roles and training required to work in EOC. The trust had a small rota of bank staff, which consisted of staff who used to work for the trust to cover gaps in rotas.

- Sickness rates for EOC were low with Nottingham EOC having a slightly higher rate than Lincoln EOC (Lincoln 5.22% and Nottingham 6.1%) with the exception of February 2015 and June 2015 (Lincoln 6.25% and Nottingham 3.81%), when the rate for Lincolnshire was notably higher. There did not appear to be any reason for the difference in sickness rates.

- Managers supported staff upon returning to work after long absences. Staff said they received settling sessions and a communication plan in order to receive updates at home. Managers kept in contact with staff on long-term sickness on a regular basis.

- Staff worked to an annualised rota system meaning that they had fixed shifts and days off throughout the year. Annual leave was fixed for staff across the year so staff were unable to take leave when required. Some staff were unhappy about the rota system and had to rely on swapping shifts with colleagues in order to get days off at short notice. Managers had introduced an extra member of staff into the dispatch team to cover staff meal breaks. However, dispatch staff told us sometimes staffing levels meant this extra member of staff was not available and therefore duty managers or EMDs had to cover for dispatch meal breaks. This affected staff as there was no one to replace them.

- The trust did not train staff specifically in providing a safe service to children. Staff relied on their experience and using the electronic systems and prompts provided. The systems used kept patients of all ages safe.

- A new management structure, developed to support staff, led to a high proportion of seconded and interim managers across both EOC sites. Five teams covered a twenty-four hour period, each with a designated duty manager and or team leader.

Anticipated resource and capacity risks

- There were procedures to understand and manage foreseeable risk. The EOC used a capacity management plan (CMP) to assess and respond to changes in demand. The CMP was an operating procedure that changed how staff worked, for example, shortening EMD scripts to deal with high demand for the service.

- Every month EOC conducted an exercise where they would operate without electronic systems to understand how the service would work if electronic systems failed.

- There were processes for dispatchers when allocating resources in bad weather. Air ambulance crews, for example, would be deployed in cars rather than helicopters if the weather was too poor to fly. This meant that patients were still able to receive the same level of care and expertise at serious incidents.

- During our inspection, we saw there were delays to hospitals receiving patients. On several occasions ambulances were waiting over two hours to hand patients over to the care of hospital staff, this created capacity risks. The EOC had procedures for when this occurred and the Regional Operations Manager (ROM) was responsible for coordinating a response to this issue.

- Staff in EOC discussed resource and capacity risks on a daily basis. There were two conference calls daily as well as an additional morning EOC handover. The handover discussed capacity and skill mix of crews, staffing levels and potential service risks. The EOC manager attended divisional meetings to feed back any issues and discuss long-term resource and capacity planning.

- The regional operations manager produced escalation reports to identify and raise capacity and resource issues across the trust. They sent this to senior managers and directors. We saw an example of an escalation report for the 10 November 2015 and the report contained key issues such as hospital handover times.

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- Dispatch staff we spoke with expressed their concern about paramedic team leaders being taken off duty so they could check the cleanliness of ambulance stations. The reasons staff gave was our inspection. We saw examples on handover sheets of team leaders taken off duty. In one city, there were four out of six team leaders off duty. This meant this hindered what response a dispatcher could send to certain incidents. Staff felt this contributed to capacity issues. A senior manager confirmed to the inspection team this had happened. The trust responded stating Team Leaders responded to emergencies for 75% of their time. The remaining 25% of time was spent on management duties, including ensuring the necessary quality standards were met, sometimes on ambulance stations.

- There were restrictions on when helicopters could fly but there was a specialist helicopter able to fly later and/or earlier than other air ambulances. This was available for night-time search and rescue operations.

Response to Major Incidents

- Staff had participated in mock examples of major incidents using a major incident vehicle. The major incident vehicle was a mobile operations centre manned by managers, EMD, and dispatch staff. It was able to manage and dispatch resources from different sites. This prepared staff for what to expect if such an event was to happen.

- Staff received briefing sessions from partner organisations as part of their learning regarding responding to major incidents. The counter terrorism unit from the police for example, visited the service to brief staff and talk to them about their role.

- There was an incident command desk (ICD) at the Nottingham EOC manned by a single member of staff. The role of the incident command desk was to take over and coordinate responses to major incidents so dispatch staff could concentrate on responding to other emergencies across the region. Managers communicated effectively with staff when the ICD took over responses to incidents. The ICD desk was next to the helicopter emergency medical service desk (HEMS) which helped in coordinating an air ambulance response.

- The EOC could dispatch specialist resources in the event of a major incident. The Hazardous Area Response Team

(HART) are a specialised team of medical personnel who attend and support serious incidents including firearms incidents, collapsed buildings, exposure to harmful materials, water rescue and flooding. The incident command desk was responsible for dispatching the HART team. Staff identified when to deploy the HART to emergencies by using the dispatch procedures.

- Managers trained in the Joint Emergency Services Interoperability Programme (JESIP). JESIP supported the ambulance service working together with the Police and Fire and Rescue and Services when responding to major multi-agency incidents. Between March 2014 and March 2015 22 EOC managers had undertaken initial JESIP training. The trust had developed internal bespoke training for dispatchers based on JESIP training principles.

- The terrorism threat level at the time of inspection meant managers issued all staff with The EOC extreme threat guidance, which summarised what actions staff should take in the event of a terrorist threat or incident. One member of staff told us their line manager had talked through the guidance face to face with them to check they understood it. An additional member of staff said they had received training on firearms situations. We saw a copy of the guidance at each workstation. One regional operations manager (ROM) trained to respond to incidents such as; marauding terrorism and firearms, and three of the ROMs had previously been HART team leaders. This meant there was experience in EOC to deal with major incidents.

- The trust had an emergency preparedness and business continuity procedure which prepared staff to deal with a range of major incidents. The ambulance service worked closely with the six local resilience forums across the region, each of which included Local Authorities, Police and Fire services. This helped to ensure the service could continue in the event of an incident affecting normal operations.

- The trust had clinical guidelines for major incidents based on national ambulance resilience unit (NARU) command and control guidance. The trust used major incident cards, which gave detailed instructions on procedures and staff roles. In the event of a major incident, the duty manager would distribute the major incident cards.

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- We saw a call taking, aide memoire for staff to use in the event of receiving a call from a terrorist or a member of staff under extreme threat. This included instructions to inform the duty manager immediately who then implemented major accident procedures.

- The AMPDS included a protocol for infectious diseases such as Ebola. There was also a paper version of this protocol, last used during the H1N1 'swine flu' outbreak.

Is emergency operations centre effective?

Good ●

Overall, we rated the effectiveness of the EOC service as good.

- Staff used evidence-based systems to provide care, advice and treatment to patients.
- The International Academies of Emergency Dispatch (IAED) accredited EOC as a centre of excellence.
- The clinical assessment team could assess pain and discuss care and treatment with patients.
- Clinicians worked to national guidance and standards such as National Institute for Health and Care Excellence (NICE) when providing advice over the phone.
- The trust took part in national audits and we saw actions and learning from these. Managers shared actions and learning with staff.
- There were additional training opportunities for staff and opportunities for professional development.
- There were support mechanisms for staff had taken distressing calls.
- The two EOC's worked effectively with other emergency services.

However, we also found:

- While data from the trust showed 95% of staff had received an appraisal between April 2014 and March 2015, when we looked at staff records we saw only a half of staff had received appraisals.

Evidence-based care and treatment

- EOC staff used the Advanced Medical Priority Dispatch System (AMPDS) to assess and prioritise emergency

calls. The IAED, a standard setting research based non-profit organisation, oversaw the creation, development and updates of the emergency protocols. The trust used the latest version of the system.
- The EOC service had accreditation by the IAED as a centre of excellence. In order to be accredited EOC had to meet and demonstrate several minimum standards and criteria every three years.
- The trust Medical Director was a member of the Joint Royal Colleges Ambulance Liaison Committee. The clinical assessment team (CAT) worked to NICE and JRCALC guidelines and the CAT had a desktop computer containing all NICE guidelines.
- Clinical advice and support for the emergency medical dispatchers (EMD) was available from the CAT. Emergency medical dispatchers could approach the CAT for advice and support in person and by phone. The CAT could listen in to calls and provide information to EMDs via real-time electronic notes. .

Assessment and planning of care

- The clinical assessment team (CAT) were a team of registered nurses and paramedics split between both EOC sites. They conducted a detailed assessment of a patient's needs. The work of the CAT had led to a reduction in the number of people taken to hospital. Data from the trust showed that in October 2015 55% of calls resulted in patients taken to hospital. This was an improvement of two per cent compared to March 2015 (57%). This meant more patients treated safely in their own home, over the phone or in the care of a community based services, and reduced unnecessary admissions to busy emergency hospitals.
- A general practitioner based in the CAT during peak times, allowed CAT paramedics and nurses to refer patients to the GP for a more detailed medical assessment or further medical opinion.
- The AMPDS system provided strict prompts and scripts so EMDs could assess the care and treatment needs of a patient, which ultimately influenced the response sent by a dispatcher. The CAT used pain scores with patients to assess their level of discomfort and pain. We observed staff asked patients how bad their pain was between one-to-ten; 10 being the most pain.
- There were arrangements to receive NHS 111 referrals. NHS 111 is a telephone service that the public can use if they are unwell and need advice on what to do or where to go to get treatment. NHS 111 can refer patients to

emergency ambulance services. We saw the CAT clinically inter 111 calls and at times, they changed the patient pathway to prevent an inappropriate response. The trust reported all inappropriate calls received from 111 to the provider of the service.

- Training in mental health and the Mental Capacity Act was not mandatory. Staff were not required to attend training to understand the needs of those with mental health conditions. Staff told us about a mental health workshop scheduled for 30 November 2015 however, it was not mandatory. This meant it was likely not all staff had suitable training or knowledge about mental health.

- Section 136 of the Mental Health Act 1983 allows a police officer to remove a person they think is mentally disordered and "in immediate need of care or control" from a public place to a place of safety. The trust had protocols for section 136 and transporting patients to and from places of safety. The National Ambulance Mental Health Group approved the Trust's protocol. We observed staff using the protocol when receiving calls from police to transport patients.

- Dispatchers could send a mental health triage car, which operated between 4pm and midnight seven days a week. The mental health triage car operated in Lincolnshire only meaning they could assess people in Lincolnshire with mental health needs. Those people could receive appropriate care, sometimes avoiding a section 136.

- Community First Responders (CFR) provided life-saving support to patients in their workplace or community until the arrival of an emergency ambulance. Dispatchers in Lincoln EOC were responsible for deploying CFRs. Dispatchers did not deploy CFRs as a replacement for an emergency ambulance.

- Dispatchers used dispatch protocols, which provided the guidance and framework for when and what to dispatch to different coded emergency calls. We saw dispatchers were using this protocol and referred to it if they needed further guidance.

- Dispatchers had challenges sending appropriate responses because crews were waiting for long periods at hospitals. A senior manager said it was hard to free resources and the majority of staff said they needed more resources out in the field. We saw on one occasion dispatchers allocated a patient to a vehicle over 50

minutes away. Where necessary, dispatchers would divert nearer crews who were on lower priority calls. However, this affected the response times of less seriously ill patients waiting for help.

Response times

- We saw staff at EOC struggled to send vehicles, which would meet response time targets. We saw dispatchers were not able to send crews because they had the wrong technical skill. The trust said this was because of a shortage of trained paramedics. There was an ongoing recruitment drive for paramedics.

- The proportion of calls abandoned before being answered was better than the England average and consistently lower than one percent of all calls. Data between April 2014 and July 2015 showed the trust were the best performing ambulance trust.

- Between April 2014 and July 2015, the proportion of patients who contacted the service again (following discharge of care by telephone) within 24 hours was similar to the England average of eight percent. By October 2015, this had fallen to three percent, compared to the England average of six percent. The trust was the third best performing trust regarding re-contact by telephone.

- There were targets for lower priority calls not requiring an ambulance response to be telephone assessed by clinicians within a certain amount of time. The target for green three calls (requiring telephone assessment within 20 minutes of a call) was 85% and the trust averaged 90% between April 2015 and October 2015. Green four calls required 85% of calls assessed by telephone within 60 minutes and the trust consistently performed better (average of 98%) than this target across the same period. This meant that the majority of patients requiring telephone assessment were receiving calls from clinicians in a timely manner.

- The trust monitored call answering times as a way of measuring the performance of staff in EOC. The average time taken to answer a call by EOC was two seconds between April 2014 and July 2015. This was worse than the England average of around 1.4 seconds. The trust was one of the worst performing ambulance trusts compared to other ambulance trusts in England.

Patient outcomes

- The trust collected and monitored information about outcomes for patients. The trust produced monthly

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board and performance reports, which monitored outcomes. Outcomes monitored included; patients treated at the scene, treated over the phone, or taken to hospital. Managers shared information with staff about outcomes on a monthly basis by email.

- Hear and treat is a term for callers who dialled 999 and received telephone triage and advice from trained clinicians. The Care Quality Commission conducted a survey of people who had used hear and treat. The trust were in the worst 20% of all ambulance trusts in nine out of 21 experience questions in the 2013/14 hear and treat survey.

- The percentage of emergency calls resolved by telephone advice and support (hear and treat) had increased. Between March 2015 and October 2015, the percentage of patients treated over the phone had increased from 13.6% to 16%. This meant there were more calls closed by hear and treat outcomes therefore avoiding an emergency response and possible transfer to hospital.

- The trust participated in national clinical audits. Managers distributed recommendations from clinical audits to frontline staff to improve clinical practice. Managers used staff bulletins, the clinical up-date publication and face-to-face contact with staff as well as divisional and strategic learning review groups. An example of change because of audits was the development of a tool (Paramedic Pathfinder). This assisted ambulance clinicians to treat patients safely in the community without transporting them to Emergency Departments.

- The trust conducted audits on ST-elevation myocardial infarction (STEMI), a heart attack because of a complete blockage in a coronary artery. The proportion of patients who received an appropriate bundle of care was on average 77% between June 2014 and August 2015.This was better than the national average of 65% and the organisational target of 70%. Data from the trust showed that survival to discharge rates were better than the England average and the trust was one of the best performing ambulance trusts. The trust scored an average of 93% between June 2015 and June 2015 and the England average was 83%. This meant the majority of patients were getting access to the care and treatment they needed.

- The trust monitored patients involved in the return of spontaneous circulation (ROSC). This was the resumption of sustained breathing and circulation

associated with resuscitation after a cardiac arrest. The trust was worse than the England average but steadily improving. In April 2015, the trust scored 24.4% compared to the England average of 28% and in September 2015, the trust scored 26% compared to the national average of 27.3%. Therefore, there was visible improvement and the trust had closed the gap to the England average.

- During 2014 to 2015, the trust worked jointly with the regional stroke network to align stroke admission processes across the region. This meant there was a more streamlined process ensuring patients could access services in a similar way. The trust consistently performed in the top four ambulance services when accessing Hyperacute Stroke Units. Data showed that the trust scored an average of 98% between August 2014 and August 2015, which was better than the 90% target.

- There were processes to support appropriate deployment of the Hazardous Area Response Team (HART). A dispatch protocol provided guidance and escalation procedures to determine whether deployment of the HART was necessary. The incident command desk (ICD) operator was immediately responsible for the deployment of the HART. One ICD operator said they deployed HART appropriately and managers never asked to send them to an incident inappropriately. If HART were deployed this was reviewed by the regional operations manager and other senior managers on an incident-by-incident basis. At the time of our inspection the trust were reviewing their deployment criteria.

Competent staff

- The trust reported the completed appraisal rate for all EOC staff between April 2014 and March 2015 was 95%. This was an improvement on the previous year of 63%. All staff we spoke with said they had received an appraisal in the previous twelve months. One member of staff said they felt "encouraged to develop through the personal development review process".

- While data from the trust showed the majority of staff had received appraisal we found just over half of staff files we looked at contained appraisal records. Out of eight staff records we inspected in Lincoln, we could only see evidence of appraisal in the last twelve months for two of them. We viewed five staff files in Nottingham and all five members of staff had received an appraisal

in the last twelve months. In order to measure staff performance and identify learning and development needs appraisals are used. Therefore, just over half of the staff files we viewed had not had the opportunity to discuss their development needs and performance.

- All staff we asked said they had regular one to one meetings with their manager. Three members of staff said they had a one to one supervision every ten weeks, which coincided with week ten of the rota. They said managers discussed learning and performance objectives in one to ones. Managers gave staff feedback and learning from call audits in these sessions. We saw a copy of a one to one record. The record included staff welfare, general service updates, forthcoming training and individual performance.

- Most of the staff we spoke with said managers conducted one to ones during night shifts because they were generally quieter. However, at times there was not the capacity to meet because of staff shortfalls.

- The service had processes to challenge and deal with poor staff performance. If a member of staff had not performed well against their call audits, they received an action plan and there would be an increase in the number of monthly audits taken. Managers would sign off the action plan and reduce the number of audits taken when satisfied the member of staff was performing at the desired level. Alternatively, the service could dismiss staff because of poor performance.

- The dispatch duty managers produced monthly reports from the computer aided dispatch system (CAD). The reports enabled managers to identify gaps in performance and missed targets. Managers addressed staff performance through one to ones and support and mentoring by managers.

- Each team in EOC were audited each month to check competency and compliance against protocols. This was part of the license agreement to use the AMPDS system . The clinical assessment team had an average of six calls audited per month, emergency medical dispatchers (EMDs) five a month. Emergency medical dispatch staff had an average of three or four audits per month.

- The EOC had a dedicated training manager and team, which oversaw recruitment and training for EMDs and dispatch. There were five team members, two based in Lincoln and three at Nottingham. This meant there were specific training courses and induction programmes for EMDs and dispatchers.

- Induction programmes for EOC staff included five weeks of classroom training and time spent with a mentor or buddy. There was a structured induction programme, which covered AMPDS training, safeguarding, conflict resolution and customer service. Two EMDs said they felt prepared for their role and well supported throughout their induction period.

- All new staff received clinical training to help understand the AMPDS questioning and all staff had received Cardio Pulmonary Resuscitation (CPR) training which was refreshed every year.

- There was a proactive approach by the trust to additional training. In addition to mandatory training, the trust had allocated 24 hours of training to each person to engage in other training activity. This had been introduced by the operations director as well as funding to work with staff on behaviour and personality profiles. Personality profiles identified how people learn and communicate their strengths and areas for development. This helped staff to understand how best to communicate with each other and their own development needs.

- The majority of staff across both sites were appreciative of the training offered. Staff said training opportunities were good and they had protected time for development. Staff we spoke with said they had the opportunities to shadow and take part in additional training.

- Managers used bank staff to cover any shortfall in rotas were former EOC staff. For Bank staff to be considered for shifts they had to undertake at least one shift per month. Bank staff were involved in any updates and training including updates in software to the AMPDS system. The trust did not deliver mental health, dementia or learning disabilities training as part of the essential education programme. This meant EOC staff knowledge about these areas was inconsistent and at different levels.

- There were clear career pathways in the EOC, which meant staff could progress, develop, and have the opportunities to do different jobs. Staff could move from the EMD role to dispatch and dispatch staff had moved to incident command, HEMS, or manager positions. Because of a staff restructure, some managers had moved into senior management roles. We spoke with staff that had progressed and undertaken different roles. They all said EOC was a positive environment for progression.

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- There was support for staff following a distressing call or a safeguarding issue. All staff told us they could access traumatic incident management (TRIM) debriefing. Peer support and chaplaincy was also available for staff as additional or alternative support routes. Staff could refer themselves for counselling. Staff told us managers allowed them to have "time out" after a distressing call.

- Four members of staff said there was nowhere to go after a distressing call at Nottingham EOC. If the member of staff was upset after a call they had to go either outside or to the bathroom. There was a sofa situated in the kitchen, which was too noisy and not private. There were meeting rooms situated next to the control room However, staff said managers often used the meeting rooms meaning they were not available. One member of staff said, "we just need a room, with a sofa and some tissue" so staff could receive support or take time out in comfort and privacy.

- There was sufficient knowledge in EOC at all times to assess and/or treat children. All clinicians we spoke with had experience of working with children and the AMPDS and CAD systems met the needs of patients of all ages. Some clinicians had previously been midwives and therefore staff would utilise their experience if calls came through regarding pregnant women or young children. However, there was no specific training for staff on supporting and working with child callers. This meant that while staff could follow prompts there was a risk of staff being unable to communicate with children appropriately to get the right information.

Coordination with other providers

- The electronic systems used by the different teams in EOC enabled all staff to be involved and work together in the assessment, planning and delivering care and treatment of patients. Emergency medical dispatchers (EMD) made initial assessments of patients using specific prompts on the Advanced Medical Priority Dispatch system (AMPDS). The clinical assessment team (CAT) and dispatchers used the information from AMPDS to assess, plan and ensure the appropriate delivery of care .This meant by using one system patient care and treatment was coordinated involving all staff.

- The duty manager at the Lincoln EOC contacted other health care providers in Lincolnshire if they became aware of any issues which could affect patient care or delivery of the service. A dedicated team at Nottingham liaised with other health care providers on a regular basis.

- The trust had procedures for inter-hospital or inter-facility transfers and responding to urgent GP calls. A dedicated EMD officer provided a 24-hour service for any urgent GP transfers to hospitals. Hospitals and EOC had direct telephone lines to each other. We saw dispatch staff allocating the appropriate response to inter-facility and urgent calls. If requests from health care professionals ran over the designated response time, the EMD would call to advise them and extend the pick-up time.

- There were direct lines between the EOC, the fire service and the police meaning there was fast and responsive contact between the services. It was the EMDs responsibility to call and receive calls from fire and the police. We saw examples of effective communication between the services However, there were occasions where there was a lack of understanding and differing expectations about what the ambulance service could provide. An example of this was when the police believed a higher priority (quicker) response was required to the one identified by the ambulance service.

- There was effective communication and cross boundary working with neighbouring ambulance services. Other ambulance services supported incidents and emergencies in the East Midlands and the trust supported other ambulance services with resources. We saw there was regular communication about and sharing of air ambulance resources.

- Patients with do not attempt cardio pulmonary resuscitation (DNACPR) orders were not routinely identified on the 999 Computer Aided Dispatch (CAD) system. If a caller telephoned about a patient in cardiac arrest, and felt CPR was in the patient's best interests, the call taker would support the caller until a clinician arrived on scene. Staff informed ambulance crews or clinicians attending the scene there might be a DNACPR in place.

Multidisciplinary working

- There were twice daily handover meetings between the two EOC's. A senior manager conducted the meetings by teleconference. Handovers included what had occurred on the previous shift, performance, what the current issues were and what issues could occur during the next

shift. We observed a handover; communication was clear and possible risks to services identified. We saw actions implemented to mitigate potential issues affecting performance.

- We observed shift handovers in the EMD, CAT and dispatch team. The handovers were smooth with effective communication involving any issues with crews or incidents, vehicles not tracking, which crews were due breaks and ongoing incidents/emergencies. There were handover sheets so the incoming dispatcher had a hard copy of the information to hand.
- We observed supportive relationships between dispatchers and crews. Conversations were respectful but friendly and good-humoured and dispatchers spoke highly of crews. Overall staff in different teams worked well with each other including crews on the road.
- The CAT worked with a variety of other agencies. They linked in with the crisis team for people who had mental health conditions and signposted to other agencies.
- Lincoln EOC was located in a compact space where staff had easy access to each other. This meant if an EMD required support with a challenging call there was always a clinician or more experienced member of staff nearby to assist.
- We spoke with staff about how they worked with other agencies such as the Fire and Rescue Service, Police and voluntary services. They explained how under the Joint Emergency Services Interoperability Programme (JESIP) they used a joint decision model for working with fire and police.

Access to information

- Staff referred people who called regularly (frequent callers) to the high volume service user lead. Staff could refer callers if a person called 10 times or more per day. Staff told us the process to put alerts on the CAD system was slow because there were so many stages to go through. At the end of the process, the service placed the outcome or plan for the caller on the CAD system for example, "refer to the CAT". There was only one person doing this work meaning that plans for callers were not appearing on the system in a timely manner.
- A specific icon on the AMPDS system clearly identified frequent callers. Clicking the icon led the EMD to specific instructions for the caller usually in the form of a care plan. A dispatch officer made sure ambulance crews attending to the patient received the information. An electronic alert identified frequent callers on the system

even if they did not have care plans. There were review dates for all alerts on a monthly basis. Referrers received an email alert asking whether they felt the alert should stay on the system.

- The EOC quality officer monitored the number of calls EOC received from the same phone numbers. Many frequent callers were hard to identify due to calls made by anonymous and unregistered numbers. Part of the quality officer role was to compile evidence for the police and telephone services to cut off nuisance frequent callers. This helped staff to support genuine patients and prevented them being tied up on nuisance calls.
- The AMPDS system was able to alert staff to avoid potential duplicate calls and responses. If EOC received calls from the same caller three times, staff passed the caller to the CAT to triage.
- Call handlers could raise concerns with the trust mental health team from known frequent callers. Emergency medical dispatchers could also take clinical advice from the CAT if there were no alerts or outcomes on the system.
- We saw each workstation had an AMPDS flip file for use as a back up in case of information technology faults or for planned system shut downs for upgrade or maintenance work. A member of staff demonstrated to us how they would use the flip file.
- Staff used joined up electronic systems in EOC. All staff could see calls and incidents come in to the EOC in real time. Staff could see any electronic notes instantly seen by other teams and members of staff. Staff could listen to each other's calls in order to provide information or responses that were more appropriate. The instant access to information this provided enabled staff to make decisions and send appropriate responses quickly.
- The trust had introduced "change Wednesdays" across the trust to avoid daily contact with staff about minor change to policies and systems. Staff were confident any changes to policies or procedures would take place on the same day every week. The service told staff in advance of any changes and the notice period depended on the scale of the change. The majority of staff liked change Wednesdays and said it provided some consistency.
- The safeguarding team worked with multiple local authorities on safeguarding issues. However, the biggest

concern for the safeguarding team was systems, which did not link up properly with social care providers. This meant exchanging information was sometimes a challenge.

- The trust had taken actions to address NHS England's 2015 Patient Safety Alert: Harm from delayed updates to ambulance dispatch and satellite navigation systems. The EOC systems team updated the CAD system every six weeks to ensure the system had the most up to date information when providing information to staff. The team also managed queries concerning difficulties with addresses. We saw that third party providers regularly updated satellite navigation systems. Therefore, the trust had mechanisms to ensure staff had access to the latest information to help prevent delays.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- It was difficult for staff to judge whether a patient or caller had capacity simply by speaking to them over the phone. Emergency medical dispatchers dealing with people who were contemplating suicide said that sometimes patients or callers would change their mind. However, staff still needed to send a response because staff in EOC were not necessarily able to make judgements on a patient's capacity to make decisions.
- EOC staff asked crews to assess the capacity of patients if there were concerns.
- Some staff said they had received training on the mental capacity act (MCA). Trainers briefly mention mental capacity during induction as part of the customer service module.

Is emergency operations centre caring?

Good ●

Overall, we rated caring for the EOC service as good. We found:

- Staff were compassionate and caring towards patients and callers. Staff treated patients with dignity and respect including those in mental health crisis.
- We observed some examples of patients in distressing situations supported excellently by staff at the end of the phone. Staff were passionate about patient care and providing the best response possible.

- Staff recognised when patients and callers needed further support to understand their treatment and care and provided it.
- The service had systems and processes for clinicians to advise patients how to manage their own health as well as to provide information about alternative patient pathways.

Compassionate care

- We observed excellent examples of compassion demonstrated by staff to callers. We observed calls where patients were seriously ill or had attempted suicide and staff treated callers with dignity and respect. We observed staff talking to vulnerable patients with empathy and kindness.
- We listened to 45 calls. Without exception, staff were calm, reassuring, empathetic and kind. Staff were patient with callers when they became anxious. This enabled the caller to relax and answer the questions required to obtain information about the patient.
- Staff induction training included how to be caring and compassionate. The training lead told us there was an emphasis in induction training for EOC staff on good customer service and treating callers with dignity and respect.
- Feedback from patients during and before the inspection highlighted at times emergency medical dispatchers (EMD) did sound "cold" and unfriendly because they were reading scripts. During busy periods, staff did not take patients through the full triage process. Staff asked patients a limited number of questions and then told them the service was very busy. We listened to calls and heard several examples of patients told to call their GP or find alternative responses to their condition. EMDs read from a script, which required them to end calls as quickly as possible so there were several occasions when an EMD did not sound compassionate. EMDs did not lack compassion and several we spoke to felt helpless when they felt they could not do anything more.

- The service had a new standard operating procedure was in place for staff to use when they did receive an abusive call. Staff knew the trust abusive caller procedures and described how they would handle and escalate abusive callers. Staff had scripts they could use for abusive callers to enable them to work through the

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call and escalate the call appropriately to managers and the security department. Staff remained calm and respectful to abusive callers and supported by managers.

Understanding and involvement of patients and those close to them

- Staff recognised when patients and callers needed additional support and they showed us the resources they had. Staff could access interpreters or requested chaperones when vulnerable patients required transport to another health service.
- Staff communicated with patients and callers effectively. We saw staff making sure callers understood the information they provided. We saw staff explaining what would happen next and callers could ask questions so they fully understood what was happening.
- The Advanced Medical Priority Dispatch System (AMPDS) had standard evidence based advice for callers on what they could do whilst waiting for an ambulance, which ranged from keeping someone warm and comfortable to full cardio pulmonary resuscitation advice. Staff clearly communicated this advice to patients.

- We observed staff providing cardio pulmonary resuscitation (CPR) advice to callers. Staff involved the caller and provided clear, step-by-step instructions. Staff supported the callers while they were resuscitating a patient. The member of staff was encouraging and told the caller how well they were doing. One member of staff had won an award for helping an 11-year-old boy perform CPR on his father which saved his life.

Emotional support

- We observed staff supporting callers and patients who were distressed and anxious. Staff spoke in a calm yet authoritative manner, which gave the caller confidence. Staff communicated clearly about when help was on the way and what patients needed to do while help was coming. Staff re-assured patients before ending calls.
- The clinical assessment team CAT showed understanding of the impact of a patent's care, treatment and condition on their well-being. Clinicians gave appropriate advice and used the telephone assessment software (TAS) system as a support tool for their advice and decision-making.

- Staff showed kindness, respect and compassion for those experiencing mental health crises. We observed staff talking with and supporting patients until further help arrived. Staff listened to patients and where possible empathised.

Supporting people to manage their own health

- EOC were part of an initiative called 'call for care.' Paramedics or the CAT could request a nurse visit when there were no care pathways available for the patient. This meant more patients not admitted to hospital because of this initiative.
- The CAT had access to a directory of services (DOS) and a 'Pathfinder' booklet. The DOS and pathfinder booklet provide staff with clinically safe, evidence based information to help assess the needs of a patient. When speaking with patients staff used these to signpost patients to services other than hospital.
- The CAT used clinical decision support software which included evidence based self-care advice. This meant staff could advise some callers as to how to manage their symptoms themselves so they did not require referral to other health care services. For children under two years of age the CAT would make use of other pathways such as midwives and GP's.
- The trust had several alternative pathways across the region but ambulance staff made decisions on whether or not to follow these pathways. However, the CAT advised crews if necessary on pathways for patients.

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

Good ●

Overall, we rated responsive for the EOC service as good. We found

- The service had a number of different clinical specialist services designed to meet the needs of the local population. This included a dedicated mental health vehicle in Lincolnshire, community first responders (CFR) and emergency first responders (EFR).
- The service had a capacity management plan to cope with different levels of demand. The environment enabled staff to be responsive to patients.

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- Patients could phone or text the service and staff identified where patients had additional needs including interpreting services for patients whose first language was not English.
- Staff had supported callers who were thinking about suicide. The service had systems and processes in place for frequent callers and children with complex needs.
- Staff informed patients of how to complain and knew how to support them to do so. Lessons were learnt from complaints and staff received feedback.

Service planning and delivery to meet the needs of local people

- There were a number of different specialist clinical services designed to meet the needs of the local population. The trust had emergency and community first responder schemes to respond to life threatening emergencies in rural areas where ambulances might take longer to arrive. The trust could deploy several air ambulance services to provide quick responses to major incidents or to incidents where it was difficult for ambulances to access.
- The trust had an East Midlands Immediate Care Scheme (EMICS), which EOC deployed to provide pre-hospital urgent care. The EMICS were doctors in fast or rapid response vehicles. They could provide support to crews or act as a first response. Dispatchers could deploy volunteers from the Lincolnshire Integrated Voluntary Emergency Service (LIVES). LIVES are a charity that provides response to road traffic collisions, cardiac arrests and work place incidents.
- The trust had a 'hear and treat' service. The clinical assessment team (CAT) could assess and triage patients that required medical help without sending an ambulance. This meant more patients could be treated and assessed in their home and ambulances deployed more appropriately to serious incidents.
- The trust had planned EOC capacity to cope with a range of different demands on the service. The trust used a capacity management plan (CMP) to change staff working practices depending on demands for the service. The CMP changed, for example, scripts and questions staff used to assess and triage calls became shorter when there was high demand for the service. The clinical assessment team (CAT) concentrated on welfare calls or particular coded calls depending on the guidance provided by the CMP.

- Facilities and premises at Nottingham EOC were appropriate for the services planned and delivered. The environment enabled staff to focus on their particular roles and geographical area as well as helping to ensure staff across different teams could communicate with each other. The regional operations manager, heli-med service (HEMS), and incident command desk were in the centre of the room so they could communicate with all teams and coordinate responses to incidents where necessary.
- Our inspection team found the Lincoln EOC to be quite crowded and noisy. The headsets used by staff only had one earpiece. Staff told us while they were taking calls the background noise was quite distracting. One manager told us double earpiece headsets were expensive and there was not the funding to purchase these. This meant that there was a risk of mishearing important information provided by callers. There were no reported incidents or near misses in relation to this. However, in a call centre environment a noisy environment could lead to tension headaches.
- The East Midlands hosted several large events on a yearly basis including a rock festival and large motor racing events. The service did not provide medical cover at these events but managers told us they had access to the organiser's event plan. A senior manager attended the event as silver command (part of a multi-organisational command structure used for major incidents and events) and attended planning meetings for the event itself. The trust developed its own event plan, which considered road closures and access to major routes so events did not cause delays for patients. The incident command desk kept event plans to ensure there was a single point of coordination if any serious incidents occurred.
- The hazardous area response team (HART) is a specialised team of medical personnel who attend and support serious incidents involving hazardous materials or environments. Staff viewed the HART team as a specialist resource and staff said they did not feel pressured to use the HART team for regular emergencies, but used when capacity demanded it. We observed HART crews deployed appropriately.
- The trust had developed a mental health steering group at the beginning of 2015. The steering group met once a

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month and senior EOC managers attended. The group aimed to improve the service provided to patients with a mental health illness. Managers sent information to staff sent to staff from the steering group.

Meeting people's individual needs

- Interpreting services were available for callers and patients whose first language was not English. Staff in the EOC had access to these services and demonstrated how they could access and use them. Staff could call on members of staff who spoke different languages to support them.
- There was an SMS emergency text service for callers who were profoundly deaf or who could not speak so they could still access the emergency services.
- The proportion of calls from patients for whom a locally agreed frequent caller procedure was in place was worse than the England average. Data from NHS England for the reporting period April 2014 to July 2015 showed the proportion of patients averaged between 0.1% and 0.5% against the England average of almost one per cent. Less than 10% of frequent callers, 43 out of 468 had care plans on the system, which were visible to staff by a special icon on the patients electronic record. This meant only a small number of patients had a response, which suited their needs.
- The computer aided dispatch (CAD) system included care plans for children with complex needs. GPs, consultants and other healthcare practitioners sent them through to the service. These included plans for children with sickle cell who needed to be taken to specific wards rather than an emergency department. These were only a guide and if staff needed to take a child to the emergency department, they would do so.
- Emergency medical dispatchers (EMD) supported patients who were attempting or contemplating suicide. They stayed on the phone and supported patients until help arrived.
- All silent calls answered, calls where no one speaks, were transferred automatically to the Police. The police force had specialised equipment, which could detect the slightest of sounds in order to try to locate the caller.
- There was no coordinated training for staff in dementia awareness. The trust had not delivered a dementia education module to staff since 2011/12. This meant services delivered might not take account of the needs of patients and callers living with dementia.

- The trust held a programme of awareness raising and education for learning disabilities which they delivered to relevant staff. This was one off training and was not part of the essential education programme. This included recognition of learning disabilities, assessment of mental capacity and the importance of making reasonable adjustments for individuals with learning disabilities. The trust developed easy read information for patients, which they could find on the trust website.
- The trust had produced a CD ROM and accompanying workbook in easy read format entitled "The Ambulance Service and Me". The aim of the workbook was to assist people with learning disabilities to access the ambulance service and to reduce their anxiety when using the service.
- Staff always ensured there were chaperones for patients with learning disabilities who called needing transport. In the case of 999 emergency calls staff remained on the telephone with the patient or their carer until a frontline member of staff arrived. Staff attempted to identify a family member or carer to accompany the patient to hospital.
- A mental health triage car operated in Lincolnshire between 4pm and midnight. A paramedic and a mental health nurse staffed the car. The patient had a mental health assessment and could receive treatment at the scene, which could avoid crews taking patients to hospital. Staff told us outside these working hours they struggled to find pathways for patients who had a mental illness. We saw examples of this during our inspection.
- Staff showed us how they dealt with patients who had a mental illness. They assessed the risk to patients and identified individual needs through a set of triage questions. The trust allowed staff to spend as long as necessary on calls with mental health patients.
- The CAT received mental health training so they knew how to triage and identify people who were at risk of harm. Callers who mentioned suicide always received a response from a crew regardless of the priority symptoms. Staff followed a step-by-step process if callers were threatening suicide and the CAT liaised directly with the community mental health crisis team.

Access and flow

- Dispatch staff experienced problems with some hospitals in the region as to patient handover. However, crews were often waiting for long periods to hand

patients over at hospitals. Crews had a target of 30 minutes to hand over a patient at a hospital and then get the vehicle ready for the next patient. The delays affected dispatchers who could not respond quickly enough to other patients and incidents. While ambulances were waiting at hospitals they could not respond to other emergencies.

- Staff in the EOC monitored the queue of calls in real time. The service had a display screen showing how many people were waiting on the phone, how many staff were on calls and available to answer calls. Managers could use the screen to quickly identify and respond to a queue of calls. The procedure for a queue of calls waiting was to ask additional staff to take calls. They would ask trainers, line managers, staff in training, and staff in meetings to support answering calls. The service had an alarm to alert staff callers were waiting on the phone. This meant the service had processes in place when calls were waiting.

- During busy periods, a duty manager could contact community first responders (CFRs) and ask them if they were available to respond to patients. This would help to minimise the time patients had to wait for treatment or care.

- The trust used capacity management plans (CMP) which influenced patient access and flow through the service. The CMP had levels, which reflected how busy the service was and how long patients were waiting for emergency responses. When the service was extremely busy, the CMP would determine that only life threatening emergencies would receive an emergency response. Staff explained to patients at the end of a call how busy the service was, and where appropriate, advised them to use other healthcare providers such as their GP or a minor injuries unit. This meant there was a system in place to prioritise patients with the most urgent needs and minimise waits.

- Clinical staff used the Paramedic Pathfinder triage tool. This helped staff identify and treat patients safely through alternatives to the emergency department. Frontline paramedics and technicians used this to help avoid sending non-urgent patients to hospital.

Learning from complaints and concerns

- The trust had a dedicated page on the trust website, which provided information to patients on how to complain. The information described the role of the Patient Advice and Liaison Service (PALS) so patients knew what support they could receive. The PALS service had a dedicated email address and telephone number so patients could contact them directly. Patients with hearing difficulties could access the service by using the minicom (a text-based service) number. The website provided details of the local NHS complaints advocacy service along with an explanation of how they could help and support patients.

- Staff could inform patients of how to complain and knew how to support them to do so. Staff attempted to resolve issues early by first referring the caller to a duty manager. Staff could also refer patients to the Patient Advice and Liaison Service (PALS). All staff we spoke with said that receiving a complaint via 999 was rare but they could refer patients to a non-urgent phone number if a 999 caller wanted to complain. This was in line with the trust complaints policy.

- Complaints investigated had appropriate actions and identified learning points. Managers and call auditors investigated complaints and they reviewed calls as part of the investigation. Learning was shared for example, through training, clinical case reviews and amendment to policies, procedures and practice. This was in line with the trust complaints policy.

- Staff gave examples of when the service had changed because of a complaint. One example followed complaints received about incorrect information taken about a patients breathing. The trust introduced a breathing tool to assess breathing before ending calls. This led to more accurate assessment and response.

- All staff we spoke with said that they had received feedback and learning from complaints when it affected them. One to ones and appraisals were used to feedback to staff about learning from complaints.

- Managers said they were attending more local resolution meetings with patients. Local resolution meetings are face-to-face meetings with a person to try to resolve the complaint. Local resolution meetings are considered good practice and a more effective way of dealing with and resolving complaints. Managers said the service was becoming more proactive in their complaints investigation and in the way they talked to complainants. A manager gave an example of visiting a complainant's house to talk with them, answer questions and inviting them to the control centre to see how the service worked.

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- A Learning Review Group reviewed any themes of complaints. They were the EOC quality assurance officer, auditors, managers, and clinicians. The Deputy Director of Quality chaired the group, which meant there was a detailed review of complaints, themes and trends..

Is emergency operations centre well-led?

Good ●

Overall we rated well-led for the EOC service as good. We found:

- The service had a clear vision and there were service changes made in support of the strategy.
- There was a clear governance structure with accountable roles for staff and managers.
- There were frameworks in place to manage risk and quality assurance. Managers and staff knew the key risks to the service.
- The operations director for EOC was popular amongst frontline staff and managers.
- Both EOCs had supportive cultures and environments and all staff felt supported by their immediate line manager.
- The service had systems to engage and listen to staff and the public. There were recognition and reward schemes for staff.

However, we also found:

- There was a difference in morale between Lincoln and Nottingham EOCs. In Nottingham, morale was low, staff felt middle managers did not listen and communication with them was not always clear. This was different to Lincoln EOC, which was a more positive environment and staff seemed unaffected by changes to support the delivery of the EOC strategy.

Vision and strategy for this service

- There was a clear vision and strategy for the trust and this was visible around the emergency operations centre buildings and as computer desktop backgrounds. The operations director had a clear vision for EOC and managers supported it. The senior

management team (SMT) reviewed progress against the strategy and fed back to the board. We saw a presentation to the board from September 2015 giving an update on the strategy for EOC.

- Managers implemented service changes to reflect the vision and strategy. These included 24 hours of protected training time over twelve months, reviews of rotas and changes to the EOC working environment. These changes contributed to improving the quality and consistency of the service.
- Operational staff were not always clear about the strategy or vision for the service. They saw some changes as hindrances or having a negative impact on their working life. Staff did not understand their role in achieving the strategy and vision for the service because of this. Managers agreed there needed to be better communication with staff about plans for the service.

Governance, risk management and quality measurement

- The service had a clear governance structure with accountable roles for staff and managers. The governance structure had recently changed after a review, with the introduction of new management roles. The service had roles to support staff on difficult calls as well as managers who would support and work with managers in the regions to deal with major incidents or delays in hospital handovers. The clinical assessment team (CAT), dispatchers, and emergency medical dispatchers (EMD) all had an allocated service delivery manager. An interim general manager provided management and support to service delivery managers. This meant there were clear lines of reporting throughout all teams into the EOC senior management structure.
- The governance structure did not always support clear communication from management to teams. There were several layers of managers and senior managers passed on key messages to line managers to deliver to staff. Therefore, at times there was a lack of understanding over some issues. Staff perceived an alarm sounding to highlight callers were waiting was there to punish them or highlight they were not doing their job properly. This negatively affected morale. Managers explained they used the alarm to highlight to

staff who could assist with answering calls that callers were waiting and they should help with answering calls. When we raised this issue, managers acknowledged that their communication with staff could be more direct.

- The governance structure had a framework to support the delivery of the strategy, manage risk and discuss quality assurance. There was a regular SMT meeting discussing day to day performance, risks and operational issues. The control service delivery group discussed projects and potential issues. The group discussed assurance, quality and risk in minutes of meetings between March and June 2015. The meetings reflected discussion held at the trust quality and governance committee. This meant there was a clear link to operational and strategic activity.

- Managers and staff knew of the key risks to the service. Staff and managers identified staffing shortages, lack of resources on the road, and finance as the biggest risks.

- Managers responded to and were proactive in managing risks. They reviewed and amended the risk register regularly. There were clear actions, responsibilities and learning. Agent 'walk-aways' occurred when staff left their desk but did not log out of the phone system. The service highlighted this on the risk register because staff could potentially miss emergency calls. We saw managers had implemented actions including posters and reminders to staff to log out of the phone system when they left their desk.

- Operational managers did not always have control over operational matters. This meant making changes to the service was sometimes difficult. We saw, for example, that decisions about rotas and staff swapping shifts taken out of managers' hands. Therefore, managers were not able to be flexible with staff when they needed to take time off outside of their rota pattern.

- Lincoln EOC used a different meal break rota to Nottingham EOC. This meant there was 36 hours per year difference in the time spent working between Lincoln and Nottingham staff. Therefore, the service had to manage rotas differently. A senior manager had tried to standardise rotas across the whole service but was unable to make the decision to do so. This led to frustration from managers and staff who saw these differences as unfair.

- Monthly call audits measured the quality and safety of telecare services. Telecare is health care delivered by telephone and includes assessment, prioritisation and care instructions. There were dedicated staff who

audited calls. Staff told us they received feedback on their call audits by e-mail. However, we saw feedback was limited via email and did not contain much detail. This meant staff did not fully understand their audit results. If learning had been identified the team leader would discuss the call with them.

- The board conducted quality visits to provide board members and senior managers with the opportunity to observe and evidence patient safety, experience and clinical effectiveness. Quality visits enabled managers to see what was good and what could be improved through seeing practice and talking to staff. The 2014/15 trust Quality Account identified several areas for improvement and good practice

- There were occasions where dispatch codes changed on the computer aided dispatch system. We saw evidence of this through reports generated by the EOC quality officer. Codes were changed to reflect more accurately what a crew found when they arrived on scene. Both a senior manager and the quality officer said staff should not change codes, which was why a validation process was under way.

Leadership of service

- Managers said recent changes in the executive team had made a positive impact and led to greater management consistency and stability. All staff we spoke with were complimentary about the chief executive. Staff liked the way the chief executive was visible, approachable and wanted to engage staff face to face.

- The majority of staff had confidence in the direct line managers and leaders. Staff felt supported by their managers. One member of staff said while on long term sick they appreciated the effort the manager had gone to support them.

- Leaders were visible and encouraged a supportive culture amongst the teams. They were proud of their staff, valued their effort and recognised how hard they worked. Managers and staff worked closely together and we saw team leaders walking the floor, talking to and supporting staff. Managers and team leaders were very proactive in communicating and identifying issues early. Managers used words such as "dedicated" and "committed" to describe staff attitude towards their work.

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- Staff told us they would feel happy raising concerns with their line managers or any other member of the management team. All staff said their line managers listened to them and understood their concerns.
- At weekends, team leaders often needed to take emergency calls and this could happen at other times to manage demand. This meant at these times staff felt less supported and team leaders had less time to spend with their teams.
- The board went on 23 quality visits during 2014/15. Quality visits were visits made by board members and senior managers to different teams and locations across the trust in a bid to engage staff but also to demonstrate visible leadership.

Culture within the service

- Staff working at Nottingham EOC did not feel respected and valued by some service middle managers. Staff felt undervalued and morale was low. Staff said this was down to changes made by managers including the rota, the new policy on food and drink in the call centre, staff shortages and increasing workloads. The majority of staff did not feel they listened to ny these managers. Managers said they had introduced changes to improve the working environment for staff and to provide a better service for patients. However they acknowledged communication around the changes had not been effective.
- Morale was high at Lincoln EOC. Staff we spoke with at the Lincoln EOC told us they felt well supported by their managers. They said all the managers were approachable and they could easily raise any concerns with them. Staff felt respected and valued and there was a 'family atmosphere' at Lincoln.
- All staff we spoke with said they loved their job and working in their own teams. We observed a supportive culture between staff and a desire to provide the best possible services to patients. Staff worked collaboratively together to solve problems, for example, complicated incidents or resource demand. Despite working in a highly stressful environment, staff remained upbeat with each other and focussed on their work.
- In April 2015, the trust introduced traumatic incident risk management (TRiM). This included post-traumatic stress debriefing, peer-to-peer support and pastoral

care workers. Staff knew about the scheme and some staff said they had used it. The trust introduced the scheme following staff engagement where staff had said they did not feel supported after traumatic events.

- EOC had a dedicated quality officer who was responsible for addressing the quality of data and system anomalies. The quality officer reported to the EOC senior management and support teams. They contributed to identifying the performance of the service and individuals by providing call data and information. The quality officer was part of the validation process, which ensured codes generated when EOC received 999 calls were correct and the data reported to senior management and commissioners was correct.
- Deployment of resources was to meet patient needs rather than meet targets. Staff prioritised emergencies against competing demands and used emergency first responders (EFR) and community first responders (CFR) appropriately. The EFR and CFR and were deployed alongside ambulances and provided an additional resource to dispatchers. Staff did not consider them a replacement service.

Public and staff engagement

- The trust had a staff engagement programme called Listening into Action (LiA). Listening into Action aimed to empower staff to lead and drive change both locally and at an organisational level. We saw LiA posters displayed and staff told us about listening events they had attended. We found there was a genuine desire from managers to listen to staff. Managers had acted on staff feedback, for example the introduction of the TRiM scheme.
- During our inspection, we saw staff engaged at Nottingham EOC about a new rota system. Managers said they had decided previous rota changes and acknowledged there was very little consultation with staff. Therefore, managers asked staff to suggest ideas for the new rota on this occasion. Managers selected four options from staff ideas and asked EOC staff to vote on their favourite.
- However, staff perceived that managers did not listen to them. Staff did not always receive feedback or understand changes made by managers because of feedback. While managers were implementing a new rota system based on staff suggestions the four options

available to staff were similar versions of an existing rota. Staff did not receive an explanation as to why those four options chosen were better than others put forward.

- Managers were generally aware of the concerns of staff and issues they raised. We found managers had different levels of understanding (including some managers not aware) of why staff had objected or felt undervalued by some changes implemented. Some managers we spoke with recognised communication needed to be better with frontline staff.

- At an operational level, teams did not have regular team meetings mainly due to the shift patterns of staff. Therefore, communications with staff varied according to the team leader and the team. Line managers communicated to staff verbally and face-to-face. We saw managers passing on individual and team related information as the day progressed. The advantages to staff were they could receive information in a timely manner especially as it was such a responsive service.

- The trust held a patient experience forum chaired by the director of nursing and quality. Patients and their carers attended the forum. The trust held focus groups and events across the region to engage with patients including those in "seldom heard" groups. The trust had a community engagement strategy for 2014 to 2016.

- The trust produced materials for the public and distributed them at public events and through social media. They explained how emergency and urgent calls are graded, alternative pathways to emergency care, sources of professional medical advice for non-urgent problems and methods of self-care.

Innovation, improvement and sustainability

- The trust had an annual award ceremony. The chief executive handed awards to staff. The trust announced nominees and winners on the trust website and included a range of examples of positive work by staff.

- Staff received monthly awards, for example EMD or dispatcher of the month. Staff received certificates when they were involved in successfully resuscitating a patient. Most of the staff we spoke with knew about the awards.

- The service awarded staff badges for good customer service and 100% in individual staff call audits. There were bronze, silver and gold badges depending on the results and level of the audit results. We saw these announced in the trust EOC bulletin and staff notice boards.

- The trust had worked with six fire services across the East Midlands to introduce a regional Emergency First Responder (EFR) Scheme. This was the first service of its kind for an ambulance service nationally. The scheme covered 23 rural communities and worked with retained fire stations. The ambition of the EFR service was to improve the survival rate of people with life threatening illnesses and injuries. The scheme was widely publicised in both local and national media.

- Managers and staff told us about workshops held to support continuous development and improvement of the service. Some workshops were for specific teams such as EMDs or dispatchers. Staff could attend workshops for other teams to access training, share information and discuss ways of improving relationships and the service. A recent workshop had concentrated on effective communication between EOC staff contributing to the quality of response and care a patient received. Managers expressed enthusiasm about the workshops and most staff we spoke with said they were a good idea.

- Staff and managers at all levels identified shortage of finance as a key issue, which affected the delivery, and improvement of the service.

Outstanding practice and areas for improvement

Outstanding practice

- A project was in place to improve the treatment for patients in acute heart failure. This involved issuing crews with continuous positive airway pressure (CPAP) machines. These are machines often used for patients with sleep apnoea. The CPAP machine improves oxygen saturation levels in these patients.

- In Leicester, Leicestershire and Rutland a Smartphone project was being piloted with the issuing of five phones which had been uploaded with an application linked to a mobile directory of services. This was currently in the test phase and will be rolled out to all staff in 2016. Access to alternative care pathways and the paramedic pathfinder pocket book will be included. This will give frontline staff on the road instant access to information.

- In Lincolnshire, a rapid response vehicle (RRV) had been made available from 16:00 hrs until 24:00 hrs manned by a paramedic and a mental health nurse from the local mental health trust. It was commissioned by the local mental health trust. Based in Lincoln, the RRV could respond to any mental health crisis in the division that was not in a hospital. The acute trust and police force were positive about the initiative which had reduced the number of double crewed ambulances attending such patients and the number of them admitted to an emergency department. At the time of our visit the paramedics manning the RRV were doing this on an overtime basis as the funding had not been approved to recruit to the post on a substantive basis. Staff felt three more RRVs were required to cover the large county of Lincolnshire as well as rolling the system out across all EMAS divisions.

- Lincolnshire Fire and Rescue Service had supported EMAS by co-responding to medical emergencies for over 15 years. However, a project was in place which commenced in April 2015 and had been rolled out across all five divisions in the EMAS region to launch the UK's first regional Emergency First Responder (EFR) scheme. EMAS had trained each EFR to enhance their existing medical care knowledge, including basic life support, cardiopulmonary resuscitation (CPR) and oxygen therapy. The EFRs were equipped with a kit which included oxygen and an automated, external defibrillator (AED) to help patients in a medical emergency such as a heart attack, collapse or breathing difficulties. The scheme officially launched in June 2015 when Derbyshire, Leicestershire & Rutland, Northamptonshire and Nottinghamshire also went live with the pilot. 24 cars had been provided for the project by the six fire service areas. EFR's were deployed by EMAS operations centre who contacted the fire service control and requested assistance.

- Three ambulances had been bought by Lincolnshire Fire and Rescue Service with the same specification as EMAS ambulances. The vehicles were based in Woodhall Spa, Stamford and Long Sutton. EFRs manning the vehicles had received further training in diagnostic techniques from EMAS staff but were not trained in further clinical practice. Such vehicles attending an emergency were backed up by a paramedic in a rapid response vehicle (RRV) from EMAS. If a patient required admission to hospital the paramedic would accompany the patient in the ambulance.

- The trust had direct access to electronic information held by community services, including GPs. This meant that patient transport service could access up-to-date information about patients, for example, details of their current medicine.

- Guide dogs were allowed to accompany visually impaired patients. Staff name badges included their name in Braille to assist patients with visual impairment.

- The patient information and liaison service (PALS) had recently commenced a 'secret shopper programme'. This had involved recruiting existing patients to report to PALS about their planned journey and their experience of PTS. There had been positive feedback with one patient telling her story to the trust board. PALS planned to recruit from different patient groups to give a broad view of patient experiences of PTS.

- We observed many excellent examples of non-clinical staff supporting patients and saving lives in what were extremely difficult and stressful situations. Staff remained calm, supportive and gave callers confidence to deliver lifesaving treatment.

Outstanding practice and areas for improvement

- The Lincolnshire Mental Health Triage Car enabled patients have a mental health assessment and treatment at the scene, which could avoid crews taking patients to hospital.
- The trust had introduced "change Wednesdays" to avoid daily contact with staff about minor changes to policies and systems. Staff were confident any changes to policies or procedures would take place on the same day every week.

- The trust had worked with six fire services across the East Midlands to introduce a regional Emergency First Responder (EFR) Scheme. This was the first regional service of its kind for an ambulance service nationally. The EFR service aimed to reduce waiting times in rural areas.
- The trust were the best performing ambulance trust in England for the number of calls abandoned before answered.

Areas for improvement

Action the trust MUST take to improve

- The trust must ensure there are sufficient frontline paramedic and other staff with an appropriate skill mix to meet patient safety and operational standards and national target levels for Red 1 and Red 2 calls.
- The trust must ensure there are sufficient ambulances and other vehicles to respond to emergency calls in a manner that meets patient safety and operational standards and national response targets for Red 1 and Red 2 calls.
- The trust must ensure ambulances, rapid response vehicles and their equipment are checked on a daily basis as per trust policy to ensure patient and staff safety.
- The trust must ensure all clinical, domestic and hazardous material is managed in line with current legislation and guidance.
- The trust must endure all staff are fitted for and trained in the use of filtered face pieces (face masks) according to the Health and Safety Executive requirement in Operational Circular 282/28.
- The trust must ensure the servicing of all equipment is undertaken at the correct intervals stipulated by manufacturers to ensure the safety of patients.
- The trust must ensure medicines are always stored safely and securely and audited effectively from the distribution of drugs to ambulance personnel, to their destruction or return. In addition they must take action to ensure staff follow the trust's policy in relation to countersignatures for controlled drugs.
- The trust must take action to ensure paper report forms are stored securely, on vehicles and in ambulance stations.

- The trust must ensure all staff have sufficient opportunity to complete essential education training at the required frequency
- The trust must ensure statutory and mandatory training updates are delivered to PTS staff.
- The trust must ensure checks of PTS volunteer driver's documentation including MOT and insurance certification are performed and recorded annually.
- The trust must put systems in place to promote sharing and learning in PTS following a reported concern or incident.
- The trust must ensure that all PTS staff receive an annual appraisal.
- The trust must ensure there is an effective governance process in place to manage the quality of third party provision for PTS such as taxi services.
- The trust must ensure all staff in EOC understand what an untoward incident is and report them consistently in line the trust policy.
- The trust must ensure all reported incidents are investigated in line with the trust policy.
- The trust must ensure that staff mandatory training achieves the trust target of 95%.
- The trust must ensure there are sufficient staff in the EOCs to meet planned staffing levels and demand, including at weekends.
- The trust must ensure all staff in EOC receive annual appraisals, which are accurately recorded by managers.

Action the trust SHOULD take to improve

- Consider how feedback from incidents is supplied to individual staff raising the issues in a timely manner.

Outstanding practice and areas for improvement

- Consider how lessons learnt from incidents can be effectively shared across the trust and how resulting actions can be consistently implemented.
- Consider how all staff understand the Duty of Candour and their responsibilities under it.
- Consider how all frontline staff receive on-going training relating to the care of patients with mental health illnesses.
- Consider how line managers can have sufficient allocated time to manage their teams effectively.
- Consider appropriate career development opportunities for staff.
- Consider how mental health pathways could be improved by working with other partners across the whole of the region.
- Consider how to provide an effective system of regular clinical supervision for paramedic and other clinical staff.
- Consider how to ensure staff have sufficient time to clean vehicles before being allocated to another call.
- Consider the effectiveness of processes for approval of annual leave for staff.
- The trust should consider how all risks associated with PTS can be captured and reviewed on the risk register.
- The trust should consider providing PTS staff with protected time to access work related emails and other communication.

- The trust should consider how to ensure staff in EOC have adequate training in mental health awareness to be able to support patients calling with mental illness.
- The trust should consider how to ensure staff in EOC have adequate training in dementia awareness to be able to support patients calling who are living with dementia.
- The trust should consider how to ensure staff in EOC have adequate training in awareness of learning disabilities to enable them to support patients calling who have a learning disability.
- The trust should consider whether EOC staff have received sufficient training in the Mental Capacity Act 2005 to be able to support callers appropriately.
- The trust should ensure EOC staff receive training to enable them to support and work with child callers.
- The trust should consider communication with and support to EOC staff, which would enable them to understand changes to services, which support the ongoing strategy.
- The trust should consider working with partners to develop 24-hour mental health pathways.
- The trust should consider the provision of an appropriate space for EOC staff to use following a distressing call.
- The trust should evaluate the effectiveness of single piece ear sets issued to staff at the Lincolnshire EOC.
- The trust should work towards having Care Plans in place for all frequent callers that require them.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment must be provided in a safe way for service users. A registered person must comply with this by assessing the risks to the health and safety of service users and doing all that is reasonably practicable to mitigate any such risks. How the regulation was not being met: Relevant checks of volunteer PTS drivers were not always completed. This included motor insurance, vehicle MOT (where applicable) and driving licence checks

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 by the service provider in provision of the regulated activity must: - receive 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 regulation was not being met: PTS Staff were not receiving annual appraisals in accordance with trust policy PTS staff were not attending mandatory training, as defined by the provider for their role.

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

Requirement notices

Systems or processes must enable the provider to assess, monitor and improve the quality and safety of the services provided.

How the regulation was not being met:

There is no service level agreement with named taxi companies to assure the quality of service provision.

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 must assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. How the regulation was not being met: The provider did not always report incidents or investigate reported incidents.

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 by the service provider in provision of the regulated activity must: - receive 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 regulation was not being met: EOC staff were not receiving annual appraisals in accordance with trust policy

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Requirement notices

Transport services, triage and medical advice provided remotely

Treatment of disease, disorder or injury

Persons employed by the service provider in provision of the regulated activity must receive 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 regulation was not being met:

The provider was not delivering mandatory training to sufficient staff in EOC.

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 Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this part. How the regulation was not being met: The provider did not have sufficient staff deployed to meet the demands of the service in EOC

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment All premises and equipment used by the service must be appropriately located for the purpose for which they are being used. **How the regulation was not being met:** The provider did not have sufficient ambulances and other vehicles for deployment to meet the demands of the service in Emergency and Urgent care in order to attain and sustain national target response times for Red1 and Red 2 calls.

Regulated activity	Regulation

Diagnostic and screening procedures

Transport services, triage and medical advice provided remotely

Treatment of disease, disorder or injury

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Domestic, clinical and hazardous waste and materials must be managed in line with current legislation and guidance

How the regulation was not being met

The provider was not ensuring domestic, clinical and hazardous waste and materials were managed in line with current legislation and guidance.

Regulated activity	Regulation

Diagnostic and screening procedures

Transport services, triage and medical advice provided remotely

Treatment of disease, disorder or injury

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Providers must make sure that they meet the requirements of relevant legislation so that premises and equipment are properly used and maintained.

How the regulation was not being met

The provider was not ensuring the servicing of all equipment was undertaken at the correct intervals stipulated by manufacturers to ensure the safety of patients.

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

The provider must ensure the proper and safe management of medicines.

How the regulation was not being met

Requirement notices

The provider was not ensuring medicines were always stored safely and securely and audited effectively nor ensuring staff followed trust policy relating to controlled drugs.

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 Records relating to the care and treatment of each person must be kept secure at all times and only accessed, amended or securely destroyed by authorised people. **How the regulation was not being met** The provider was not ensuring paper report forms were stored securely, on vehicles and in ambulance stations.

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 by the service provider in provision of the regulated activity must: - receive 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 regulation was not being met:** The provider was not delivering mandatory training to all staff in emergency and urgent care.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Requirement notices

Transport services, triage and medical advice provided remotely

Treatment of disease, disorder or injury

Systems or processes must enable the registered person to assess, monitor and mititgate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.

How the regulation was not being met:

The provider did not ensure staff were fitted for and trained in the use of filtered face piece masks to protect them from the risk of infection.

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

The table below shows why there is a need for significant improvements in the quality of healthcare. The provider must send CQC a report that says what action they are going to take to make the significant improvements.

Why there is a need for significant improvements	Where these improvements need to happen
The Registered Provider does not ensure care and treatment is provided in a way which is safe because there are insufficient numbers of suitably qualified, competent, skilled and experienced persons employed. We have issued a s.29A Warning Notice to the Registered Provider, as the quality of health care provided for the regulated activities listed requires significant improvement.	Trust Headquarters