East Midlands Ambulance Service NHS Trust

Emergency and urgent care

Inspection report

1 Horizon Place, Mellors Way
Nottingham Business Park
Nottingham
NG8 6PY
Tel: 01158845000
www.emas.nhs.uk

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Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services effective?	**Inspected but not rated**
Are services caring?	**Inspected but not rated**
Are services responsive to people's needs?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Emergency and urgent care

Inspected but not rated

East Midlands Ambulance Service NHS Trust (EMAS) provides emergency 999 and urgent care services for a population of approximately 4.86 million people within the East Midlands region.

This region, which covers approximately 6,425 square miles, includes the counties of:

Derbyshire

Leicestershire

Lincolnshire

Nottinghamshire

Northamptonshire

Rutland.

The service operates from over 90 facilities including ambulance stations, community ambulance stations (smaller facilities which are often shared buildings with other organisations and are used as standby points for our crews), two emergency operations centres (Nottingham and Lincoln), training and support team offices and fleet workshops. EMAS has a fleet of over 746 vehicles, including emergency ambulances, fast response cars and specialised vehicles.

EMAS responds to over 730,000 emergency and urgent incidents per year, with over 2,000 emergency calls per day being received. The front-line Emergency and Urgent Care staff include specialist practitioners, paramedics, technicians and emergency care support workers. They are based in up to 90 ambulance stations across the region. The trust also subcontracts some of its work to voluntary and private organisations.

The trust employs over 4, 077 staff, the majority being frontline accident and emergency ambulance personnel. Patient Transport Services (PTS) are currently provided for people who have routine (non-urgent and scheduled) clinic appointments across Derbyshire and Northamptonshire.

The trust has AMPDS accreditation: Advanced Medical Priority Dispatch System (AMPDS) which is a unified system used to dispatch appropriate aid to medical emergencies including systematised caller interrogation and pre-arrival instructions. Priority Dispatch Corporation is licensed to design and publish MPDS and its various products, with research supported by the International Academy of Emergency Medical Dispatch (IAEMD).

We carried out this short notice announced inspection on 12 and 13 April 2022. We had an additional focus on the urgent and emergency care pathway for patients across the integrated care system in Leicestershire. As the trust serves six counties, not all information will relate to Leicestershire, but we have included specific data and evidence where we can.

Our findings

A summary of CQC findings for the overall urgent and emergency care services in Leicester, Leicestershire and Rutland.

Urgent and emergency care services across England have been and continue to be under sustained pressure. In response, CQC is undertaking a series of coordinated inspections, monitoring calls and analysis of data to identify how services in a local area work together to ensure patients receive safe, effective and timely care.

We have summarised our findings for Leicester, Leicestershire and Rutland below:

Provision of urgent and emergency care in Leicester, Leicestershire and Rutland was supported by services, stakeholders, commissioners and the local authority.

We spoke with staff in services across primary care, integrated urgent care, acute care, mental health services, ambulance services and adult social care. Staff had worked very hard under sustained pressure across health and social care services.

People reported difficulties when trying to see or speak to their GP. Some GP practices had invested in new technology to improve telephone access. Staff working in GP practices signposted patients to extended and out of hours services to prevent people attending emergency department whenever possible.

Staff working in urgent care reported an increase in demand and an increase in acuity of patients presenting to their services. Some staff reported frustrations in relation to urgent care pathways; staff working in advanced clinical practice were not always empowered to make referrals into alternative pathways.

Staff working in urgent care services reported challenges due to the volume of pilots focused on admissions avoidance running across Leicester, Leicestershire and Rutland. Many pilots ran for relatively short periods of time and were often impacted by staffing issues. This made it difficult to maintain oversight of pathways available to avoid acute services. However, some pilots had proved successful and prevented ambulance responses and hospital admissions.

Staff working across urgent and emergency care services raised concerns about their skills set. Some ambulance staff feared the shift from dealing with multiple emergencies to providing longer term care for one patient in a shift. Some staff in urgent care services felt they needed additional training to meet the needs of patients presenting with higher acuity.

Patients seeking advice from NHS111 in Leicester, Leicestershire and Rutland experienced some delays getting through to the service, when compared against national targets. However, at the time of our inspection, performance was better than England averages for key indicators including the percentage of calls answered within 60 seconds, and call abandonment rates. Staffing continued to be a challenge across NHS111, however recruitment was on-going.

Out of hours care had been challenging throughout the pandemic as staff were redeployed to other key services, this had particularly impacted on home visiting services.

The emergency department serving Leicester, Leicestershire and Rutland is within a large, city centre hospital. and poor patient flow across health and social care has further increased the significant pressure on the emergency department. This pressure has resulted in long delays in care and treatment. Long delays in ambulance handovers have, in turn, resulted in a high number of hours lost to the ambulance service whilst their crews wait outside hospital. This causes further delays in responding to 999 calls to patients in the community with serious conditions.

Our findings

Ambulance crews reported an increase in the volume of patients calling 999 who told them they had been unable to see their GP and crews often signposted patients back into primary care.

We found psychiatric liaison services at the city centre hospital were well run and designed to meet people's needs. Staff demonstrated effective partnership working with a person-centred approach and good use of alternative pathways to avoid admission into acute or social care services.

We found that staff working across specialisms in acute services did not always provide sufficient in-reach into the emergency department to improve patient flow and the care received. This was particularly apparent at night. Beds were not allocated to patients until they had been accepted by specialists, this meant some patients spent additional time waiting in ED. During our inspection, between 45 and 60 beds were needed for new patients waiting in ED. Some patient transfers to other hospitals in Leicester, Leicestershire and Rutland stopped at 8pm, this restricted patient flow out of the city centre hospital.

Some staff reported frustrations with escalation processes across health and social care in Leicester, Leicestershire and Rutland. At times when the city centre hospital and the ambulance service was under significant pressure, staff felt there was a lack of diverts available to other sites or services and that system partners were slow to respond. There was a rapid ambulance handover process when services were in escalation; however, staff reported these were not effective.

There was a high number of patients in hospital who were medically fit for discharge but remained in acute services. System stakeholders worked together to consider discharge pathways; however, at the time of our inspections the number of patients awaiting discharge remained very high. Delays were still commonplace and capacity in community and social care services impacted on the ability of staff to safely discharge patients. Communication about discharge and discharge processes were impacting on the quality of transfers of care to social care services.

People living in social care setting experienced long delays, particularly when accessing 111 or 999 services. Although advice was provided, this had resulted in significant waits and poor outcome, especially for people who had fallen and remained on the floor. Staff working in social care services told us they had limited access to support and advice and relied on GPs, 111 or 999.

System wide collaboration, accountability and risk sharing needs to improve to alleviate pressure on key services in Leicester, Leicestershire and Rutland.

Summary of East Midlands Ambulance Service NHS Foundation Trust

As this was a focused inspection, we did not look at every question in our key lines of enquiry, we did not re-rate the service at this time. This inspection was focused around system pathways focusing on Leicester, Leicestershire and Rutland, we did not visit any other regions during this inspection. We continue to monitor services provided by EMAS.

At our previous inspection published in 2019, we rated emergency and urgent care services at the trust as good overall with caring rated as outstanding and the other key questions as good.

On this inspection we reviewed emergency and urgent care services. For this core service we looked at elements of the safety, effectiveness, caring, responsiveness and leadership of the staff and teams responding to 999 calls, and those supporting the emergency departments on site.

For emergency and urgent care, we found:

Our findings

- The service was under immense pressure from a lack of bed-capacity in the acute hospitals and the community with patients waiting in ambulances at emergency departments (which were also full). The service was staffed and resourced safely to meet people's needs in most areas for commissioned and planned levels of demand. Staffing levels had been increased to deal with some of the predicted increase in demand for ambulances, but not to cope with the lack of bed capacity experienced. However, additional recruitment of staff continued across the service.
- Delays in the handover of patients at emergency departments meant the service was unable to reach all patients who needed an ambulance in a timely way, in line with national targets. There was evidence to show the trust had taken internal action to manage the increasing demand on urgent and emergency care capacity. However, incidents of patients waiting long periods of time for an ambulance were increasing and occurred on most days. This was having a significant impact on patients waiting and the morale of staff across the service
- There were risks for patients because of ambulance handover delays in emergency departments. There were known and unknown risks of harm to patients who were held in an ambulance or waiting in the community and an ambulance was not available or excessively delayed. This led to harm for some patients.
- The NHS contractual response times for ambulances to attend patients were not being met and some were exceptionally long and increasing, ambulances were waiting at emergency departments due to the increase demands and capacity pressures in hospitals and other parts of the health and social care system.

However:

- Staff were discreet and responsive when caring for patients. Staff took time to interact with patients in a respectful and considerate way.
- Patients said staff treated them well and with kindness.
- Staff treated patients with exceptional compassion and kindness, respected their privacy and dignity, and took account of their individual needs in increasingly difficult circumstances.

How we carried out the inspection

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

For our emergency and urgent care inspection, we met with staff operating in Leicester, Leicestershire and Rutland. We spoke with the trust's commander and the deputy commander for Leicester, Leicestershire and Rutland. We talked with paramedics, emergency care assistants and other members of staff on duty at the emergency department at Leicester Royal Infirmary Hospital NHS Trust. We spoke with 15 paramedics, emergency care assistants and other support personnel, and the tactical commander.

We spoke with patients while on site at the emergency department. Some were still in ambulances and others had arrived by ambulance and been taken into the emergency department. Although we observed care delivered by ambulance staff for a number of patients, some of these were not well enough to talk with us. Due to rules of safety in the COVID-19 pandemic, and in light of the pressures of demand on the ambulance service, we did not ride out with crews or observe them on the scene with patients.

Our findings

Is the service safe?

Inspected but not rated

Cleanliness, infection control and hygiene

The service-controlled infection risk well. Staff used equipment and control measures to protect patients, themselves, and others from infection. They kept equipment, vehicles, and premises visibly clean.

We visited four stations in Leicestershire and all vehicles we saw were visibly clean and well maintained. Records we saw were up-to-date and showed vehicles were cleaned regularly. All vehicles underwent maintenance checks and were booked in for a deep clean every 42 days in line with policy, or sooner if required. For example, if a patient with a diagnosed contagious illness was conveyed, vehicles were scheduled for an emergency deep clean.

The vehicles were well-stocked and tidy. We saw an empty ambulance when staff were taking the patient into the emergency department, and this was visibly clean and tidy. This included the floors, the cab, the equipment, and the cupboards.

Ambulance staff attending emergency departments were wearing the appropriate personal protective equipment (PPE) including masks and gloves at the right time. They said they were equipped with PPE and trained to use it effectively.

The trust undertook regular briefings on infection prevention and control and had a helpline for staff with questions and problems. Infection prevention and control videos and images were also provided to give additional guidance around cleaning and protection for staff.

There was a regular COVID-19 testing programme for staff and those staff we met said they were following the guidance to check their status and reporting this to the organisation. The trust monitored rates of staff vaccinated against flu and COVID-19. The trust was able to provide flu and COVID-19 vaccinations to staff, including the booster, or staff could also use their local NHS service.

Environment and equipment

The design, maintenance and use of facilities, premises, vehicles, and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Each ambulance station we visited had a signing in book for visitors; all visitors were required to have their temperature checked and wear face coverings as per trust COVID 19 guidance.

At the start of their shift, ambulance staff carried out daily safety checks of the ambulance on-board specialist equipment. There was a system for recording defective equipment so that the maintenance team could make timely repairs. We were told equipment was regularly serviced and defective equipment was stored separately from useable equipment. Equipment we inspected was said to be readily available and usually repaired quickly. Staff had access to up-to-date communication systems and felt the trust responded well if there was any equipment failure or fault.

Vehicles had identical layouts and equipment storage. This meant that crews from any station could easily access equipment without delay. Equipment including blood pressure cuffs, thermometers and blood glucose monitoring kits were standardised across vehicles which ensured staff knew how to use the equipment during patient treatment.

Our findings

There were additional risks to ambulance crews and patients at one of the emergency departments in Leicestershire. The ambulances were having to queue outside of the entrance to the emergency department and at times on the side of a busy road. However, ambulance crews were very aware of the potential safety issues and were mindful of the risks.

Staff disposed of clinical waste safely. We saw general, infectious, and hazardous (including sharps') waste stored safely. Waste was collected once a week from each site but could be collected more frequently if required.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and where possible minimised risks. Staff identified and quickly acted upon patients in their care at risk of deterioration. However, the extensive delays experienced by several patients being handed over to the emergency departments were adding risks to patient safety and welfare.

According to the NHS contract, all handovers between an ambulance service and an emergency department must take place within 15 minutes with none waiting more than 30 minutes. The role of the ambulance crews was to treat a patient on the scene and if required take them to an emergency department for ongoing care. The risk to the patient would then be handed over to the emergency department teams on arrival. The responsibility for the patient is that of the emergency department when the ambulance arrives.

Ambulance crews had additional pressures around assessing and responding to the risks to patients, due to extensive delays in handover. Ambulance crews were required to assess and respond to risk and deteriorating patients in situations and timeframes they had not been trained or expected to manage. To help with this they used the National Early Warning Score (NEWS2) tool to monitor and manage deteriorating patients. Staff we spoke with said due to handover delays they are now required to always care for the patient for far longer than optimal for safety and the best outcome for the patient. Due to delays, the NEWS2 tool was now being used extensively beyond how it was designed or expected to be used by ambulance crews.

EMAS has implemented a safety prevention of harm tool, this was a tool designed to prevent patient harm. This tool was used if there were more than eight vehicles waiting outside ED (Emergency Department) for in excess of one hour. Ambulance crews we spoke with said this gave them some assurances that as a trust they were doing all they could to prevent harm to their patients whilst delayed outside ED.

Many crews were extremely frustrated by the system; many said the system was failing NHS staff and patients. Crews were able to share many examples from their experiences of system failure with us. One example that upset many crews was hearing on their radio that patients in the community were suffering. One call was a patient in cardiac arrest that was 10 minutes down the road from ED and that the nearest resource of vehicle was 30 minutes away, crews waiting outside ED with patients in the back of their vehicles felt disempowered and frustrated, that they were not able to provide the urgent and emergency service that they have all been trained to do.

The trust had policies and procedures in place to manage disturbed or unacceptable behaviour from members of the public; this included protecting staff who were lone workers. If acts of violence or aggression had occurred whilst ambulance staff were treating a patient this would be documented and a flagging note placed on the system to inform future staff of these actions.

During our observations, we saw appropriate manual handling techniques used for the transfer of patients. This ensured that staff and patient safety was well maintained, and injuries were avoided.

Our findings

The contribution of ambulance crews was significant. Since going live in September 2020, they have seen approximately 21,000 patients with a conveyance rate of only 24% for Category 3 calls. The medical director was able to monitor the specialist practitioners activities through a specific audit tool, which allows data analysis down to individual practitioner level. Senior management told us that specialist practitioners were specifically employed to prevent conveyancing to hospital and to target cardiac arrests and lower category three calls to avoid admission.

Some ambulance staff said at times they waited much longer for handover including some between eight and 12 hours. This required ambulance staff to assess and respond to any deterioration of their patient in their health or condition. Staff told us this was particularly challenging for them with patients experiencing a mental health crisis or with cognitive impairment or anxiety. Risks associated with these waits included: skin damage; delays in tests, treatment, medicines and nutrition and hydration; and a lack of access to toilet or washing facilities. EMAS had acted for prevention and had implemented a Hospital Handover Harm Prevention (HHHP) tool, where senior crew members went around each vehicle and reviewed all patients that had been delayed for long period of time in the back of the vehicle.

Staff we spoke with were able to give us examples of the impact of lengthy delays. Staff told us of three separate serious incidents that had happened in the back of their vehicles three days prior to the inspection with one serious incident resulting in a death of a patient following a cardiac arrest.

On 4 January 2021, an audit of hospital handover delays over 60 minutes was undertaken by all ten ambulance services in England. The audit was commissioned by the Association of Ambulance Chief Executives (AACE) to measure the impact of patient harm. A total of 470 cases were reviewed by senior clinicians using an agreed assessment tool to identify the level of potential harm associated with the delay. This represented 35% of all patients experiencing a delay in their handover that day. Over eight out of 10 (85%) of those whose handover was delayed more than 60 minutes were assessed as potentially experiencing some level of harm with one in 10 (9%) having potentially experienced severe harm.

The national AACE work was undertaken in January 2021, the hospital handover position and prolonged waits have deteriorated significantly since then which may mean that patient safety risk has increased. This was reflected in rising serious incidents numbers (22 delayed response reported from September 2021 to April 2022) compared to one in 2020/21 and 22 in 2019/20 full years.

Some patients waited in ambulances for many hours, and data showed how many hours were lost (lost hours refers to anything above 15 minutes) this data was based on Leicester, Leicestershire and Rutland only. In the reporting period of January 2022: 4312 hours lost, February 2022: 4389 hours lost, and March 2022: 5914 hours were lost. For three years, EMAS have consistently lost more time to hospital handovers than is expected. In January Leicester Royal Infirmary received 4,775 handovers from EMAS, equivalent to 13% of all EMAS' handovers in the month. These handovers account for 25% of all EMAS' handover time.

Crews did not always start their shift with a new job or call to a patient. For example, crews started their shift at an emergency department to take over from crews standing outside.

Ambulance crews said the medical and nursing staff at the emergency department responded as quickly as they were able to, if they believed a patient was rapidly or significantly deteriorating. However, there was no routine clinical emergency department support to the crews except for the coordination and management from the tactical

commander. They risk assessed the patients to liaise with the hospital staff as to the priority and risk of patients on the ambulances. The work they did was spoken of as highly valued by the ambulance service and the emergency departments. When handovers were made to emergency department staff, ambulance staff shared key information with them.

Staffing

The service had staff with the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and to provide the right care and treatment. However, the ambulance handover delays, unplanned absence through sickness or COVID-19 isolation rules, and the pressure from increasing demand meant staff could not always provide the care patients needed.

Many staff were working beyond their hours and not always getting breaks on time in what were already long shifts. Staff were able to give us many examples of long shifts they had completed that had exceeded their working hours. Most staff said they did not always get breaks, or these were delayed. Some staff were waiting outside emergency departments for eight hours with no breaks. However, staff said, the organisation was committed and working hard to prioritise staff wellbeing to ensure crews were able to take breaks and find cover as soon as possible, to allow those crews waiting outside ED to finish their shift on time.

In the reporting period of January 2022 and April 2022, and 7.58% sickness rate in March 2022 against trust target of 5%.

The trust was working extremely hard to recruit into roles to support with the additional pressures the NHS is currently under. The Medical Director had been working on the recruitment drive of the specialist practitioner role, which was developed during the COVID 19 period. The target number of specialised paramedics was currently at 66, giving coverage of two specialised paramedics per division plus a team in control. EMAS have recruited and trained 50 specialised paramedics so far, following four recruitment processes.

Is the service effective?

Inspected but not rated

Response times

Due to extreme demand, the service was not meeting any NHS constitutional ambulance response times, which was a similar picture across the ambulance services nationally.

The NHS constitutional standards are set out in the Handbook to the NHS Constitution as below. All ambulance trusts to:

- Respond to Category 1 calls in 7 minutes on average, and respond to 90% of Category 1 calls in 15 minutes
- Respond to Category 2 calls in 18 minutes on average, and respond to 90% of Category 2 calls in 40 minutes
- Respond to 90% of Category 3 calls in 120 minutes
- Respond to 90% of Category 4 calls in 180 minutes

The times for response are those considered as the most clinically safe for the patient's assessed risk and to send a response to the sickest patients first. The categories are determined by a clinical triage system based on national standards with category 1 being the most seriously ill or injured patients.

Our findings

East Midlands Ambulance Service responded to patients as follows:

Monthly performance mean (minutes) for March 2022:

Category 1: 00:08:45

Category 2: 01:10:07

Category 3: 04:33:25

Category 4: 03:59:03

Monthly performance 90th percentile (90%) for March 2022:

Category 1: 00:15:55

Category 2: 02:44:29

Category 3: 11:00:43

Category 4: 07:12:25

EMAS' conveyance to ED rates were notably lower than prior to the pandemic at 51% in January 2022. They were consistently similar to the England average. In January 22, EMAS conveyed a higher proportion of incidents (5.4%) to another healthcare setting than the England average (4.9%). Of those that were conveyed, EMAS conveyed a higher proportion to a non-ED setting in 2021 (9.7%) compared to the England average (9.0%). Prior to the pandemic, this proportion was lower than the England average.

Performance for the trust had deteriorated over time since the pandemic. However, the trust was significantly reducing conveyancing to hospitals and increasing treatment of patients by other forms of patient alternative pathways, such as "see and treat". This was to help the additional pressures on the rest of the urgent and emergency care system. Latest data seen on inspection day 13 April 2022 was that 35% of patients within Leicester, Leicestershire and Rutland were conveyed to an Emergency Department.

Since March 2021, the trust has had more clinical incidents each day. At the time of our interview with the senior team on 13 April 2022, the trust had lost 22 hours at Leicestershire that day due to handover delays, with additional hours lost across other Counties; with highest lost hours recorded on the 5 April 2022 of 434 hours, this was the highest number of hours lost in the period reviewed, with additional hours lost at other Counties. Crews were able to share examples with us of several patient safety incidents that had occurred relating to long waits.

Ambulance crews we spoke with during the inspection shared their frustrations with us around the system and the demanding pressures the system is under. Operational staff also reported how the 111 services were increasingly not able to triage all patients calling them for clinical advice. This was recognised as due to significant growth in the volume of calls to 111 services and the 111 services dealing with their own issues caused by staff shortages and unplanned

absence. A senior member of the operational team at the ambulance service told us they saw a rapid increase in demand for 999 services when 111 services were unable to provide all patients with clinical validation due to internal capacity pressures. This meant the triage system used by the 111 call handlers being more likely to advise call takers at 111 to send for an ambulance far more often than when a clinician triaged the patient.

EMAS used a “see and treat” model of care at a similar rate to the England average. In January 2022, 11.07 % trust wide of incidents were treated at the scene with no further conveyance. EMAS have used a Hear and Treat model of care at a slightly lower rate than the England average. In January 2022, 10.5% of incidents were treated or given advice over the phone compared to an England average of 11.1%. Of those incidents that are not conveyed, the proportion treated or given advice over the phone (24.7%) was reflective of the England average in 2021.

A major incident is any emergency that requires the implementation of special arrangements by one or all the emergency services and include the involvement, either directly or indirectly, of large numbers of people. All the staff we spoke with told us they had either received training or were booked in to participate in response to major incident training and that this was part of the mandatory training programme.

Patient outcomes

The service monitored the effectiveness of care and treatment. In times of normal demand patterns, it used the findings to make improvements and achieved mostly good outcomes for patients in line with national averages. However, with the rise in demand alongside the reduction in capacity due to handover delays, some patients were coming to unintended harm as the ambulance was unable to get to them in a clinically safe time.

The trust routinely collected and monitored information about patient’s care and treatment and produced these as Ambulance Clinical Quality Indicators. These measured the overall quality of care and outcomes for patients following treatment.

A review by the trust of incidents of serious harm due to delays in ambulances arriving on scene had been conducted. A report had been produced for clinical commissioners and regulators. These incidents included older people waiting many hours for assistance following falls, and patients in cardiac arrest not being reached in time. Many staff from across the organisation said how these incidents also had a negative effect on staff morale and wellbeing. The trust was fully aware of all these issues but staff we spoke with told us they were not able to affect change while demand was impossible to manage.

There were eight delayed response serious incidents reported in November 2021.

There were five serious incidents reported during March 2022. The total reported in 2020/21 was 38 with 74 reported in the year to date for 2021/22.

Multidisciplinary working

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide safe care and communicated effectively with other agencies.

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.

Our findings

Staff worked closely with the police and fire service, especially during serious or large-scale car accidents. During our inspection, we saw ambulance crews worked closely with police within the emergency department.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff in the emergency departments worked closely with the ambulance crews to support a shared approach to patient care as much as possible. We observed a dedicated working relationship between the tactical commander, other ambulance personnel and the emergency department team.

EMAS liaised with local NHS trusts, worked jointly on investigations of deaths in the community and shared learning across EMAS and the hospital trusts.

Ambulance staff we spoke with including management praised the 'make ready' teams and their working relationships with them. Staff stated that equipment was always suitable for use and if they had problems, they could easily approach the make ready team and have a discussion on how to resolve it. We were told there was mutual trust amongst ambulance staff and make ready teams which helped the service run smoothly and efficiently.

Most staff we spoke with were highly complementary about the ambulance service and felt that the crews worked well with them. Some staff told us they felt there was sometimes confusion during busy times over who was clinically responsible for patients.

We heard that some relationships were stretched within the system due to the demanding pressures; however, staff we spoke with were all understanding of one another's pressures in services and genuine advice and support were extremely valued. Staff told us that crews had support and advice available from social services, community matrons, mental health teams, district nurses and GPs.

Staff told us of the good clinical support available for crews on the scene with options including clinical assessment team in control, tactical commander, station managers and continually active group of medical volunteers.

Is the service caring?

Inspected but not rated

Compassionate care

Staff treated patients with exceptional compassion and kindness, respected their privacy and dignity, and took account of their individual needs in increasingly difficult circumstances.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients in a respectful and considerate way. With the guidance around COVID-19 safety for staff and patients, it was harder for staff to support patients who all came to the emergency departments by ambulance without family or carers. Staff said this had required them to be as sensitive as possible to patient's needs and recognise their discomfort or emotional distress.

Our findings

Staff did their best in difficult circumstances to provide privacy and dignity for patients, and most of the time were able to achieve this. However, this was almost impossible at times when the patient was required to be transferred few yards away from ED due to ambulance vehicles backlog on the hospital car park or on the road. When some patients were required to use the bathroom, crews had no other alternative but to transfer the patient on to the trolley to use the bathroom within the hospital site and then transfer the patient back to the ambulance vehicle.

Patients said staff treated them well and with kindness. Staff took the necessary time to engage with patients. Staff communicated in a respectful and caring way, always considering the wishes of the patient. Staff asked personal questions in a consistently professional manner.

When a patient became distressed, staff told us they responded in a sensitive way. Staff gave time for the patient to explain the reasons for their distress and treated these reasons respectfully by actively listening and asking further questions where appropriate. Staff told us many patients were extremely anxious and at times distressed, due to having to wait long time in the back of the vehicle.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff understood and respected the personal, cultural, social, and religious needs of patients and how they may relate to care needs. We saw staff consistently checked patients' wellbeing, in terms of physical pain and discomfort, and emotional wellbeing.

Staff understood the emotional and social impact that a person's care, treatment, or condition had on their wellbeing and on those close to them.

Is the service responsive?

Inspected but not rated

Service delivery to meet the needs of local people

The service was designed to meet the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care. However, due to demand overall urgent and emergency care pathway, there were unmet needs for patients.

The increasing demand and reduced resources had led to recommendations to the trust board from various service delivery models, all of which involved both planned, approved, and potential increases in staffing numbers and resources. Over the previous few years, the service had adapted and expanded to meet changing patient needs.

The service was part of several national and more local working groups looking at ways of reducing or limiting admissions to hospital and ensuring accurate referrals of patients to other services. The local county commanders for the ambulance service worked with commissioners and other providers to contribute to this work through collaboration and local knowledge. However, one area of increasing complexity was with the system used by the ambulance service to divert patients into other local services. It appeared this system which listed all the alternative providers in a place was difficult to keep updated. It was subject to regular change as providers moved into different areas and added or stopped some service provision. The Directory of services is not owned by EMAS and therefore not solely responsible for providing updates.

Our findings

The service had a range of triage processes to try to ensure that patients received the most appropriate initial provision. The clinical assessment team (CAT) assessed and triaged patients through a 'see and treat' service. Paramedics attended to patients and travelled in a rapid response vehicle. This provided medical assistance without sending an ambulance and avoided conveying patients to hospital, enabling more patients to be treated and assessed in their home.

The service relieved pressure on other departments when they could treat patients at home or use alternative pathways that was deemed suitable for individuals that did not require an admission to hospital.

Access and flow

Due to pressures within the system, people were not always able to access the service when they needed it or in line with national standards. Not all patients received the right care in a timely way.

The rise in "hear and treat" numbers was evidence of increased use of the ambulance service rather than alternative community-based services. 'Hear and treat' generally refers to the scenario when 999 calls are provided with a response that does not involve dispatch of an ambulance vehicle. Many and increasing numbers of hours were being lost while ambulances were held at emergency departments. There has been a strong focus on the capacity of the control centre and "hear and treat" over the past two years. The senior teams told us that one of their focus drives was on the recruiting aspect of the service, and EMAS now have a team of medical professionals with pre-hospital experience working within the "hear and treat" service, the current "hear and treat" figures were running at 12%.

Access to the ambulance service for patients was severely affected by rising demand, but to a significant extent by handover delays in hospital emergency departments. This was a severe issue at Leicestershire hospital and many hours were being lost in emergency department. There was also a growing number of patients calling the ambulance service. This was either as they perceived they had no other option or could not access other alternatives services such as GPs, 111 or community services. This was a complex picture with many factors. Some patients were also experiencing a mental health crisis and struggling to find urgent help from community services also under exceptional pressures.

Ambulance resources were stretched to a point where at times none were available to send to patients in need in the community. The 'call stack' is the term used by ambulance services to describe patients who have called 999 and an ambulance is needed, but there is no resource immediately available.

Given the pressure on local ED, there has been considerable work undertaken on alternative pathways to admission. EMAS has made effective use of technology, putting the pathways on the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) app on the new iPads. The strategy of funnelling most acute cases through an ED that frequently had extensive delays for ambulance handover remained a challenge, despite the work EMAS has undertaken in terms of clinical decision making. The EMAS medical director has been involved in developing referral criteria for the SDEC (Same Day Emergency Care) unit, which should manage several conveyances which would historically have arrived at the ED.

Is the service well-led?

Inspected but not rated

Our findings

Leadership

Leaders understood the pressures of the front line crews and their challenges, it was clear to see that leaders were trying to manage the priorities and issues the service faced. They were visible and approachable to their staff and teams.

The services were led by county commanders working deputies and a senior team. Senior leadership, officers, specialist paramedics, paramedics and emergency care practitioners based in Leicestershire said they felt supported by their leadership and the issues they were facing were understood, even if solutions were extremely hard for anyone to find. All staff knew who their local leadership were and who the senior executive teams were.

Managers told us that whilst the executive team were not always visible due to the large geographical areas of the trust, they would feel happy to approach them and contact them for discussions if necessary.

Leaders understood the challenges to quality and sustainability and were able to identify the actions needed to address them. The provider had a clear accountability and leadership structure. Managers at all levels had the right skills and abilities to run the service providing high-quality sustainable care.

Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.

There was a clear vision and set of values. The service had a realistic strategy and supporting business plans to achieve priorities. All managers we spoke with told us they enjoyed their role and felt valued as part of the East Midlands Ambulance Service leadership team.

Feedback regarding the executive team was widely positive and many staff felt that leaders for the service took pride in the service. Staff told us leaders were available and felt they could approach any senior colleagues with their concerns.

Culture

Staff felt respected, supported, and valued.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). This included support training for all staff on communicating with patients about notifiable safety incidents. The providers encouraged a culture of openness and honesty.

Each member of staff from all areas of the division we spoke with told us they enjoyed their roles providing a service to care for and keep people safe and well. However, pressure on staff was now taking its toll. Staff said they recognised there was support for them, but many said they did not have time or the energy to use it. Some said they were grateful it was there, but they were increasingly getting support from their fellow crew members or the staff they worked closely with who were in the same situation.

Many staff were working beyond their hours under intense pressure. Patients and carers were becoming more anxious, and staff were being abused at times. However, staff remained focused on the needs of patients receiving care.

Our findings

Most staff said they felt respected in the service, but the intense pressure was making some feel less valued or supported. Most paramedics and specialist practitioners in urgent and emergency care said they still felt proud to work for the organisation and the job they did. Some staff who despite the pressure on their resilience remained positive and said they were determined to do their best for patients.

Staff told us they felt demoralised by the situation of leaving patients waiting for hours for ambulances to reach them and having to treat patients in queues outside hospitals. However, some of the staff we met told us it they felt it was still a privilege to work providing emergency care and treatment in their communities.

Management of risk, issues, and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

The trust was in the last stages of introducing body-worn cameras for crews. Crews we spoke with were incredibly positive about the cameras and many had completed their training, and felt the trust were invested in staff wellbeing and safety.

The trust continued to follow the COVID-19 guidance on safety for ambulance trusts. Staff said the national guidance was now embedded with all staff, it was not always clear at the start of the pandemic in 2019, but the trust kept all staff up to date with all updated guidance as and when required. Staff were confident to speak up if they felt infection prevention and control protocols or practices were not being followed by colleagues.

Leaders had plans to cope with unexpected events; However, the service was clearly struggling with how to manage the significant increase in demand on urgent and emergency care capacity and exhausting all options that were available to them. The key challenges for the Leicester, Leicestershire and Rutland leadership team mirrored those of the wider trust. They included ambulance handover delays; safety and welfare of patients and staff; recruitment and retention of staff; and training/skills support and development.

The ambulance service was set up to cope with unexpected events but staff at all levels were becoming more concerned about the ability to manage performance with the current increase demand on urgent and emergency care capacity.

Our findings

Outstanding practice

We found the following outstanding practice:

Hospital Handover Harm Prevention (HHHP) tool processes were positively accepted by the crews, showing eight months review were completed which demonstrated an overall harm prevention rate of 36% by utilising HHHP. This harm prevention was associated to clinical interventions, but also through early escalation to ED teams where appropriate.

Areas for improvement

Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

SHOULDS

- The trust should continue to highlight to health sector partners the impact of hospital handover delays and continue to work collaboratively to influence the position, so that there is a focus and accountability across the health system on actions to reduce handover times.