

East Midlands Ambulance Service NHS Trust

Quality Report


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

Ratings

Overall rating for this trust

Requires improvement 

Are services at this trust safe?

Inadequate 

Are services at this trust effective?

Requires improvement 

Are services at this trust caring?

Good 

Are services at this trust responsive?

Good 

Are services at this trust well-led?

Requires improvement 

Summary of findings

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 and urgent 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 643, 115 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 Safe 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.
- 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

Summary of findings

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
- 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

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 2,900 WTE staff.

East Midlands Ambulance Service provides an emergency service to respond to 999 calls; a small patient transport service (PTS) in North 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. 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:

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- 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.

What people who use the trust's services say

Hear and Treat Survey

East Midlands Ambulance Service performed similar to other ambulance services for two out of the four questions in the ambulance 'Hear and Treat' survey and worse than others for the remaining two.

Local Healthwatch

We received feedback from local Healthwatch organisations in Derby and Derbyshire, Leicestershire, Lincolnshire and North East Lincolnshire, Leicestershire, Nottinghamshire and Northamptonshire. The majority of feedback about emergency and urgent services was favourable about patient experience. However concerns were raised about delayed response times. All feedback relating to the patient transport service was positive.

Patients' views during inspection

During the inspection we spoke with a number of patients across all services. Patients and their loved ones also contact the CQC by telephone and wrote to us before, during and after our inspection. The comments we received were mostly positive. The main concerns raised with us were about delayed vehicle responses to emergency patients.

Facts and data about this 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 2,900 staff who are based at ambulance stations and trust premises across the region.

Their main role is to respond to emergency 999 and urgent 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 and North East 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:

Summary of findings

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


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.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe?	Inadequate 
<p>We rated the safety of East Midlands Ambulance Service as requires improvement.</p> <ul style="list-style-type: none">• There were insufficient numbers of staff in emergency and urgent care services and the emergency operations centre. The skill mix of staff deployed was not always safe and front line managers had too many staff to support and supervise safely.• Lengthy delays at some acute trust emergency departments taking receipt of patients transported by EMAS were impacting on the trust's resource and capacity to respond safely.• Incident investigation was inconsistent and there was a lack of evidence of learning from investigation or sharing of the learning with trust staff.• Mandatory and statutory training completion rates did not meet the trust's own targets. This meant staff may not have the competence, skills and experience to provide care and treatment safely.• Although staff had a good understanding of safeguarding processes and reported appropriately insufficient staff had completed level two training.• Standards of cleanliness were inconsistent in emergency and urgent care services. The management of domestic and clinical waste was not always safe and appropriate.• Checks of emergency and urgent care vehicles and equipment did not always take place according to trust policy. At times there were insufficient emergency vehicles and staff to safely meet demand.• Medicines were not always stored and managed safely.• Patient records were not always stored safely and confidentially.• Checks of volunteer driver documentation in the patient transport service had not always been completed and recorded annually.• The trust could not assure us major incident and awareness training had been delivered to the required number of staff. The trust's major incident plans, although following requirements of the Civil Contingencies Act, were not up to date.	

However we also found that :

Summary of findings

- Infection prevention and control policies and procedures were in place. The trust's infection prevention control team worked innovatively to support front line staff.
- Processes were in place to effectively assess and respond to patient risk.
- Appropriate systems were in place to anticipate resource demand and manage risks to capacity. The trust was meeting the requirements of the Duty of Candour Regulation.

Incidents

- Staff in all services told us they did not receive feedback or learning from incidents, including serious ones, reported within their service or elsewhere across the trust. General feedback was collated by the learning review group who produced a quarterly summary of themes and learning. This was available on the trust's intranet site. Information relating to learning from incidents was on display in some ambulance stations.
- Staff in the Emergency Operations Centre (EOC) did not know what was defined as an incident and so did not always report them. EOC managers agreed there were gaps in staff knowledge about what was an untoward incident.
- Between September 2014 and August 2015 the trust reported 54 serious incidents. The majority of incidents were reported as having caused 'no harm' (76%) or 'low harm' (19%).
- 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.
- Our review of incidents on the trust's electronic reporting system showed investigating and reporting to be inconsistent and at times contradictory. There was a lack of clinical input and no evidence of the involvement of persons or staff involved in the incidents investigated. The lack of clinical input to investigations led to a lack of insight into their gravity and seriousness. We saw little

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evidence of subsequent action plans or of feedback to staff after investigations. Where action plans were available there was no evidence of actions having been completed within specified time frames.

- A number of incidents had been generated as complaints initially. Despite meeting the criteria for a serious incident they had not been logged as such by staff. There was a lack of coordination between incident and complaint investigations.
- Investigations into accidents involving trust vehicles were investigated externally by the trust's insurance provider. The driving standards lead told us there were plans to train five staff internally in accident investigation. There was also a plan to train team leaders in minor incident investigation.
- There was an effective process and policy for the reporting of incidents and near misses. Staff could report via telephone or electronically.

Mandatory training

- The trust had an essential education programme which ran over a 24 month period. This included mandatory and statutory training topics such as safeguarding and infection prevention and control. Compliance rates were below target with information governance trust wide at 57% and infection prevention control at 71.5% against a target of 95%. However at the time of our inspection, as a result of operational pressures, the trust had extended the essential training programme for 2014/15 to the end of March 2016. This also enabled the prioritisation of initial training courses including essential education to newly recruited ambulance technicians.
- 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 frontline duties because of operational pressures.
- Trust completion rates for NHS Prevent training were 29%. Prevent is part of the Government's counter-terrorism strategy and aims to stop people becoming terrorists or

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supporting terrorism. NHS England guidance states staff must be able to recognise signs of radicalisation and be confident in referring individuals who can then receive support in the pre-criminal space.

- Compliance rates at the trust were poor. The trust used a system of 'conversation cards' for the delivery of some mandatory training. This meant frontline managers used these cards to discuss mandatory and statutory updates with staff during one to one meetings and appraisals. We were concerned about the low completion rates for this method of training. We were not assured that managers who provided these updates had the capacity and competency to do so.
- The Medical Director told us the trust had recently moved to an annual update for advanced and basic life support qualifications rather than three yearly.
- The compliance rate for mandatory training of the trust's hazardous area response team (HART) was 70%.
- Emergency ambulance staff completed a three week emergency driving training course during recruitment. A further two weeks of training qualified staff to drive on blue lights in an emergency.
- EMAS had not historically examined staff for their standard of driving and this is because section 19 of the Road Traffic Act was not mandatory. However the driving standards lead told us when section 19 becomes mandatory the trust will have a challenge to deliver against demand. At the time of our inspection local driving instructors delivered updates where required.
- All staff received familiarisation with the range of trust vehicles and individual staff were required to highlight any gaps in this training during their appraisal. Staff involved in road traffic accidents were required to complete further driver training delivered by qualified EMAS driver trainers.
- Patient transport service staff (PTS) received one week of driver training and assessment at induction. There were no annual checks of driving skills.

Safeguarding

- Staff working in the emergency operations centre (EOC) were not subject to disclosure and barring checks (DBS). The DBS enables organisations to make safer recruitment decisions by identifying candidates who may be unsuitable for certain work, especially that involving children or vulnerable adults. However, following the Lampard Review the trust had plans to introduce these for

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this group of non-patient facing staff and this risk was on the trust risk register. It was also not trust policy to renew DBS checks for staff Again, following the Lampard Review and the recognition that this was best practice the trust were putting in place financial plans to do this.

- No training had been delivered to front line staff in relation to female genital mutilation; however awareness information was displayed in some ambulance stations. From October 2015 there was a mandatory reporting duty placed on regulated health care professionals. We could not be assured staff were able to meet this duty.
- All staff received an online induction in safeguarding as part of their induction training. All support service staff were required to complete level one safeguarding training and all front line staff, including volunteers, level two. Compliance rates at the time of our inspection were 100% for level one and 65% for level two against a target of 95%.
- Staff who had raised a safeguarding concern about a vulnerable adult or child did not routinely receive feedback because the team did not have capacity. This was identified on the trust's risk register. However, the head of safeguarding told us the team provided feedback to those staff who contacted them to request it.
- Staff in the safeguarding team in EOC told us their biggest challenge was working with other agencies as the systems used were not compatible. The trust geographical area covered 22 safeguarding boards and there was the potential for 44 different referral forms which could cause additional work and confusion.
- The safeguarding team did not link in with the child and adolescent mental health services (CAMHS) or the crisis team. The safeguarding team referred children to social care but told us it would be easier if they could refer directly to CAMHS which would improve information sharing. The majority of staff had a good understanding of what safeguarding concerns might be and they were all confident about the process for reporting concerns.
- There was a newly appointed head of safeguarding and vacancies for both the adult and children's lead posts. The trust was recruiting to the vacant posts and the executive responsible for safeguarding was concerned about offering support to the head during the period of reduced capacity.

Cleanliness and Infection Control

Summary of findings

- Standards of cleanliness were not consistent across the trust. The management of domestic and clinical waste at ambulance stations was not always safe or appropriate.
- Infection control audits were planned as part of the trust's Quality Everyday initiative. Team leaders or clinical team leaders were responsible for auditing stations, eight vehicles and eight staff quarterly. Vehicles and staff would be selected at random unless concerns had been identified. However, the trust's infection control lead told us the audits were not always submitted because of capacity and this risk was highlighted on the trust's risk register.
- Trust infection prevention and control policy and toolkit were available to staff on the trust's intranet. There was also an infection control summary page for staff who needed to refer to information quickly. The team provided telephone advice to front line staff and a dedicated email address for queries. Clinical staff knew where to go to get guidance on infection control issues.
- Front line ambulances were scheduled for deep cleans every 42 days. Compliance with this schedule at the time of our inspection was greater than 95%. However, emergency vehicles were not always cleaned between each patient episode. Staff told us this was because they did not have protected time to do this before they were required to answer another emergency call.
- Personal protective equipment (PPE) including gloves and aprons were available on ambulances as well as cleaning supplies such as cleansing wipes and crystallized disinfectant for use on spilt bodily fluids.
- The trust offered vaccination against influenza to their staff. At the time of our inspection 49% of frontline staff had received it. The programme continued until January 2016 to ensure the maximum number of staff were given an opportunity for vaccination.
- The head of infection control had used some innovative ideas for communicating directly with front line staff about cleanliness and infection control. These included short videos on floor mopping and in between patient cleaning. These were downloadable via a leaflet attached to the back of payslips. Monthly fact-sheets were available for staff to learn more about specific topics such as scarlet fever, for example.

Environment and equipment

Summary of findings

- The trust's safer ambulance checklist for emergency vehicles was not always completed as required at the beginning of each shift. Staff told us this was because they did not have protected time to do this and were often asked to respond to emergency calls. We found vehicles in operation which were not fully equipped. Checklists we reviewed for patient transport service vehicles were all completed appropriately.
- The director of finance confirmed the trust had secured a loan of £9million to expand the vehicle fleet. However, this amount would only replace 20%. This lower than expected investment would lead to a percentage of vehicles being more than seven years old. Fleet managers told us of concerns regarding the reliability of these vehicles and the cost of repairs and maintenance.
- 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 having reported faults. The trust informed us there was a 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.
- Staff were aware of the process for reporting faults on vehicles or equipment but they expressed concerns that replacement vehicles and equipment were not always available.
- There was a programme for the replacement of radio handsets as the current system was due to become obsolete.
- The medical director told us medical device servicing was up to date but the database used to record this information was not robust. We found some lifesaving equipment overdue for servicing.
- Checks of documentation for volunteer patient transport services (PTS) drivers were not always carried out annually. This included documentation such as MOT and insurance certification for volunteer vehicles.

Medicines

- Medicines were stored at and distributed from a central resource centre. Security at the centre included alarms, CCTV and robust staff security checks.

Summary of findings

- 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. We saw that checks were made on the expiry dates of medicines to ensure they were safe to use. Information on how to use the new medicine system was clearly displayed in medicine storage areas in ambulance stations. Paramedics we spoke with said although it was still a very new system they found it helped to ensure they had all the required medicines when they went to patients.
- 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.
- The trust had a Medicines Optimisation Group which met monthly. Reports from these meetings showed that security of medicines, patient safety alerts and any on-going medicine issues were discussed. The minutes also included action plans for improvement of medicine management.
- In response to the NHS England and MHRA patient safety alert: Improving medication error incident reporting and learning (March 2014) the trust had appointed a Medicine Safety Officer (MSO) (who was also the Head of Clinical Governance, Audit and Research). The aim of the patient safety alert was to increase reporting, improve data quality and maximise learning and guide practice to minimise harm from medication errors. We saw that the MSO was involved in the Medicine Optimisation Group where they shared any medicine safety issues. These were cascaded to staff in clinical news bulletins.
- Any updates on medicines were circulated to staff via 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 that staff meetings took place to discuss medicine management, e-mails were also sent out and they received support from a team of consultant paramedics.

Summary of findings

- Staff were administering medicines to patients with the legal authority to do so. The trust had Patient Group Directives (PGD's) 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).
- The trust was involved in a clinical trial for the treatment of acute stroke called the Right 2 Clinical trial. Training had been provided to all paramedics. We saw posters and information displayed in ambulance stations. We spoke with one paramedic who explained how the trial worked.
- Medicines were not always stored safely outside of the central resource centre. 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.
- Medical gases such as oxygen and Entonox were not always stored according to trust policy.
- 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 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.
- The management and control of access to controlled drugs was not always managed safely or following good practice. Controlled drugs (as defined in the Misuse of Drugs Regulations 2001 and its amendments) are medicines that should be stored with extra security and recording arrangements in place. We found that the current system of using a single key system to access controlled drug safes on ambulances meant that it was difficult to follow an 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. Various options for controlled drug security were being investigated.
- Controlled drug records on ambulances and within designated ambulance stations were not always countersigned by a witness. It is recognised that when

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clinical staff work alone that obtaining a witness every time is not always possible, however the trust 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. Paramedics we spoke with recognised that it was important to obtain a second witness for accurate controlled drug records but agreed that sometimes it did not always happen.

- Maintenance and cleaning staff did not have access to medicines or controlled drugs stores on ambulances for security.

Records

- The trust used a mixture of electronic and paper patient report forms (EPFRs and PRFs). Completed paper PFRs were transferred for storage at ambulance stations. They were not always stored appropriately and securely in trust premises and in such a way as to maintain patient confidentiality. On two occasions we found PRFs visible on unsecured emergency vehicles.
- The trust conducted quarterly audits of PRF completion. One in every 30 PRFs was audited by clinical team leaders and a report produced by the clinical audit team based on their submissions. The audit data from July to September 2015 indicated 92% of audited patient report forms had been appropriately completed. There was an action plan for improvement.
- The trust used 'special notes' about patients to share with ambulance crews. These detailed clinical information for patients with complex needs or risk information if there was a safety concern.
- 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 EOC were not aware frontline staff had clear guidance to follow in the trust's resuscitation guidelines for end of life care should they be presented with or told of a DNACPR decision.

Assessing and responding to patient risk

Summary of findings

- Staff at the trust used the advanced medical priority dispatch system (AMPDS) to assess and prioritise emergency calls. This enabled them to prioritise emergency calls based on the assessed risk to the patient.
- The clinical assessment team (CAT) in the emergency operations centre (EOC) used telephone assessment software (TAS) to assess lower priority calls. This software supported the clinician in assessing and deciding the most appropriate course of action for the caller.
- During busy period the CAT conducted welfare calls to check on the condition of patients waiting for a vehicle response. Where appropriate they would prioritise the response if the patient's condition was deteriorating and the risk to them increasing.
- The trust had clear pathways in place for ambulance crews to follow when responding to life threatening conditions, emergencies or non-life threatening conditions.
- If a patient's condition changed or deteriorated ambulance crews could contact the CAT team for clinical advice and guidance.
- Solo responders and volunteer community first responders were able to request double crewed ambulance (DCA) backup for the transportation of patients who needed to go to hospital. However staff told us and data showed there were often unacceptable delays in the availability of these DCAs. This meant the risk to patients could be increased because of a delay in getting to a hospital.
- Staff in the patient transfer service (PTS) were provided with appropriate information to support the needs of patients using the service. There were clear protocols for staff and volunteers to follow if there were changes to the patient's clinical condition or behaviour.

Staffing

- The trust reported a ten percent staff vacancy rate on 1 April 2015. By the end of October this had been reduced to 2.77%. The trust had secured additional funding for staff from the Clinical Commissioning Groups (CCGs) following a demand modelling exercise. This modelling found that there was a gap in the contracted workforce between the current 2080 and the requirement of 2164. This increase was being funded through revised contracts with the CCGs.
- 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

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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 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.
- 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

Summary of findings

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.

- Turnover of patient transfer (PTS) staff was high as staff transferred to emergency and urgent care for professional development. However, the service had regular recruitment drives and vacancies were low at 5%.
- There were insufficient staff to cover emergency operation centre (EOC) rotas especially at weekends. Understaffing figures supplied by the trust ranged from 6% to 28%.
- Trust sickness levels were high at 6.6%. Return to work discussions did not always take place within 14 days of a staff member returning. This was achieved for 92% of staff according to figures provided at the time of our inspection.
- The trust aspiration was to allow frontline team leaders 25% of time for their managerial role and 75% operational. However, frontline team leaders and managers told us they spent the majority of their time operational because of the demand and staffing shortages.
- The trust offered an apprenticeship scheme with a level two or three national vocational qualification in business administration. Staff employed on NHS Bands one to four could access apprenticeships in customer care.
- The trust had a volunteer workforce of approximately 1800. This included volunteer patient transport service drivers, community first responders (CFRs), emergency co responders, army and royal air force responders, medical responders and volunteer doctors as well as trust staff volunteering in their own time to respond to patient emergencies.

Duty of Candour

- There was a policy in place for Duty of Candour. This is a Regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which requires health service bodies to act in an open and transparent way with people when things go wrong. Duty of Candour officers were in place to ensure this happened. We saw evidence that the trust had followed the Duty of Candour requirements following receipt of complaints and during the investigation of serious incidents.
- Most staff we spoke with were aware of the Duty of Candour requirements and where they were not familiar with the term they indicated they would be open and honest if things went wrong.

Summary of findings

Anticipate resource and capacity risks

- A capacity management plan (CMP) was in place for the emergency operations centre to assess and respond to changes in demand.
- The trust used the national indicator resourcing escalatory action plan (REAP). This is an indicator of pressure in ambulance services and can be used to trigger specific actions when a trust is operating with significant and sustained levels of increased activity.
- There was a comprehensive business continuity plan for all services. This identified and mitigated risks which could disrupt services and affect the performance of the trust. In addition to the business continuity plan a winter operational plan was in place for 2015/16.
- Prior to and during our inspection the trust was experiencing unacceptable handover delays at some acute hospitals in their area. These delays of up to six hours in some cases were impacting significantly on the trust's capacity to respond to patients in the community as crews were tied up in hospital emergency departments. Although trust leaders had taken appropriate action to escalate concerns to and engage other health partners in resolving this problem it continued to impact on the trust's resources and capacity to respond. We saw evidence that the safety of patients was compromised because of these handover delays. Neighbouring trust counties and neighbouring ambulance trusts were sending resources to support responses to patients in the areas experiencing handover delays. However, this was impacting on their capacity to respond to their local patients.

Major Incident Awareness and Training

- Major incident plans, although following requirements of the Civil Contingencies Act were not up to date. The plan stated that procedures were to be reviewed annually or more frequently if required. The trust's major incident plan 2014/15 was overdue for review by seven months at the time of our inspection.
- Between April 2014 and August 2015 72% of staff had received an emergency planning update training session. Staff in the emergency control centres (EOC) had participated in major incident rehearsals. Some staff had been involved in live major incident scenarios and others in desk top incidents. However the figures showed that more than a quarter of trust staff had not received updated training and many front line staff confirmed this.

Summary of findings

- Bronze, silver and gold command structures are used by emergency services to establish a hierarchical framework for the command and control of major incidents and disasters. Training for bronze, silver and gold command was delivered by the hazardous area response team (HART). There was no reporting to the HR team to give assurance that individuals had been trained for the roles so the trust were unable to confirm how many staff had been trained. At least three staff allocated to these roles confirmed to us they had received no training.
- The Medical Director told us good links existed with the strategic resilience groups for emergency preparedness. We saw information stating who was responsible for attending the meetings and the minutes from a meeting of one of these groups showed attendance and engagement.

Are services at this trust effective?

We rated the effectiveness of East Midlands Ambulance Service as requires improvement.

- EMAS response times for Red One and Red Two calls were consistently below the national target and patients were not receiving care in a timely manner.
- Not all staff had the appropriate skills and knowledge to do their job. Staff were not always supported to participate in training and development opportunities.
- There were gaps in management and support arrangements for staff and appraisal completion rates were too low.
- Most staff were not confident in their understanding of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS)

However we also found:

- People's care and treatment was planned and delivered in line with current evidence-based guidance, standards and best practice. This was monitored to ensure consistency of practice. EMAS was the best performing ambulance trust for calls abandoned before being answered.
- Outcomes for patients were mainly above or equivalent to national average levels. Where below these levels outcomes were improving.
- Where patients received care from a range of different staff, teams or services this was effectively coordinated.
- Staff could access the information they needed to assess, plan and deliver care to patients.

Requires improvement



Summary of findings

- Consent to care and treatment was obtained in line with legislation and guidance.

Evidence based care and treatment

- National Institute for Health and Care Excellence (NICE) guidelines and Joint Royal Colleges Ambulance Liaison Committee (JRCALC) clinical practice guidelines were available to staff
- The trust submitted data for national clinical performance indicators (nCPIs). In fact EMAS was responsible for co-ordinating the data from all English ambulance services and producing reports.
- The report on nCPIs for cycle 14 published in June 2015 for the period December 2014 to March 2015 showed East Midlands Ambulance Service performed in the bottom three out of eleven trusts for asthma, single limb fractures, febrile convulsion and falls in older people care bundles.
- The trust had very recently appointed an associate director of para-medicine. There were a further two consultant paramedics. This group of senior clinical leaders reported to the Director of Medicine. They took a lead in geographical areas as well as leading on individual clinical issues such as end of life care, trauma and cardiac arrest. They provided clinical assurance to divisional general managers and support with clinical strategies. As part of major incidents they provided clinical on call support in the emergency operations centre (EOC) to the gold on command when they were not clinical.
- Procedures for the despatch of resources were up to date and informed by relevant guidance.
- Clinical advice and support, based on current guidance and best practice was available from the clinical assessment team (CAT) in EOC. Clinical updates were sent to clinicians via email and they were sometimes displayed on notice boards in ambulance stations.
- There was a clinical governance, audit and research team based in Lincoln, covering the whole trust area. This team collected data, analysed and prepared reports about a number of national and local clinical performance indicators which measured whether care was provided based on current guidelines. They were involved in national projects to improve patient care, with 40% of EMAS paramedics participating in research projects.

Assessment and planning of care

Summary of findings

- Trust staff followed despatch and medical protocols when assessing and prioritising patient care.
- Clinical pathways were available and varied according to locally agreed arrangements with clinical commissioning groups and other partners.
- The Medical Director told us work was being done but more was required to improve the trust's evidence base as to groups of patients who were more at risk from waiting long periods for a response. This was termed a 'risk marker for harm'. Such patients could include those who had fallen or who were diabetic.
- The Clinical Assessment Team (CAT) were proactive at carrying out welfare checks on patients whilst they were waiting for an ambulance response. This was especially important during periods of increased demand and delayed responses.
- The clinical audit team produced an annual audit plan based on national work streams, local feedback, serious incidents, complaints and suggestions from staff.
- The trust were treating an increasing number of patients at home or on scene without the need to convey to hospital. This is known as 'see and treat'.
- Standards and expectations of the patient transport service (PTS) were set out in commissioning documents.

Response times

- Calls which were immediately life-threatening (such as cardiac arrest) and termed Red One required a response within eight minutes. The trust's response was similar to the England national average from April 2014 to June 2015 and only met the 75% target in April 2014, April, May and July 2015. Data for November 2015 shows the trust as the second worst performing ambulance service in England with responses within target at 65.6% for Red One calls.
- Calls which were serious but not the most life-threatening (such as chest pain) and termed Red Two 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 Two calls.
- The emergency operations centres (EOC) were often unable to despatch crews to emergencies because of a lack of availability of staff or staff with an appropriate skill mix.

Summary of findings

- Delays in some acute hospital emergency departments taking receipt of patients transported by EMAS impacted on response times because vehicles and staff were caring for patients awaiting transfer to the care of hospitals.
- The trust was the best performing ambulance trust compared to other ambulance trusts in England for calls abandoned before being answered between April 2014 and July 2015.

Patient Outcomes

- Trust outcomes for patients having a return of spontaneous circulation (ROSC) at the time of arrival at a hospital following cardiac arrest were improving. From April 2015 results were consistently above the England average.
- Between April 2014 and April 2015 patient outcomes for the proportion receiving angioplasty (unblocking of a coronary artery) within 150 minutes were better than the England average.
- The proportion of stroke patients receiving thrombolysis within 60 minutes was similar to the England average between April 2014 and April 2015.
- The percentage of emergency calls resolved by telephone advice and support (hear and treat), although below the England average was showing an increasing trend. In October 2015 16% of patients were treated over the phone.
- The trust had the lowest (best) telephone re-contact rate of patients within 24 hours after discharge of care at three percent in October 2015 compared to an England average of six percent.

Competent Staff

- Actual trust staff appraisal completion rates at the time of our inspection were 43% with a rolling annual position of 67% which was below the trust target of 95%. Of the staff responsible for delivering appraisals 63% had been trained to do so.
- We could not be assured that staff were receiving appropriate clinical supervision. The trust's individual practice review / performance development review (PDR) policy stated appraisal and clinical supervision were a combined process. However, observational supervision is a requirement of clinical supervision and there were no mechanisms for central monitoring of this. As appraisal completion rates were below trust target it was likely

Summary of findings

clinical supervision would also be below target. Paramedic staff confirmed they were struggling to meet some of the requirements of their re-registration process with the Health and Care Professions Council (HCPC).

- Staff told us their concerns about capacity for mentorships and capacity to get newly appointed technicians trained. The ratio of clinical team mentors (CTMs) was 1 to between 60 and 120. Their role was to support professional development. They did not have sufficient capacity to support such large numbers of staff, especially as they were also expected to respond to operational demands.
- Staff had not received recent training in mental health awareness. The most recent training had been delivered in 2012/13 and had not been mandatory. This meant staff may not have the skills to deal with patients in mental health crisis, with mental health conditions and the knowledge to work within the Mental Capacity Act 2005 (MCA).
- Staff working in the emergency operations centres (EOC) had regular one to one meetings with their line managers and protected time for development.
- Staff working at NHS band levels one to four were able to access apprenticeships in customer care.

Coordination with other providers

- Processes were in place to monitor the effectiveness of services provided by third parties such as independent and voluntary ambulance services and taxi services.
- Strategic and operational managers met regularly with other NHS providers to discuss concerns and issues. Procedures were in place for inter-hospital transfers and responding to urgent GP calls.
- EMAS was signed up to the national memorandum of understanding for the provision of mutual aid to other NHS ambulance trusts. There was effective communication and cross boundary working with neighbouring ambulance trusts.
- Patient transport services (PTS) staff liaised closely with other health and care providers.

Multidisciplinary working

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

Summary of findings

- There was a joint governance agreement between the police, fire and ambulance services across the east midlands. EMAS led on clinical governance and were part of the joint emergency services interoperability programme (JESSIP).
- There was a joint ambulance conveyance project with the fire and rescue service. Fire responders, trained to First Person on Scene (FPOS) level two responded in fire ambulances and were backed up by an EMAS resource. A paramedic or technician supported the patient during conveyance. The fire ambulance and EMAS back up vehicle were driven by the fire fighters.
- Healthwatch is the consumer champion for users of health and social care services. Local Healthwatch commented prior to the inspection the trust were very positive and open to working with local organisations. This view was also shared by other stakeholders including the lead clinical commissioning group and the police.

Access to information

- Trust policies and procedures were available to staff on the trust's intranet site. They could access this at trust premises or via a dedicated log in on the trust's public website from home.
- The advanced medical priority dispatch system (AMPDS) used in the emergency operations centre (ECO) provided staff with patient specific information.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- The trust policy for capacity to consent was available to staff and had been reviewed in September 2015. Staff we spoke with understood the requirements for patient consent to care and treatment.
- There was not a jointly agreed local policy in place governing all aspects of the use of Section 135 and Section 136 of the Mental Health Act 1983. This 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 transporting patients to places of safety.
- Most staff were not confident in their understanding of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS). Completion rates for training in this subject were less than 40%.

Summary of findings

Are services at this trust caring?

Good



We rated caring at East Midlands Ambulance Service as good

- People were treated with dignity, kindness and respect.
- People were involved and encouraged to be partners in their care and in making decisions with any support they needed.
- Staff helped patients and those close to them to cope emotionally with their care and treatment.

Compassionate care

- Emergency operations centre (EOC) staff consistently spoke to callers with compassion and treated them with dignity and respect. Without exception staff were calm, reassuring and treated vulnerable callers with empathy and kindness.
- Ambulance crews were genuinely caring and sensitive to the needs of patients and loved ones. They were patient and respectful and spoke to people warmly and professionally.
- Results for the friends and family test for EMAS emergency services showed response rates were similar to the England average but scores were often better.
- Patients using the patient transport service (PTS) told us they felt safe and cared for. Results for the PTS friends and family test showed 82% would recommend the service to others.

Understanding and involvement of patients and those close to them

- Patients and those close to them were involved in their care and treatment. Ambulance crews explained what they were doing and the care and treatment options available.
- Staff listened to carers and relatives and took account of their information and views where appropriate.
- Staff in the emergency operations centre (EOC) recognised when callers needed additional support and were able to access interpreters where required. They explained to callers what would happen next and answered questions if necessary. They also provided advice to callers on what they could do whilst waiting for an ambulance.
- Clear protocols were in place for people wishing to accompany a patient on the patient transport service (PTS). Where it was appropriate and necessary carers or loved ones could travel with a patient to support them.

Emotional support

Summary of findings

- Ambulance crews consistently reassured patients and provided emotional support to them whilst they were in their care. They gave calm support and reassurance to worried carers or loved ones.
- Emergency operations centre (EOC) staff listened carefully and spoke calmly, clearly and reassuringly to callers. 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.
- All staff showed kindness, respect and compassion to patients experiencing a mental health crisis.

Are services at this trust responsive?

Good



We rated the responsiveness of East Midlands Ambulance Service as good.

- Services were planned and delivered to meet the differing needs of local populations.
- The needs of different people were taken into account when planning and delivering services. However staff had not received recent training in dementia or learning disability awareness.
- Access to care and treatment was managed to take account of people's needs, although at times there were insufficient vehicles and staff to enable people to access the right care when they needed it.
- Although systems were in place for people to complain and they were supported to do so, investigations were not always robust and learning was not consistently shared.

Service planning and delivery to meet the needs of local people

- The trust was commissioned to provide services by 22 clinical commissioning groups (CCGs) across the region. One of these took a co-ordinating role for contract monitoring and negotiations. In the months prior to this inspection the lead CCG had changed.
- A comprehensive capacity management and escalation procedure was in place and had recently been reviewed at executive level.
- An external company had been commissioned to produce a report on demand modelling. This had been based on the trust's historical performance versus activity. This report had not been adopted by the board and a senior

Summary of findings

manager from another ambulance trust was on secondment at the time of our inspection to look again at demand modelling to identify what resources were required to meet the needs of the local population.

- The trust had a large team of volunteer community first responders, volunteer co-responders, and volunteer medical first responders. These volunteers responded to life threatening emergencies in their local communities offering lifesaving treatment until ambulance staff were able to attend. East Midlands Intermediate Care Scheme volunteer doctors (EMICS) also attended incidents to support patients and EMAS staff.
- The clinical assessment team (CAT) in the emergency operations centre (EOC) provided a 'hear and treat' service where they assessed patients requiring medical help without sending an ambulance.
- A range of specialist clinical services were available to meet the specific needs of local populations. These included a falls service, a mental health triage car and liaison officers for the frail and elderly.
- The trust had a capacity management plan (CMP) including actions to mitigate the impact of increased demand on the service.
- Plans were in place to respond to any large influx of people into the region for special events such as festivals or motor racing events.
- A hazardous area response team (HART) were available to respond to serious incidents involving hazardous materials or environments. The HART consisted of specialised medical personnel with specific training for such incidents.
- The trust told us an historical under-investment in fleet had led to maintenance costs increasing and some reliability issues. Of the trust's rapid response vehicles (RRVs) 49% were five years old or older and 12% of double crewed ambulances (DCAs) were 7 years or older. After an investment plan supported by the Trust Development Agency (TDA) 86% of RRVs would be 5 years or older and 39% of DCAs would be 7 years or older. From November 2014 to November 2015 vehicle numbers had increased. However, vehicles were in constant use due to the shortages. The Trust Development Agency had agreed funding for fleet replacement.
- The trust's fleet services team provided a 24 hour telephone line for the reporting of vehicle faults. A mobile mechanic was available to visit ambulance stations for minor and running repairs. Drivers were available to collect and deliver vehicles. The team reported to the board

Summary of findings

weekly on vehicle availability and compliance. For the week of our inspection the trust had 90% vehicle availability and 94% vehicle servicing compliance. Comprehensive vehicle servicing and maintenance records were held for each vehicle.

- All ambulances were equipped with winter tyres all year round and all new response vehicles would have 4x4 capability to ensure patients received a response whatever the weather.
- One hundred of the trust's emergency ambulances were fitted with trolleys which had a 50 stone capacity in order to be able to transport bariatric (heavy) patients.
- The patient transport service (PTS) met the requirements for patient transport locally as set out in the commissioning arrangements. This included the provision of specialist equipment for bariatric patients.

Meeting people's individual needs

- Commissioning for quality and innovation payment framework (CQUINN) enables commissioners to reward excellence by linking a proportion of a provider's income to the achievement of local quality improvement goals. The trust had CQUINNs set around mental health and the frail elderly.
- The trust had appointed a head of mental health two weeks prior to our inspection and a clinical nurse specialist had been appointed in August 2015. The trust's CQUINN was about designing pathways for mental health care and reducing clinically inappropriate conveyancing of patients with mental health conditions.
- 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 the use of a Section 136 detention under the Mental Health Act 1983 and hospital admission.
- The clinical assessment team (CAT) in the emergency operations centre (EOC) had done a mental health training course on how to triage people identify who are in life threatening situations. They also were able to access on call advice from an on call external mental health team.
- The trust had a high volume service user lead. High volume service users are those who call the ambulance service five or more than times in a calendar month. Resources in the trust were insufficient to meet the demand of this service

Summary of findings

user group. As a result less than 10% of high volume service users had individual care plans in place (43 out of 468). This risk was highlighted on the trust risk register and a senior manager told us a business case along with a CQUINN had been submitted for extra resources in this team.

- A loop system was fitted in all emergency ambulances to support patients with hearing impairment.
- Staff identification badges were also in braille for patients with visual impairment.
- Arrangements were in place for the provision of interpreter services where required. Communication cards were available on some but not all vehicles.
- A patient passport system was used for patients with specific conditions or complex needs identifying where and how they should be treated most appropriately.
- There was a patient passport system for patients with a learning disability. The trust had produced a CD ROM and accompanying workbook in easy read format to assist people with learning disabilities to access the ambulance service and reduce their anxieties when doing so.
- However, although staff received training in learning disabilities awareness during induction many staff had not received any recent training or updates.
- Although staff received training in dementia awareness at induction many staff had not received any recent training or updates.
- There were no nurse specialists in place to give advice regarding learning disabilities or dementia and the trust did not measure or monitor its performance in relation to meeting the needs of these two groups of people.
- Although the trust's capacity to consent policy contained reference to patients with a learning disability or living with dementia there were no policies and processes to ensure they were identified.

Access and flow

- Lack of ambulance and staff availability was a limiting factor in the responsiveness of the service. The trust experienced significant handover delays at some of the acute hospital trusts in the East Midlands. These delays impacted on their capacity to respond to patients in the community waiting for an emergency ambulance response

Summary of findings

as the crews and vehicles were held at hospitals waiting to hand over patients to the care of the emergency departments. On occasions no vehicles were available to attend calls.

- The trust were not commissioned to provide hospital ambulance liaison officers (HALOs). HALOs work in partnership with emergency departments to support the effective and efficient management of patient streams, particularly patient handover and ambulance turnaround times within the department. Despite the lack of commissioning the trust were providing untrained staff to fulfil this role in an effort to support better patient flow. The trust confirmed paramedics in this role had been issued with guidance regarding hospital turnaround and managing delays but not training.
- Trust capacity management plans (CMP) were used to increase patient access and flow during periods of high demand.
- The proportion of calls to EMAS which were abandoned before being answered was better than the England average and consistently lower than one percent of all calls. Between April 2014 and April 2015 EMAS were the best performing ambulance trust.
- Eligibility criteria for patient transport services (PTS) were determined by commissioners based on national guidelines. The majority of PTS patients arrived before or within 30 minutes of their appointment time. Most patients were collected within 60 minutes of being ready after their appointment and most were on the ambulance for less than 90 minutes. These were the performance indicators set by the commissioners.

Learning from complaints and concerns

- The trust had a Complaints (including concerns raised through patient advice and liaison service (PALS)) Policy and Procedure which had been updated in November 2015.
- There was no information on how to make a complaint on ambulances. Frontline staff did not have any information to give to patients or relatives about how to make a complaint but when asked confirmed they would provide the telephone number for trust headquarters.

Summary of findings

- The trust's website included information about how to complain but this was on the 'contact us' page and entitled 'comments'. There was however a link to an independent NHS complaints advocacy service to support people who needed assistance to complain.
- Patients initially complained to the PALS team who would advise them whether to make a formal complaint. However the trust had no clear guidelines in place for staff to determine which category the concern fell into. The Director of Quality and Nursing told us complaints had traditionally been handled by this team and this was why the number of formal complaints was low and informal concerns high. The board were aware that there was a likelihood complaints would increase as clearer categorisation was introduced. The policy dated November 2015 included reference to a complaints and concerns categorisation matrix.
- There were limited learning opportunities for staff from complaints. The updated complaints policy stated that themes of learning identified as a result of complaints and or PALS concerns would be shared with the organisational learning team. The head of patient experience confirmed the trust did not keep a log of learning as a result of complaints and there was a need to share learning with all staff.
- NHS Trust Development Authority (TDA) carried out a desk top review of the trust's clinical and quality areas of good practice and areas for development during July 2015. The review noted the patient experience strategy required development. Clear lines of reporting to the trust board on patient experience and complaints was identified as a development requirement. There was also development required for the complaints process and responses from the patient advice and liaison service (PALS) and the trust.
- During our review of complaints we found evidence of inappropriate responses to complainants. Some complaints should have been categorised as serious incidents and this had not been done.
- Investigation of complaints was often poor and lacking detail. Frequently we found no evidence of any action plan to ensure those immediately involved and staff in the wider trust shared learning from complaints and took action to avoid a repeat situation. One step of the investigation process for complaints and for incidents was to review whether any staff involved had up to date appraisals in place.

Summary of findings

- In the 12 months from September 2014 to September 2015 the trust had received 31 level one complaints. These were defined by the trust as, “usually straightforward and easier to resolve (compared to level two)”. The majority of these complaints related to delayed responses or emergency operations centre (EOC) issues. For the same period the trust received 61 level two complaints, the majority of which related to delayed responses. These were defined by the trust as, “generally more serious in nature, requiring detailed investigations, accessing various records etc.). Contacts received by the patient advice and liaison service (PALS) between September 2014 and September 2015 numbered 1708. Of those 253 were about delayed responses and 181 about EOC issues. The remainder were about a variety of other issues.

Are services at this trust well-led?

We rated well led for East Midlands Ambulance Service as requires improvement.

- Frontline leadership lacked capacity to lead effectively and on occasions lacked the experience or knowledge to do so. The need to develop leaders was not actioned because of operational demands.
- Staff satisfaction was mixed. Staff did not always feel respected or valued and sometimes they felt bullied and harassed. Some teams were working in silos and not working consistently.
- The board functioned effectively. There were processes and information in place to identify, understand, monitor and address risks. However there were gaps in local security management and patient transport services.
- There was a focus on improvement and safe innovation supported by the chief executive. However the audit and research team did not always feel the board valued and promoted their work.
- The chief executive actively shaped the culture through effective engagement with staff. Leaders at every level prioritised safe, high quality, compassionate care.
- There was a strategy for community engagement and patients attended board meetings to tell their stories, both positive and negative.
- There was a clear statement of vision and values, driven by quality and safety.

Requires improvement



Vision and strategy

Summary of findings

- The trust's vision was to play a bigger part in the community through enhanced emergency and urgent care services delivered by proud, respected, highly skilled and compassionate. This vision had been attached to payslips in July 2015, displayed in some trust premises and on trust computers. Despite this most staff were not aware of it.
- Staff were, however, aware of the trust's values of respect, integrity, contribution, teamwork and competence and consistently displayed them in their behaviours during our observations. They were consistently passionate in their drive to provide safe, high quality services.
- A strategic plan entitled Better Patient Care was introduced in January 2015 and had been regularly updated. Progress against this plan was overseen fortnightly by the Better Patient Care Transformation Board and in between at meetings of the trust's executive team.

Governance, risk management and quality measurement

- The trust board reviewed identified risks. Board members were sighted on the most significant risks; response times, recruitment and hospital handover delays. Risk registers were held at divisional levels for emergency and urgent care, patient transport service (PTS) and within the emergency operations centre (EOC). However the risk register for the PTS did not reflect the risks we identified during our inspection.
- Actions had been taken to respond to and mitigate risks including a multi-agency risk summit looking at hospital handover delays. However, we were concerned that actions to mitigate risks to patients and staff were not always being implemented. In some cases we found the executive team's arrangements for seeking assurance were not robust.
- The board and board committees used three processes for scrutiny; alert, assure or advise. Every record of business was prepared to alert the board, assure the board or advise the board.
- Sub committees of the board included Quality and Governance, Workforce, Finance and Performance. A non-executive director chaired the Board's Quality and governance committee. A strategic learning and review

Summary of findings

group, chaired by the Deputy Director of Quality reported into the quality and governance committee and was responsible for cascading information out to the organisation via team leaders.

- The director of strategy was planning for the forthcoming national radio replacement programme and the trust had established a project board.
- The trust subcontracted emergency ambulance services to third party providers. Annual governance audits were carried out to check the quality of service delivery. However, there was no service level agreement in place with taxi companies which provided services on behalf of PTS and no mechanism for quality assurance.
- There were gaps in the trust's local security management processes and security management specialists were not aware of or carrying out the full range of their duties and responsibilities. For instance they were not carrying out audits for the security management of medicines or premises to protect trust assets.
- A Quality Everyday programme initiative was introduced in January 2015. This programme included audits of medicine management, vehicles, stations and infection prevention control. A central team went out to divisions monthly to carry out quality assurance visits. The quality everyday results were reported to the executive board.
- Locality quality managers were required to report on infection prevention and control compliance, actions and best practice at the infection control group meeting, which met bi-monthly and was chaired by the director of nursing. Stand-alone hand hygiene audits were completed by observation of crews in hospital emergency departments using the five moments of hand hygiene model.

Leadership of the trust

- Without exception all staff spoke highly of the chief executive and had confidence in their leadership. They told us she communicated well with staff and produced a weekly bulletin as well as having regular face to face meetings with groups of staff across the divisions, called 'tea with the chief'.
- The chief executive provided good leadership to the executive directors. The executive team were a relatively junior team. The chief executive provided supervision and appraisal and reviewed their development needs.

Summary of findings

- The permanent appointment to the post of chief executive had been confirmed in May 2015 although she had been in the post on an interim basis from October 2013.
- Whilst staff across all services told us there had been many years of constant change at leadership level with a resulting lack of stability, many felt the current executive team and the structure they had created was taking them in the right direction.
- The trust had a robust induction and development programme for Non-Executive Directors (NEDs). NEDs met monthly for development in addition to the formal public board meeting.
- Each member of the executive and non-executive team had responsibility for the geographical lead in one county.
- The workload and portfolio of the operations director was not sustainable. They had 14 direct reporting managers as well as a very large portfolio.
- A significant number of middle and frontline management staff were newly appointed at the time of our inspection or working in seconded positions. The trust chairperson confirmed they had increasing numbers of acting or interim posts which created vacancies and abstractions (staff not present in their substantive role for a variety of reasons including training, development or absence). This meant staff were uncertain about their futures and the trust leadership teams at middle and frontline level were not stable.
- As part of a cost improvement programme previous leadership of the trust had removed managers at middle operational management level. In the emergency and urgent care services this removed a significant amount of experience, as well as management capacity. There was a potential that the lack of middle managers at this level would impact on the trust's ability to engage at an appropriate level with staff and stakeholders as well as its ability to respond to operational incidents including major incidents. All members of the board confirmed there were real challenges around front line leadership effectiveness and cohesiveness. The team leader to staff ratio was 1:24 and clinical team leaders 1:86. Senior managers told us they recognised the need to invest in front line leadership. It was widely accepted this group did not currently have capacity to fully undertake their roles because of operational pressures. The goal was to achieve a 75% to 25% split of clinical and protected management time.

Summary of findings

- Although the trust had scoped various initiatives for leadership development the director of HR told us these were not widely accessed because operational demands reduced the capacity for staff to be released to participate.

Culture within the trust

- There was a patient focus at board level and throughout the trust. All the staff we spoke with were committed to their jobs and to ensuring high quality patient care. However, significant numbers of emergency and urgent care and emergency operations staff told us they did not feel respected and valued by the organisation.
- A number of staff from emergency and urgent care services and the emergency operations centre raised concerns with us about a bullying and harassment culture amongst some of the front line managers. They gave us examples where staff had not been given permission for time off following bereavement, or down time following particularly traumatic incidents. They also gave us examples of managers mis-interpreting policies to control staff, dissuading staff from raising concerns or reporting incidents and treating those who did so badly. We shared these concerns with the trust's leadership and they took immediate action to address them where possible.
- Staff told us there was a culture of silo working. Although there were trust wide policies in place, there were divisional differences in interpretation.
- Six weeks prior to our inspection the trust had appointed a new equality and diversity manager who was in the process of reviewing trust compliance and making plans for the future. These included training in equality and diversity and bullying and harassment.
- Patient transport services (PTS) staff felt there was a culture of openness and honesty and they were proud of their achievements as a team.

Public and staff engagement

- Patients and staff attended the trust board meetings to present positive and negative stories.
- Patients were able to give feedback on the trust's public website.
- There was a trust community engagement strategy for 2014 to 2016 which included focus groups and events across the region to engage with patients.

Summary of findings

- A patient experience forum was chaired by the director of quality and nursing and attended by patients and their carers.
- Materials for the public explaining how emergency calls are graded and alternative pathways to emergency care were available at public events and via social media.
- 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).
- A listening into action initiative (LIA) was launched in 2013. Changes had been made to the design of ambulances followed an LIA initiative where staff raised concerns about equipment being attached to rear doors.
- The trust engaged with the Mind Blue Light Programme supporting ambulance workforces in England with practical ways to stay mentally well.
- Peer to peer and pastoral care workers schemes were available to support staff who had experienced traumatic events or increased levels of stress. However, a number of staff raised concerns with us about the confidentiality of the peer to peer service.
- Sickness absence rates between May 2014 and May 2015 were consistently above six percent.
- Results from the NHS Staff Survey 2015 in which EMAS compared least favourably with other NHS ambulance trusts included questions about staff satisfaction with the quality of work and patient care they were able to deliver. However, staff engagement overall was in line with other trusts of a similar size.

Innovation, improvement and sustainability

- The infection prevention and control team had produced two videos downloadable from and icon on back of payslip to inform staff.
- The trust had appointed a chaplain in 2015. Their role was to offer multi-faith support to staff. In addition the trust had a peer to peer support programme with over 80 staff members training to provide confidential peer to peer support to colleagues. Between July and August 2015 there had been over 360 contacts with this group and further peers were being recruited. The chaplain attended each staff induction course to talk about support available to staff.
- Those staff who had attended traumatic incidents were identified and offered support along with an appointment

Summary of findings

with a Trauma Risk Management programme (TRiM) practitioner three to five days after the incident. Following this appointment and a risk assessment staff could be referred to occupational health or offered a further TRiM appointment. The trust had 48 TRiM practitioners with coordinators in each division.

- The trust had an active, enthusiastic and passionate audit and research team. The chair is a world renowned professor of primary and pre-hospital health care and the team also included staff involved in clinical audit, development and research. We saw evidence of extensive collaborative working between this team and other ambulance trusts and universities. During the period 2014-15 EMAS had been involved in 17 research studies and a programme of local and national clinical audit work. At the time of our inspection 40% of paramedics were involved in clinical audits. The team had produced a leaflet entitled, Actively Involved in Research (AIR) aimed at encouraging more staff to get involved in clinical research.
- The research team were keen to point out that successful research is measured by its effect on patient outcomes. They told us dissemination of their reports and actions plans relating to audits and learning outcomes in EMAS was poor, due in part to the lack of capacity at frontline leadership level. They were concerned that the board did not see the connection between support for research and clinical audit, the capacity of local clinical quality managers to disseminate information and resulting improved outcomes for patients. In an effort to increase dissemination the team used some innovative methods such as social media messaging.
- 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.
- A Quality Everyday programme initiative was introduced in January 2015. This programme included audits of medicine management, vehicles, stations and infection prevention control. A central team went out to divisions monthly to carry out quality assurance visits. The quality everyday results were reported to the executive board.

Fit and Proper Persons

Summary of findings

- The fit and persons requirement (FPPR) for directors was introduced in November 2014. It is a new regulation that intends to make sure senior directors are of good character and have the right qualifications and experience.
- The trust had appropriate systems and processes in place to ensure that all new and existing directors were and continued to be fit and proper persons. However, a policy had not been created or approved. Following our announced inspection the trust amended their recruitment and selection policy to include fit and proper persons requirements. The policy was due to be approved by the Workforce Committee by the end of March 2016.
- The executive directors were able to demonstrate an understanding of the regulation.
- We looked at a selection of four executive directors' personnel files. Appropriate evidence of checks were available and the files contained a recruitment checklist for posts subject to FPPR.

Overview of ratings

Our ratings for East Midlands Ambulance

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

Our ratings for East Midlands Ambulance Service NHS Trust

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

Outstanding practice and areas for improvement

Outstanding practice

- 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 scheme of its kind 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.
- PTS 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.

Areas for improvement

Action the trust MUST take to improve

- The trust must ensure staff report all appropriate incidents and they are appropriately and consistently investigated.
- The trust must ensure learning from incidents, investigations and complaints is shared with all staff.
- The trust must ensure all staff receive statutory and mandatory training.
- The trust must ensure all domestic, clinical and hazardous materials are managed in line with current legislation and guidance.
- The trust must ensure 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 vehicle and equipment checks are carried out to the determined frequency.
- The trust must ensure there are sufficient emergency vehicles to safely meet demand.
- The trust must ensure medicines, including controlled drugs are stored and managed safely.
- The trust must 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.

Outstanding practice and areas for improvement

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

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

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity

Diagnostic and screening procedures
Transport services, triage and medical advice provided remotely
Treatment of disease, disorder or injury

Regulation

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:
Medicines, including controlled drugs were not always stored and managed safely.

Regulated activity

Diagnostic and screening procedures
Transport services, triage and medical advice provided remotely
Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
The provider must assess the risks to the health and safety of service users and do 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 checks of motor insurance, vehicle MOTs and driving licence checks.

Regulated activity

Diagnostic and screening procedures
Transport services, triage and medical advice provided remotely
Treatment of disease, disorder or injury

Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care
The care and treatment of service users must meet their needs.
How the Regulation was not being met:
There were not sufficient emergency vehicles to safely meet demand for emergency care.

This section is primarily information for the provider

Requirement notices

Regulated activity

Diagnostic and screening procedures
Transport services, triage and medical advice provided remotely
Treatment of disease, disorder or injury

Regulation

Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises

The provider must, in relation to premises and equipment, maintain standards of hygiene appropriate for the purposes for which they are being used.

How the Regulation was not being met:

Domestic, clinical and hazardous materials were not always managed in line with current legislation and guidance.

Regulated activity

Diagnostic and screening procedures
Transport services, triage and medical advice provided remotely
Treatment of disease, disorder or injury

Regulation

Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises

All premises and equipment used by the service provider must be properly maintained.

How the Regulation was not being met:

Vehicle and equipment checks were not always carried out to the frequency required by trust policy or manufacturers' guidelines.

Regulated activity

Diagnostic and screening procedures
Transport services, triage and medical advice provided remotely
Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

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 was no service level agreement with named taxi companies to ensure the quality of PTS provision.

Regulated activity

Regulation

This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures
Transport services, triage and medical advice provided remotely
Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Systems or processes must enable the provider to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users.

How the Regulation was not being met:

The provider's staff did not always report incidents. Reported incidents were not always appropriately and consistently investigated.

Regulated activity

Diagnostic and screening procedures
Transport services, triage and medical advice provided remotely
Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Systems and processes must enable the provider to maintain securely an accurate, complete and contemporaneous record in respect of each service user.

How the Regulation was not being met:

Paper patient report forms were not stored appropriately and securely in trust premises and in such a way on trust vehicles as to maintain patient confidentiality

Regulated activity

Diagnostic and screening procedures
Transport services, triage and medical advice provided remotely
Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed.

How the Regulation was not being met:

The provider did not have sufficient staff deployed to meet the demands of the service in the emergency operations centre.

The provider did not have sufficient staff deployed to meet the demands of the service in emergency and urgent care.

Regulated activity

Regulation

This section is primarily information for the provider

Requirement notices

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 must receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

How the Regulation was not being met:

Staff were not receiving annual performance development reviews in accordance with trust policy.

Staff were not receiving mandatory training

This section is primarily information for the provider

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

The Registered Provider does not ensure care and treatment is provided in a safe way 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.

Where these improvements need to happen

Trust Headquarters