North West Ambulance Service NHS Trust

North West Ambulance Service NHS Trust

Quality Report

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

Letter from the Chief Inspector of Hospitals

North West Ambulance Service NHS Trust has been selected as the first ambulance trust to be inspected under the Care Quality Commission's revised inspection approach.

It is one of 10 ambulance trusts, five of which are foundation trusts. It is in the process of applying to become a foundation trust.

The announced inspection took place between 19 and 22 August 2014, and the unannounced inspection visits took place on 26 and 27 September 2014.

As the first ambulance trust inspected under the new model, we did not provide ratings for this trust.

The trust operates a 111 service. This was not looked at as a part of this inspection.

Our key findings were as follows:

The service was clinically led and focused on patients and outcomes.

The trust was only achieving one of the three key response time targets in 2014/15; although it did achieve all key national ambulance targets 2013/14.

Summary of findings

Systems, processes and practices were used to keep people safe from harm.

The ambulance service used evidence-based computer systems to support decision making when the public called 999. Special patient notes were held on the system to support and inform decisions.

The trust had clinicians based in its three emergency operations centre however they were used effectively in Manchester.

Paramedics used a Paramedic Pathfinder tool (Pathfinder allowed staff to transfer patients to the correct pathways using known clinical guidance to determine the correct treatment) to ensure that patients received care in the most appropriate setting.

The patient transport services provided transport for people who met the eligibility criteria. These were people who needed to be taken to hospital for a planned appointment and who were unable to make their own way to hospital because of clinical or medical needs.

The trust's leadership team had a clear vision that was freely quoted by many staff. It was underpinned by a strategy to make the trust one that provides not just a good service but a great one. The trust had a system to communicate its messages via different media such as notice boards, bulletins and emails. However some staff cited lack of time, lack of face to face meetings and lack of access to emails to be able receive those messages.

Overall, staff felt supported and well equipped to carry out their duties. It was compulsory for advanced paramedics to have a Master's qualification; operational managers were encouraged to partake in Chartered Management Institute schemes. Some staff expressed concerns that they had not received the training they needed to manage obstetric emergencies, although mandatory training included an obstetric update.

There was a procedure for staff to report this colleagues' poor practice and staff were encouraged not to tolerate this.

There were challenges in the delivery of the patient transport services. However, there was a commitment to this service and recognition that it was part of the future plans for the trust.

Staff treated patients and their families and carers in a caring manner with dignity and respect, and valued them as individuals. We observed exemplary care being given across the whole trust.

We saw several areas of outstanding practice including:

Numerous examples where staff showed a caring, committed and compassionate manner, despite the situation or the environment they were in, or the challenges they faced.

Patients who called more than twice in 7 days or 4 times in 28 days were recognised as 'frequent callers'. The trust had a 'frequent callers' team that liaised with the caller, their GP and other social care providers to ensure that the person's health and social care needs would be met by the right provider.

Clinical staff performance was monitored and all paramedics' results were published within the team. Each paramedic had a unique identifying number so only they would know which results related to their performance. This meant they could compare their performance against their colleagues without knowing which results related to whom.

'Prevent' is part of the UK government's counter-terrorism strategy known as CONTEST, which aims to reduce the risk to the UK and its interests overseas from terrorism. At the time of our inspection, 55% of staff had completed their training.

Emergency Medical technicians in order to progress to paramedics they've had to apply to a University to undertaken the Paramedic Diploma which meant that they had to leave the trust. Recently, a trial had been undertaken for them to enhance their level of education to the point where they can apply to the trust's own internally sponsored Paramedic course.

The trust showed commitment to ongoing education and development of their staff at all levels. It appointed one of the first consultant paramedics back in 2008 and was focused on ensuring that staff were equipped to carry out their roles.

Summary of findings

The commitment and enthusiasm for the use of volunteer community first responders and their support was evident. They received a comprehensive 6-month package of training, and then continuing training and support.

The trust had developed a process for responding to calls when a patient had already been seen by ambulance staff within the previous 24 hours. These calls were automatically flagged and referred to the clinical governance team who then immediately reviewed these incidents to understand and share any learning from these incidents.

The purpose-built emergency operations centre at Parkway in Manchester provided a good working environment and a positive atmosphere to work within.

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

Getting the most appropriate vehicle to the patient (a key objective for ambulance services) is known as 'best allocation' and the trust aimed to achieve this target 60% of the time. However, this had only been achieved in 40% of cases from July to September 2014. It varied but was around 40% for the trust.

The service took a high number of patients to hospital when alternative services may have been more appropriate in meeting their needs. The trust was the worst performing nationally in this area. Less than 4% of calls to the trust were closed with telephone advice.

Some staff raised concerns that they did not have access to pain relief medication for children experiencing significant pain. The issue had been raised with senior staff who were in the process of addressing it.

Pulse oximeters (which check the oxygen levels in blood streams) with probes suitable for children were not available to all staff at all times.

There were some areas within the trust where staff had not had appraisals and regular communication was not taking place.

Importantly, the trust must:

Review the process for pre-alerting hospital accident and emergency (A&E) departments to make sure that communication is sufficient for the receiving department to be made fully aware of the patient's condition.

Make sure that emergency operations centre staff across all three EOCs are consistently identifying and recording incidents as appropriate.

Make sure dosimeters (that measure exposure to radiation) on vehicles are in working order.

Improve access to clinical supervision for all clinical staff.

Review medicines formulary guidance issued to front-line staff to make sure it is current.

Ensure that all staff are receiving the mandatory training necessary for their role.

Ensure that all staff across all divisions are consistently receiving appraisals.

The trust should:

Assess the impact and mitigate of any identified risks by call-handling staff not accessing clinical advice, in contrast to regular clinical advice being sought by Manchester Parkway call-handling staff.

Assess the impact and mitigate associated risks of non-clinical staff re-triaging calls.

Ensure measures in action plans are SMART (specific, measurable, achievable, realistic and timed), in the Broughton emergency operations centre.

Audit and assess individual call-handling performance at all emergency operations centres.

Assess and implement measures to improve performance for the proportion of calls closed with telephone advice when clinically appropriate.

Review the adoption of the urgent disconnect policy at all emergency operations centres.

Assess and implement measures to improve performance against the national target for the percentage of calls abandoned before being answered.

Share learning and good practice across emergency operations centres.

Review the system for managing controlled drugs at ambulance stations to ensure that they are managed appropriately.

Review systems to assess if access to new stocks of controlled drugs in rural areas can be improved.

Summary of findings

Evaluate the availability of training and opportunities for career progression for emergency medical technicians across the trust.

Assess and implement measures to improve performance against the 40-minute transfer target for transport services patients having haemodialysis or cancer treatment.

Ensure that the public know how to complain should they wish to.

Improve complaint response times.

Ensure that the various communication media that the trust employs be supported to be effective by the ability of staff to access them in both time and physical access, recognising the geographical spread of the trust.

Consider bringing forward the programme to provide a new Emergency Operations Centre (EOC) at Elm House Liverpool or consider renting purpose built accommodation

Re-examine and improve basic cleaning processes for ambulances such as standards for replacement of mop heads and processes for replenishing buckets containing cleaning fluids

Instigate team meetings or training in specialist subjects, such as the Mental Capacity Act 2005 or deprivation of liberty safeguards for Liverpool Elm House EOC staff.

Develop a system for EOC staff to deal with requests for information from the police.

Call-taking and dispatch staff arranged call-backs to Green 3 and 4 calls (non-life threatening) that had passed the expected response time, in order to explain delays and check for any deterioration in the patient. This was organised in an ad hoc way and sometimes overlapped with call-backs undertaken by staff at the urgent care desk. Set up a process to undertake this is a systematic way.

Improve the frequency of face-to-face interactions between managers and staff ensure that team meetings take place on a regular basis.

Professor Sir Mike Richards
Chief Inspector of Hospitals

November 2014

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Emergency and urgent care		Cumbria and Lancashire Incident reporting was challenging for ambulance crews, but we found that incidents were being reported by staff. The service used various communication methods to feedback learning from incidents, but not all staff accessed these communications Vulnerable people were safeguarded and systems and processes enabled staff to assess and respond to patient risk. Staff displayed compassion and kindness and provided reassurance to patients and relatives. Ambulance staff were able to respond to the individual needs of patients National and local guidelines were available and used to support patient care and treatment. Staff had the necessary skills and knowledge to deliver care to patients of all ages, including children. Staff had access to and made good use of clinical advice from advanced paramedics. However, a large number of ambulance staff told us that, while they could access clinical advice, there was a lack of sufficient direct clinical supervision or observation on the road to support them. In Cumbria and Lancashire between 1 April and 19 August 2014, the service was performing below the national average for response time targets. Hospital staff commented positively on the quality of the service provided by the ambulance trust and the information given when patients were handed over. However, hospital and ambulance staff were concerned that operations centre and not clinical staff were making the calls to emergency departments to alert them of a patients imminent arrival and their status.

Summary of findings

The trust employed increased numbers of volunteer drivers across Cumbria and Lancashire and we found that the service used these response vehicles appropriately to respond to patient need.
A number of clinical front-line paramedics and their local managers in Cumbria were concerned about a risk to patients as they were often unable to replenish stocks of morphine readily.
Staffing levels were determined in terms of numbers and skill mix, and monitored to ensure the quality of the service provided and to minimise risk to patients.
Many of the crews we spoke with told us the organisation was good to work for and they felt supported by the service; however they thought staff morale was low.

Greater Manchester

The trust's services for people with emergency and urgent care conditions were delivered by committed, caring and compassionate staff.
Systems were used for the reporting and managing of risk, but due to the high demand on the service staff did not always have the time to report every minor incident or complete the vehicle and equipment checks needed at the start of their shifts.
Overall response times were close to the national average. The care being delivered was effective; however the service took a high number of patients to hospital when alternative services may have been more appropriate in meeting patients' needs. Staff were well-trained and competent in performing their roles. They were supported by the trust to access learning and development. The service worked in collaboration with other emergency services and providers.
There were clear management structures in place for ensuring staff were supported to carry out their duties. Clinical leadership was seen on the frontline and most staff knew who to contact if they needed to raise clinical concerns or operational issues such as

Summary of findings

annual leave. The culture of the teams differed across the sectors. Staff we spoke with were honest and committed to doing the right thing for people who accessed the service. They all recognised the increasing demand on the service and some were involved in trying to reduce this by new initiatives such as the GP referral scheme or having a liaison officer based at A&Es at peak times.

Services were planned and delivered to meet the needs of local people. Hospital ambulance liaison officers managed the access and flow of the ambulances at some hospitals during peak times to predict busy patterns and manage any potential diverts. Translation services were available for patients whose first language was not English, and ambulance staff carried communication books that included easy-to-follow visual prompts. The trust sought feedback from patients by encouraging comments, complaints and patient engagement, and then used this information to look for ways to improve the service.

Cheshire and Merseyside

The trust services for people with life-threatening conditions were delivered by hard-working, caring and compassionate staff. People were treated with dignity and respect, and care and treatment were delivered in a way that took their wishes into account. National guidelines were used to treat patients, and pathways were in place to provide the most effective care to patients with life-threatening conditions.

There were systems in place for the reporting and managing of risk, but the way in which some minor incidents were reported was inconsistent, making it difficult to analyse trends. There was no effective system for ensuring that important safety information was given to the appropriate staff.

Front-line ambulance staff were not given sufficient time off the road during their shifts to clean emergency vehicles and access

		important safety-related information electronically. Some infection control and manual handling practices we observed were unsafe, and the storage of patient and staff records in ambulance stations was unsatisfactory. In some cases, the triage system used to initiate a pre-alert to A&E departments differed from the triage system within the hospitals, meaning that the hospitals were sometimes either over- or under-prepared to receive patients. **Many front-line ambulance staff felt the organisation was target driven, sometimes to the detriment of patient care, while others only felt connected with other the trust staff within their immediate geographical area and not within the trust as a whole.**
Patient transport services		**Cumbria and Lancashire** **Staff we spoke with were aware of how to identify abuse and report safeguarding concerns. Staff could raise safeguarding concerns through a support centre team based at Carlisle. Patients' needs were assessed by the control room staff as part of the booking process and the most suitable resources were deployed to meet patient's needs. As part of the booking process staff were able to identify patients with specific needs, such as learning disabilities, a mental health condition or dementia.** **The service was supported by a team of volunteer drivers who were overseen by a delivery and performance manager based at Broughton in Lancashire. The volunteer drivers accounted for approximately 64% of all patient journeys in Cumbria and 22% of those in Lancashire.** **There was an escalation process in place so key risks and capacity issues could be escalated to senior managers. When a patient or their representative made a request to use the service, they were assessed to determine their eligibility. Between July 2013 and June 2014 local teams achieved or were slightly below the**

expected local targets for patient transport times. There were no significant differences in performance between the Lancashire and Cumbria teams.

Ambulance staff spoke positively about the mandatory training they had received and told us they felt it was sufficient for them to carry out their role effectively. Staff told us they had good working relationships with the police when escorting patients under Section 136 of the Mental Health Act 2005.

The general manager and team leaders attended routine engagement meetings with commissioners and hospitals to discuss key concerns and performance.

Patients were treated with dignity, compassion and empathy. We observed staff providing care in a respectful manner.

Hospital staff we spoke with were positive about the attitude displayed by the ambulance staff. They told us the staff were friendly and had a good rapport with the patients. Patients gave positive feedback about the care they received.

Collection times were planned in advance for morning and afternoon collection slots across Cumbria to make efficient use of resources. This meant that some patients who had an appointment early in the morning or early in the afternoon might need to wait longer for collection.

Transport to appointments for haemodialysis patients was available up until 7.30pm with collection after appointments up to 1am, Monday to Saturday, including bank holidays. Transport was available for cancer patients from Monday to Friday, including bank holidays.

Key issues, such as performance against targets, audit findings, organisational issues and the PTS risk register, were reviewed at the PTS business group meetings that took place every two months. During the inspection, we looked at the PTS risk register and saw that key risks had been identified and assessed.

Summary of findings

From July 2014, 32% of Lancashire PTS staff had had an appraisal within the last 12 months, but only 4% of PTS staff in Cumbria had received an appraisal in the last 12 months

There was a positive culture of reporting incidents and safeguarding concerns. However, the staff we spoke with were unable to describe how learning from incidents was shared to aid learning and improve the service. Ambulance staff told us they received good support from their team leaders but felt disengaged from the wider organisation.

Cheshire and Merseyside

There were systems for reporting actual and 'near miss' incidents across the patient transport service, and staff did report incidents. However, we found processes for feedback were poor and staff we spoke with were unaware of the key risks for the service.

Overall, we found that the service was compliant with infection prevention and control processes. However, we found that some stations were not fully adhering to specific infection prevention and control guidance.

The trust had been issued with a contract query notice on 12 February 2014 because of non-achievement of the standards of performance expected to be delivered for access to the patient transport service.

Service managers told us that they had invested in the introduction of mobile data terminals in vehicles. This had improved planning and communication, and contributed to improved performance. The inspection team noted that, although significant improvements had been made, The trust was still reporting below target on arrival within a 60-minute window and on passenger time on vehicle of less than 40 minutes.

Staff told us, and we observed that individual needs were taken into account

		when planning transport, such as a 54 year old patient needing an early appointment or a cancer patient needing a stretcher to make a hospital appointment. **Most patients we spoke with raised the issue of eligibility and the 10 questions they had to answer every time to prove they were eligible for transport, even if they were a regular user of the service.** **We found that the patient transport service was delivered by committed and caring staff. We observed that all staff treated patients with dignity and respect. Most patients we spoke with were positive about the care they had received. Some told us they would have welcomed more information on the procedure for booking the patient transport service.** **We did not see any evidence of a project plan or timelines for the delivery and implementation of a patient transport service strategy. We found that there appeared to be a disconnect in communication and understanding of key issues between managers and staff across the transport service. During discussions, the Head of Patient Transport Services acknowledged the challenges of working in such a huge geographical area and the need to increase the visibility of the senior management team.** **Most staff at the control centre in Chester felt under pressure, and morale was low. Transport service staff also told us that they felt unsure and anxious for the future of the service, and that they were less patient focused since the new contract had come into force.**
Access to the service		**Cumbria and Lancashire** **Staff in the trust's Emergency Operations Centre in Broughton were proud to work for an ambulance service. The systems that call handlers and dispatchers used made sure that patient safety was a priority and that they maintained accurate and detailed**

records. Staff had received appropriate training and most staff felt confident they had been supported to gain the competencies for the role.
However, many call handling staff did not feel listened to or engaged by managers, and minutes of meetings showed that staff suggestions were not responded to or acted upon in a timely manner.
Systems and processes supported the responsive deployment of emergency vehicles and coordination with other emergency services.
Call handlers were compassionate, reassuring and gave people appropriate support and information.
While call handlers at one of the trust's other operations centres had regular input from clinicians, call handlers at Broughton did not. Non-clinical staff re-triaged calls with competing priorities.
Individual audit data for call handling staff was not available to support the effective performance management and development of staff.

Greater Manchester

The emergency operations centre was well-led, effective, responsive, and provided a caring and safe service to people accessing the service. The practices and environment at Parkway, Manchester enabled staff to provide access to the service.
Systems, processes and practices were used to keep people safe and safe from abuse. Staff learned when things went wrong and took steps to improve. Staff assessed and monitored safety in real time, reacting to changes in risk levels for individuals. Staff anticipated potential risks and planned for them in advance, working with a range of other providers to keep people safe.
The service was effective in ensuring people with healthcare needs could access the service. Staff used a internationally approved call triage system called the 'advanced medical priority dispatch system' (known as AMPDS) to triage the high volume

of people attempting to access the service. Staff worked well with other emergency services and health and social care providers to ensure people's health and social care needs were met.
We saw several examples of call handlers and paramedics based at the emergency operations centre talking with people compassionately. They listened carefully to the patients details and asked clear questions to gather more information to ensure the right action was taken, whether that was an ambulance or a telephone conversation with another healthcare professional.
There were clear escalation protocols in place for increasing levels of demand. All staff were well equipped to provide care for people in consideration of their needs. Screens were visible to staff to make them aware of the demands on the service and the flow.
Staff were proud of their roles and felt supported and well-led. Their health and well-being was considered and there was a 'no blame' culture within the team.

Cheshire and Merseyside

The concept of safety was embedded into clinical practice throughout the service. There were systems, processes and practices in place to keep people safe from abuse.

North West Ambulance Service NHS Trust

Detailed findings

Services we looked at
Emergency and urgent care; Patient transport services; Access to the service

Contents

Detailed findings

Background to North West Ambulance Service NHS Trust

The North West Ambulance Service NHS Trust was established on 1 July 2006 by the merger of ambulance trusts from Greater Manchester, Cheshire and Merseyside, and Cumbria and Lancashire.

The trust headquarters is in Bolton, and there are four area offices serving Cheshire and Merseyside (Liverpool), Cumbria (Salkeld Hall, Carlisle), Lancashire (Broughton near Preston) and Greater Manchester (Whitefield).

The trust serves a population of seven million over 14,000 square kilometres. Services to this area are commissioned by 33 clinical commissioning groups; the lead commissioner is Blackpool Clinical Commissioning Group. The trust works with 39 NHS trusts, 46 local authorities, five police forces and five fire and rescue services.

At the time of our inspection, there were 108 ambulance stations, three emergency operations centres, one support centre, three patient transport services control centres and two Hazardous Area Response Team buildings – one shared with Merseyside fire and rescue. The trust operates around 1,000 vehicles on both emergency and non-emergency operations.

The trust receives over 1.2 million emergency calls per year, with emergency crews attending more than 952,000 incidents each year; around 800,000 of these need emergency transport. The trust undertakes over 1.1 million non-emergency patient transport journeys each year. It currently employs over 4,900 staff.

Our inspection team

Our inspection team was led by:

Chair: Mr Leslie Hamilton, Consultant Cardiac Surgeon, Newcastle Upon Tyne NHS Foundation Trust

Head of Hospital Inspections: Siobhan Jordan, Care Quality Commission.

Inspection Lead for Cheshire and Merseyside: Robert Throw, Inspection Manager, Care Quality Commission.

Inspection Lead for Cumbria and Lancashire: Damian Cooper, Inspection Manager, Care Quality Commission.

Inspection Lead for Greater Manchester: Hayley Marle, Inspection Manager, Care Quality Commission.

The team included CQC inspectors, analysts, paramedics, emergency medical technicians, doctors, nurses, midwives, mental health specialists, call centre specialists, patients and public representatives, experts by experience and senior NHS managers.

How we carried out this inspection

Cumbria and Lancashire

We visited one of the North West Ambulance Service's control centres in Broughton in Lancashire and a support centre in Carlisle in Cumbria.

We spoke with a range of staff including paramedics, emergency medical technicians, operations managers, assistant operations managers, planning assistants, sector managers, local team leaders, heads of service, call handlers and dispatch operatives.

We visited several ambulance stations. These included those in Preston, Accrington, Blackpool, Lancaster and Burnley in Lancashire, and those in Kendal, Ambleside, Penrith and Carlisle in Cumbria. We also visited the accident and emergency (A&E) and outpatients departments of several hospitals including the Royal Preston, Royal Blackburn, Chorley and South Ribble, Furness General, Westmoreland General and Cumberland Infirmary. We spoke with patients who used ambulance services at all of these hospitals.

Detailed findings

We met with support staff, local and senior managers, and crews who provided the patient transport service for Cumbria and Lancashire. We also spoke with hospital staff about the trust's patient transport service, and with patients who used the service.

At some hospitals, we visited other services. For example, at the Cumberland Infirmary, we visited the percutaneous coronary intervention centre, a delivery suite and a paediatric ward. We also spoke with the A&E paediatric lead and a clinical director about the ambulance service.

Greater Manchester

Greater Manchester is an area covered by the trust and is led by the Head of Services. The area is divided into four sectors central, south, east and west. Each sector has a sector manager with a management reporting structure and clinical reporting structure in operation. Our inspection covered the whole of Greater Manchester.

The emergency operations centre is based at Parkway. It receives all 999 calls for the area, triages and handles these calls and dispatches vehicles and crews to patients. It has an urgent care desk where Senior Paramedics perform secondary triage and offer information about alternative care services that maybe required instead of an ambulance.

The centre uses a call triaging system called the 'advanced medical priority dispatch system' (known as AMPDS), which is used by about 50% of ambulance services nationally.

During our inspection we:

- Spoke with 65 patients and families.
- Observed numerous interactions of care and treatment between patients and staff.
- Spoke with approximately 120 frontline staff – paramedics and emergency medical technicians.
- Spoke with over 25 staff in management and administrative roles.
- Observed care whilst riding on four different ambulances during the day and evening.
- Visited 17 ambulance stations, some more than once.
- Visited eight accident and emergency (A&E) departments during the day and evening and an urgent care centre.
- Spent time during the day and evening at the call centre, Parkway where staff receive 999 calls.
- Spoke with 20 call centre staff and observed how patients accessed the service.
- Spoke with over 50 hospital staff who worked with the trust on a daily basis.
- Checked over 40 vehicles including ambulances and rapid response vehicles.
- Visited the Hazardous Area Response Team (HART) and spoke with six staff.

Cheshire and Merseyside

During our inspection of the Cheshire and Merseyside area we:

- Spoke with 40 patients and families.
- Observed numerous interactions of care and treatment between patients and staff.
- Spoke with approximately 104 frontline staff – paramedics and emergency medical technicians.
- Spoke with 21 staff in management and administrative roles.
- Observed care whilst riding on six different ambulances and rapid response vehicles during the day and evening.
- Visited 15 ambulance stations, some more than once.
- Visited 13 accident and emergency (A&E) departments during the day and evening.
- Spent time during the day and evening at the Emergency Operations Centre (EOC) at Elm House Liverpool.
- Spoke with 11 call centre staff and 3 paramedics at the call centre and observed how patients accessed the service.
- Spoke with 13 hospital staff who worked with NWAS on a daily basis.
- Checked 18 vehicles including Emergency and PTS ambulances and 4 rapid response vehicles.
- Visited the Hazardous Area Response Team (HART) and spoke with six staff.
- Listened to thirty 999 calls to the Emergency Operations Centre.

Detailed findings

Facts and data about North West Ambulance Service NHS Trust

Context

- Established on 1 July 2006
- Not a foundation trust but is seeking to become one
- 108 ambulance stations
- Three emergency operations centres
- One support centre
- Three Patient Transport Services control centres
- Two Hazardous Area Response Team buildings - one co located with Merseyside fire and rescue
- Circa 1,000 vehicles
- Serves seven million people and covers 14,000 square kilometres
- Employs 4,932 staff
- Annual turnover of £261.3 million
- Surplus of £2.7 million (2012/13)

Activity (2013/14)

- 1,240,645 emergency calls received
- 728,809 emergency journeys
- 75.86% Red 1 calls responded to within 8 minutes (target = 75%)
- 77.43% Red 2 calls responded to within 8 minutes (target = 75%)
- 95.79% of all category A calls resulting in an ambulance arriving within 19 minutes against a national target of 95%

Safety

- No Never Events reported between July 2012 and March 2014
- 26 serious incidents reported between April 2013 and March 2014
- Reported to the National Reporting and Learning System between July 2012 and March 2014; 10 deaths, six incidences of severe harm and 30 incidences of moderate harm.

Effective

For national ambulance quality indicators:

- Performance much better than expected for one indicator - proportion of suspected stroke patients assessed face to face who received an appropriate care bundle
- Performance worse than expected for one indicator - proportion of calls managed without transport to A&E, where clinically appropriate
- Performance much worse than expected for proportion of calls closed with telephone advice, where clinically appropriate
- Performance for four other indicators similar to expected

Caring

For Hear and Treat Survey:

- Better than other trusts for two questions - were you told when you would be called back, for those that spoke to a second person and whether the clinical adviser that they spoke to listened to what they had to say
- Worse than other trusts for one question - when asked overall, if they had questions, did patients have the opportunity to ask them?
- Scores were similar to those for the other ambulance trusts for remaining 22 questions

Responsive

- Target for Red 1 calls met in 8 out of 12 months in 2013/14
- Target for Red 2 calls met in 11 out of 12 months in 2013/14
- Between 2011 and 2014 the trust has been below the average for resolving calls via telephone advice
- Calls managed without transport to A&E were higher in last three years compared to the national average
- Re -contact rates following discharge after telephone advice was more than double the national average in 2011/12 and 2012/13 but changed in June 2013 to be more in line with other services
- Re-contact rates following discharge at the scene were higher in the last three years compared to national average

Well-led

NHS Staff Survey – 28 questions:

- Better than average for 10 questions
- Worse than average for eight questions
- Within expectations for 10 questions

Detailed findings

- Sickness rate 1% above the national average of 5.82% between April and June 2014.

Emergency and urgent care

Information about the service

Cumbria and Lancashire

The local authorities within Cumbria and Lancashire have populations of less than the England average for under 16 and people aged 16–44, and above the England average for people aged 45–65 and older. The area's population was stated in the 2011 Census to be approximately 1.9 million people.

There are 40 ambulance stations across Cumbria and Lancashire.

Greater Manchester

Greater Manchester is an area covered by the trust and is led by the Head of Services. The area is divided into four sectors central, south, east and west. Each sector has a sector manager with a management reporting structure and clinical reporting structure in operation. Our inspection covered the whole of Greater Manchester.

Greater Manchester has a higher than average population of 16-44 years olds compared to England, especially in the Manchester LA (53.21%). This particular LA also has by the far the smallest percentages of 45-64 year olds (17.97%) and over 65s (9.45%) in the North West.

There are 32 ambulance stations across Greater Manchester.

Cheshire and Merseyside

North West Ambulance Service (the trust) responds to life-threatening conditions, predominantly using ambulances and rapid response cars staffed by paramedics and emergency medical technicians. Rapid response cars are vehicles staffed by an experienced clinician that provide an emergency response to people with potentially life-threatening conditions; they are not designed to transport patients.

During our inspection, we spent time with two paramedics who were responding to life-threatening conditions and we visited the A&E departments at Southport, Arrowe Park, Countess of Chester and Leighton hospitals. We also visited The trust emergency operations centre for Cheshire and Merseyside, the Hazardous Area Response team (HART) base and Southport, Fazakerley, Arrowe Park, Bebington, Ellesmere Port, Sandbach and Warrington ambulance stations. We spoke with 17 paramedics, 15 emergency medical technicians, two advanced paramedics, two student paramedics, six members of HART and one operations manager. All the staff we spoke with usually worked within the Cheshire and Merseyside region.

We also spoke with 10 patients who had received care and transport from the ambulance crews within the previous 24 hours, and four of their relatives. Interviews with four A&E consultants and six senior doctors working in A&E, along with seven senior nurses, also formed part of our inspection visit.

Emergency and urgent care

Summary of findings

Cumbria and Lancashire

Incident reporting was challenging for ambulance crews, but we found that incidents were being reported by staff. The service used various communication methods to feedback learning from incidents, but not all staff accessed these communications

Vulnerable people were safeguarded and systems and processes enabled staff to assess and respond to patient risk. Staff displayed compassion and kindness and provided reassurance to patients and relatives. Ambulance staff were able to respond to the individual needs of patients

National and local guidelines were available and used to support patient care and treatment. Staff had the necessary skills and knowledge to deliver care to patients of all ages, including children.

Staff had access to and made good use of clinical advice from advanced paramedics. However, a large number of ambulance staff told us that, while they could access clinical advice, there was a lack of sufficient direct clinical supervision or observation on the road to support them.

In Cumbria and Lancashire between 1 April and 19 August 2014, the service was performing below the national average for response time targets.

Hospital staff commented positively on the quality of the service provided by the ambulance trust and the information given when patients were handed over. However, hospital and ambulance staff were concerned that operations centre and not clinical staff were making the calls to emergency departments to alert them of a patients imminent arrival and their status.

The trust employed increased numbers of volunteer drivers across Cumbria and Lancashire and we found that the service used these response vehicles appropriately to respond to patient need.

A number of clinical front-line paramedics and their local managers in Cumbria were concerned about a risk to patients as they were often unable to replenish stocks of morphine readily.

Staffing levels were determined in terms of numbers and skill mix, and monitored to ensure the quality of the service provided and to minimise risk to patients.

Many of the crews we spoke with told us the organisation was good to work for and they felt supported by the service; however they thought staff morale was low.

Greater Manchester

The trust's services for people with emergency and urgent care conditions were delivered by committed, caring and compassionate staff.

Systems were used for the reporting and managing of risk, but due to the high demand on the service staff did not always have the time to report every minor incident or complete the vehicle and equipment checks needed at the start of their shifts.

Overall response times were close to the national average. The care being delivered was effective; however the service took a high number of patients to hospital when alternative services may have been more appropriate in meeting patients' needs. Staff were well-trained and competent in performing their roles. They were supported by the trust to access learning and development. The service worked in collaboration with other emergency services and providers.

There were clear management structures in place for ensuring staff were supported to carry out their duties. Clinical leadership was seen on the frontline and most staff knew who to contact if they needed to raise clinical concerns or operational issues such as annual leave. The culture of the teams differed across the sectors. Staff we spoke with were honest and committed to doing the right thing for people who accessed the service. They all recognised the increasing demand on the service and some were involved in trying to reduce this by new initiatives such as the GP referral scheme or having a liaison officer based at A&Es at peak times.

Services were planned and delivered to meet the needs of local people. Hospital ambulance liaison officers managed the access and flow of the ambulances at some hospitals during peak times to predict busy patterns and manage any potential diverts. Translation services were available for patients whose first language was not English, and ambulance staff carried

communication books that included easy-to-follow visual prompts. The trust sought feedback from patients by encouraging comments, complaints and patient engagement, and then used this information to look for ways to improve the service.

Cheshire and Merseyside

The trust services for people with life-threatening conditions were delivered by hard-working, caring and compassionate staff. People were treated with dignity and respect, and care and treatment were delivered in a way that took their wishes into account. National guidelines were used to treat patients, and pathways were in place to provide the most effective care to patients with life-threatening conditions.

There were systems in place for the reporting and managing of risk, but the way in which some minor incidents were reported was inconsistent, making it difficult to analyse trends. There was no effective system for ensuring that important safety information was given to the appropriate staff.

Front-line ambulance staff were not given sufficient time off the road during their shifts to clean emergency vehicles and access important safety-related information electronically. Some infection control and manual handling practices we observed were unsafe, and the storage of patient and staff records in ambulance stations was unsatisfactory. In some cases, the triage system used to initiate a pre-alert to A&E departments differed from the triage system within the hospitals, meaning that the hospitals were sometimes either over- or under-prepared to receive patients.

Many front-line ambulance staff felt the organisation was target driven, sometimes to the detriment of patient care, while others only felt connected with other the trust staff within their immediate geographical area and not within the trust as a whole.

Are emergency and urgent care services safe?

Cumbria and Lancashire

Due to having very little time to reflect during a shift, incident reporting was challenging for ambulance crews, but we found that incidents were being reported by staff. The service used various communication methods to feedback learning from incidents, but not all staff accessed these communications

Ambulance vehicles were clean and well maintained and staff followed infection prevention and control guidance. Vehicles were regularly given a deep clean. Staff had the equipment they needed to keep people safe, and this equipment was well maintained and ambulance vehicles were regularly serviced.

Vulnerable people were safeguarded and systems and processes enabled staff to assess and respond to patient risk.

Mandatory training had been delivered for slightly over 85% (above the trust's internal target of 80%) of staff that worked in its emergency services division in Cumbria and Lancashire.

The numbers, deployment and skill-mix of staff met the needs of patients. However, many staff raised concerns about the impact on the delivery of care and treatment of a shortage of paramedics.

Incidents

- Between April 2013 and March 2014, 26 serious incidents were reported by the trust. None of these were recorded as Never Events - serious events that are preventable.
- Since 2004, trusts had been encouraged to report all patient safety incidents to the National Reporting and Learning System (NRLS). There were 768 incidents reported by this trust to the NRLS between July 2012 and March 2014.
- Across Cumbria and Lancashire, we saw two systems in use for staff to report incidents.
- Lancashire had an electronic system available within the electronic patient clinical report Toughbook (a handheld electronic record) that some vehicles carried, and information could be captured immediately after an incident.

- However, staff in Cumbria relied on a paper system, which was effective in capturing the same details but staff told us it was time consuming. Staff who only had access to paper records said that they often waited until after their shift when they could access a computer to record details of an incident.
- Staff were aware of how to report incidents. However, they said that unless they were involved in an incident, they did not receive feedback and any lessons learned from incidents were not widely shared.
- Nonetheless, learning and changes to practice were communicated through newsletters and emails, and we saw that clinical updates and alerts were displayed on noticeboards for staff to access. Staff confirmed that they were aware of a recent alert.
- Staff gave us an example of an incident relating to harm from equipment that had not been stored securely in an ambulance. Health and safety notices relating to this were displayed in the ambulance stations to advise and update staff.

Cleanliness, infection control and hygiene

- Staff were aware of current infection prevention and control guidelines.
- They observed 'bare below the elbow' guidance and we saw them following hand hygiene procedures. We also observed ambulance staff using hand-sanitising gel.
- The service had a system that identified when a vehicle was due to have a deep clean. This was in the form of a coloured disc displayed in the window of each vehicle, including response cars. The tax-style disc contained the information of when the last deep clean had been carried out and when the next one was due.
- Staff had access to sufficient supplies of personal protective equipment, such as gloves and aprons, and wore this when delivering care. There were cleaning schedules in place for staff to complete.
- At five hospitals, we observed ambulance crews thoroughly cleaning their vehicles and equipment between patient transfers.
- Suitable arrangements were made to safely manage and dispose of clinical waste and disposable medical equipment, such as hypodermic needles.
- Infection control audits were carried out at ambulance stations and in ambulances on a monthly basis. The infection control lead carried out spot checks.
- The trust had introduced a number of improvements to ensure high standards of cleanliness, and infection prevention and control. This included a 'Mind the Gap' report, which highlighted the comparative differences between specialist audit data results and their own service delivery audit data. This data was then used to improve standards and reduce the disparity.

Environment and equipment

- We saw that the equipment available was suitable for all age groups, and the trust had specific equipment to deal with emergencies involving children.
- We looked at written records that showed systems were in place to ensure that ambulance stations and ambulance vehicles were appropriately equipped and resourced for the safety of both patients and staff. Staff knew the system for the replenishment of vehicles during operational shifts and reporting faulty equipment.
- We saw that spare vehicles were kitted out, which reduced downtime for ambulance crews, and that at larger ambulance stations there was always a spare ambulance available.
- All the equipment we looked at had portable appliance test certification. This was identified on each piece of equipment, and showed when the next safety and service test was due.
- Each ambulance had the same storage layout, with numbered cupboards and tags on certain pieces of equipment to show which had been checked and were ready to use.
- The vehicles held log books for daily, weekly and monthly checks.
- Staff told us that at times they were unable to carry out the necessary checks before they were assigned their first job when they came on duty. This had the potential for patients to be at risk if the necessary equipment was not on board.
- The trust had some concerns with regard to the environment of individual ambulance stations, and there were strategic estate plans in place to address these. Some station had co-located with local fire stations as part of this planning.
- Ambulance vehicles were serviced and maintained regularly at prescribed intervals. We saw that this maintenance was documented for each vehicle.

Emergency and urgent care

Medicines

- Staff were issued with trust clinical guidelines, and guidance for the doses of medicines to be administered to adults and children were held in 'Clear Vision' booklets that were carried by paramedic staff.
- In order to reduce the checking time for medications, the trust was trialling a 'bag and tag' system to assure staff that there was a minimum level of medications for them to access. Staff had protocols to follow to maintain a minimal level of stock drugs.
- Within Cumbria and Lancashire, the trust used a specific pharmacy that was only based within certain towns. On occasion this had caused concerns, with remote ambulance stations based on the west coast of Cumbria having to travel to the branches in larger towns (and long distances away) to replenish their drug supplies.
- An operational paramedic based in Lancashire told us that the ambulance vehicles carried a stock of controlled drugs and, because of the demand for emergency calls, it could prove difficult to get controlled drugs replenished.
- We saw that medicines were stored appropriately on ambulance vehicles and documented accordingly with a clear audit process.
- Medicines were checked daily by each ambulance crew coming on shift, and also by staff with the correct clinical skillset authorised to handle each medicine.
- We found that controlled drugs were not securely stored at two stations in Cumbria. The trust addressed this issue as soon as we informed them about the failure to meet requirements.

Records

- The ambulance service used paper and electronic hand-held clinical patient records for patient information. Some of the ambulance crews used laptops to input patient information. Operational staff completed either an electronic or a paper clinical record for each patient contact. The service across Cumbria used electronic records.
- Ambulance staff checked that the electronic documents had been transmitted when they arrived at hospitals.
- We looked at a sample of patient clinical records and found that they covered all aspects of clinical care, with clinical fields completed and clinical observations recorded appropriately.
- We saw that there was a regular audit process of the completed patient clinical records carried out by advanced paramedics.
- In A&E departments, staff made sure that the receiving staff member signed the patient record at handover.
- We saw that patient records were held securely in both the ambulances and at the ambulance stations.

Safeguarding

- Case reviews were discussed as necessary with other multidisciplinary healthcare teams to improve patient care and identify the most appropriate care pathway.
- Ambulance staff understood when a safeguarding referral should be made, and could give examples of when this had been necessary. They were aware of the process to follow to make a safeguarding referral.
- We listened to a referral being made by ambulance crew to the trust's support team in Carlisle who logged and coordinated all safeguarding alerts and referrals in Cumbria and Lancashire .
- A senior nurse on a paediatric ward told us they received invaluable information from ambulance crews about the social circumstances of children admitted directly from home. The hospital staff could then make a referral to a health visitor or other agency if necessary.
- The trust had a system whereby a call was automatically flagged if the patient had already been seen by ambulance staff within 24 hours. The clinical governance department would be alerted and the information passed to a local advanced paramedic to investigate any potential long-term care needs or learning that would be of benefit to the person concerned.

Mandatory training

- The trust gave staff five days mandatory training every two years.
- This training had been delivered by the trust for slightly over 85% (above the trust's internal target of 80%) of its staff that worked in its emergency services division in Cumbria and Lancashire.

Assessing and Responding to Patient Risk

- Within the trust, patients and staff both played an essential role in identifying risks that emerged day to day.

- Accompanying ambulance crews during shifts, we observed that risks to individuals were assessed before care and treatment. These included health risks and risks of harm to the person or others.
- There was a community first responder desk in the emergency operations centre that demonstrated appropriate coordination and monitoring of staff as to their suitability to attend specific types of incident.
- The staff used their training, skills and knowledge as well as Paramedic Pathfinder (Pathfinder allowed staff to transfer patients to the correct pathways using known clinical guidance to determine the correct treatment e.g. an out-of-hours GP service rather than A&E) to assess patients against protocols, and to administer appropriate care and treatment.

Staffing

- From observations and discussions with ambulance crews, there were sufficient numbers of appropriately trained staff with the necessary skills mix to ensure that patients were safe and received the right level of care.
- An emergency medical technician told us that they were often being sent to emergency calls that were outside their scope of expertise. However, when they called for a registered clinician to attend in support, they were often told to "get on with it" because of a lack of available staff.
- We spoke with an ambulance crew in Cumbria about staffing arrangements. They raised some concerns about a shortage of paramedics. They told us that sometimes issues arose as a result of sending out emergency medical technicians.
- They said that emergency medical technicians may not be able to deal with a patient's deteriorating condition, and it may take time for a paramedic crew to arrive. Because of the geographical area covered, it could take considerable time to get to a patient, and this delay could put them at risk.
- We looked at staff rotas and spoke with ambulance managers. During the week most shifts were covered. Weekends were a continual problem with late sickness reported, and it proved difficult for the service to cover shifts that had suddenly become available.
- We were told by staff of different grades and from various parts of the organisation that staff sickness levels and recruiting difficulties (especially in Cumbria) posed particular challenges and pressures to those managing and delivering the services locally.
- Front-line ambulance staff in Cumbria and Lancashire told us they rarely got off on time, and there was an expectation by senior managers that they would work extra shifts to cover absent colleagues or vacancies.
- We looked at copies of duty rotas, which showed the deployment of staff and the distributions of skill mix. The service covered for staff shortfalls by using bank staff and allowing existing staff to work overtime.

Anticipated resource and capacity risks

- Observing and speaking with ambulance crews, we found that in most cases the procedure was to convey patients to an A&E department.
- Although this was a fail-safe approach, it potentially had a wider impact on the local health economy's ability to safely respond, manage and care.
- Staff told us that at times an ambulance was staffed with two emergency medical technicians. This meant that a paramedic might be needed to assist in administering medication. The team was aware of this as a potential risk. However, operations centre staff were able to organise the re-deployment of some staff to ensure an appropriate skill mix within teams.
- The trust used the national resource escalation action plan. This outlined how key risks that could affect the provision of services should be managed, including major incidents, surge in demand, adverse weather and disruption to staffing levels.
- Senior managers told us that daily telephone conferences were held across geographical areas when the service faced extra demand.
- Lancashire, and particularly Cumbria, faced considerable geographical challenges with regard to capacity and the risks associated with the weather and rural locations.
- The service had a good infrastructure of community first responder schemes within Cumbria, and strong working relationships with groups such as the mountain rescue service.
- Within certain areas of Lancashire, there was a co-location scheme between the trust and the Lancashire Fire and Rescue Service.
- This was evident in Preston where ambulance service estate issues had been identified and a cost improvement programme initiative achieved by co-locating.

Emergency and urgent care

Response to emergencies and major incidents

- The trust had robust and well-practised major incident plans in place to respond to and deal with identified large-scale emergency incidents.
- We spoke with emergency planning managers at public and private locations throughout Cumbria and Lancashire. They told that us that engagement with the trust was pro-active and the relationship effective.
- In certain specific ambulance stations, there were vehicles identified as public support vehicles that carried masses of equipment to support injured people at large-scale incidents.
- The ambulances we looked at all held a 'major trauma pack' in the event of that vehicle being the first responding vehicle at a major incident. Vehicles also carried other kits in case of emergencies (for example, spill kits (to absorb chemicals and oils), triage packs (equipment to assist with trauma such as bandages and slings) and maternity packs.
- However, personal electronic dosimeters (pager-like devices to detect and measure radiological incidents) were often in vehicles without batteries and with no batteries immediately available.
- The trust had a system in place to easily identify staff trained as special operation response team members and/or chemical, biological, radiological and nuclear contamination practitioners.
- These staff wore different-coloured epaulettes and notified the emergency operations centre when booking on shift.
- Staff told us that learning from major incidents was positive and that shared learning from clinical incidents was generally via bulletins.
- The trust accessed national learning from previous national major incidents, including the London bombings in July 2005.
- Staff said they felt adequately prepared as they undertook major incident training.

Responsibilities under the Civil Contingencies Act 2004

- We spoke with operational and senior managers who explained their responsibility and the need to rehearse responding to emergencies and major incidents under the Civil Contingencies Act.
- Information was available on the trust's website, in accordance with the Civil Contingencies Act, in order to identify potential risks that might affect communities. These were listed on the community risk register (CRR).
- The CRR provided the basis for the responder agencies to develop emergency plans. The register contained the areas of potential risk to the population and infrastructure, and the nature of that risk.

Greater Manchester

Overall patients received care and treatment in clean vehicles. Medicines were handled safely. Systems were used for the reporting and managing of risk, but due to the high demand on the service staff did not always have the time to report every incident or complete the vehicle and equipment checks needed at the start of their shifts. Staff knew what to do in the event of a major incident.

Incidents

- All staff recognised the importance of reporting and learning from incidents, but they did not always find the time to report incidents during their shifts. Most staff reported that they completed incident forms in their own time because specific time during shifts was rarely allocated.
- Most staff reported serious incidents but they did not always report incidents perceived as less serious. For example, it was rare to report not completing checks on vehicles before leaving on a call to a patient; however, we saw at Central ambulance station that not completing vehicle checks was a common occurrence, and this was confirmed by staff.
- Staff knew how to report an incident using the trust's electronic reporting system. Some staff had difficulties accessing a computer, however they could complete a paper form and hand it into a manager to input on to the electronic system.
- Staff received an automated email when the report was submitted and another email when it was closed and actions known.
- Staff who had difficulties accessing a computer told us that they did not see the value in completing an incident form when they were not informed of the outcome. However, some ambulance stations had noticeboards that displayed up-to-date information on learning from incidents.

- Staff gave us an example of learning from an incident: a standardised paediatric kit list had been introduced as a result of a coroner's ruling, and the trust had issued a clinical information sheet explaining the new procedure.
- If an incident needed investigation, staff would be asked to contribute.
- Senior managers were trained in root cause analysis and carried out investigations in other sectors if required.

Cleanliness, infection control and hygiene

- Dedicated staff at different seniority levels led on infection prevention and control. Staff were aware of whom to contact if they needed advice or to raise infection control issues.
- All the vehicles we inspected, including their equipment, were found to be clean. There were kits for cleaning up spills and body fluids, and a vehicle could return to base for the interior to be cleaned if needed.
- Deep cleans were undertaken by a dedicated team on an ongoing rolling basis. All vehicles that were used for transporting patients were included in this rota. When cleaned, we saw discs were placed in the vehicles' window indicating when the last deep clean had taken place and when the next was due. Spot checks on vehicles indicated that all the vehicles had had a deep clean within the past 3 months.
- Personal protective equipment (for example, gloves and arm sleeves) was available and staff were seen to be wearing this when attending to patients. Staff were also observed washing their hands in the A&E departments we visited, and cleaning their hands with the hand gel provided for this purpose in the vehicles.
- All staff involved in clinical activity were observed adhering to the trust's 'bare below the elbow' policy.
- Ambulances were equipped with a clinical waste disposal bin and a bin for the disposal of sharps. There were dedicated locked bins for the disposal of these containers at the ambulance stations.
- Each crew was supposed to complete a daily, weekly and monthly check list that included the cleanliness of the vehicle. This information was then used to complete a monthly audit.
- At the start of each shift, policy dictated that staff had 12 minutes to complete the vehicle and equipment checks before leaving to see a patient. However, all staff reported that it was rare to get time at the start of their shifts to carry out the checks. We saw crews were called out to see patients within 1 or 2 minutes of starting their shift. Staff said they did the checks as and when during their shifts.
- The monthly audit results for cleanliness of vehicles mostly met or exceeded the target of 95%.
- We observed that the cleanliness of equipment was maintained when a vehicle was in use. Staff were seen cleaning equipment between patients when it needed cleaning.
- In one vehicle we noted a seat that had been ripped. There was evidence that this had been reported and logged in the vehicle's check book and on visual inspection it was clear that a temporary repair had been undertaken. However, we found three further damaged seats in other vehicles and the staff were not able to say if they had been reported. These maintenance issues were potential risks in terms of infection control.
- All ambulance stations we visited were visibly clean and well maintained.

Environment and equipment

- Equipment in ambulances had been standardised. Included were loading lists for each type of vehicle and for response bags to ensure that they were packed consistently.
- Stations had a dedicated restock cupboard. Items were found to be within the date for safe use.
- Assistant operation managers at ambulances were clear on their roles and responsibilities in ensuring equipment and stocks were always available and ambulance crews reported they had the equipment they needed nearly all the time. However we found three ambulance stations did not have pulse oximeter with probe suitable for children, although the stock was available to order.
- At the Hazardous Area Response Team (HART) station, the organisation of storage did not identify which items needed to be used first. New items were placed on top of others with an earlier expiry date and there were mixed batches in boxes. There was therefore a risk that items would become out of date but still be used, and, if for any reason specific stock had to be recalled from use, it would not be straightforward to identify that stock.
- Spot checks of mechanical equipment identified that items were labelled in a variety of different ways. Not all equipment had an asset number, some had labels that

indicated that the next intervention was overdue for example needed 2013/14. It was not clear to all levels of staff if these labels related to a service or electrical testing. However most ambulance stations managerial staff were aware of when equipment had last been serviced or which items were on an asset register as they were responsible for the oversight of equipment.

- The HART was in the process of compiling a dedicated electronic asset register for all its dedicated kit. There was a system for monitoring where the team's dedicated equipment was, to ensure that it was returned. However, this list was not linked to the trust-wide asset register, and staff were not aware of how to access that register.
- We saw records that confirmed that all breathing apparatus equipment used by HART was checked daily when in use and serviced at least yearly. There was a robust checking and logging system for all equipment used for working at heights.
- HART maintained a clear log of faulty equipment that was stored in a dedicated locked area to ensure that it was not used until repaired.
- The vehicles had been serviced and each had a disc in the window that indicated when the last service had been completed and when the next was due. We found one car that was overdue a service; this had already been reported and action had been taken to book the vehicle in the following week.
- There were systems to ensure vehicles were restocked with equipment when needed.
- Ambulance staff assessed the equipment in vehicles during their shift. Any faulty or broken equipment was taken to the ambulance station and replaced. In most cases faulty equipment was marked and as waiting for repair.
- Any faulty vehicles were reported centrally for repair, if a vehicle is taken off the road a substitute vehicle was sourced. Staff were empowered to take vehicles off road if necessary.
- An external contractor calibrated and serviced all equipment. A log of service dates and dates due were provided by this company. All the equipment we looked at had been tested.
- Road crews told us that there was an effective and efficient system for reporting repairs and break downs and that requests were quickly actioned.
- Equipment for vehicles such as suction units and personal protective equipment were held at ambulance stations so that staff were able to access quickly.
- At one ambulance station, we found broken equipment that had not been managed appropriately and there was a risk that it could have been used.
- There had been a recent change in the provision of children's basic life support equipment, which had been merged with the adult kit. This meant that only one bag needed to be carried to a scene. A new standardised children's kit had recently been introduced as the result of a coroner's ruling; staff had been informed of the change in a clinical information sheet.

Medicines

- Medicines were handled safely.
- Medication was carried in the ambulance in a dedicated pouch stored in a cupboard that was locked. The ambulance crew checked the medicines on a daily basis and expiry dates were checked monthly.
- We saw that only qualified staff handled controlled drugs. Controlled drugs were stored in a dedicated locked cupboard. The stock level was checked at each shift change when the keys were also handed over. If the vehicle was not in use these keys were stored in the station in a dedicated cupboard that had key pad access.
- Controlled drugs were removed from vehicles going for maintenance or repair at an external company. These medicines were placed in drug safe in an envelope that only paramedics could access. However the log book was kept with the medicines and they were not checked daily. There was no way of ascertaining how many drugs were taken if any went missing or who the last person to access the safe was. Safe lock numbers were not regularly changed or when a member of staff left the organisation.
- From discussions with staff, there did not appear to be a procedure for changing the code for access to this cupboard. This had the potential of enabling people other than employed paramedics to gain access to the medication.
- We saw staff recording the use of medication and we checked that the records were accurate in some of the vehicles we inspected.
- Some staff in the West Manchester sector were trialling a system by which medicine bags remained tagged and sealed until they were used. The aim was to speed up the checking process for crews at the beginning of their shift. If a seal was broken, that stock of medication needed replenishing.

- Some staff raised concerns that they did not have access to pain relief medication for children, who were experiencing significant pain. The issue had been raised with senior staff who were in the process of procuring appropriate medication.

Records

- Staff completed a patient report form for each patient. The forms were carbon copied: one copy remained with the patient; another was put in a secure box and collected for scanning when the vehicle returned to the ambulance station. The third copy, which did not contain any patient information, was used for audit purposes at the ambulance station.
- We checked some patient report forms with staff in A&E departments and found they were comprehensive; information recorded was concise but covered key positive findings and relevant negative findings (for example, whether a patient with chronic obstructive pulmonary disease [COPD] had nebulisers or oxygen at home, and their exercise tolerance).
- Hospital staff reported that the information recorded by the ambulance staff was detailed, clear and accurate.

Consent and Mental Capacity Act 2005 Responsive

- Staff were aware of the importance of obtaining and recording consent and we observed them doing so in difficult situations.
- Staff had attended mandatory training on the mental capacity act
- We observed staff obtaining consent and treating patients in accordance with the Mental Capacity Act.
- There was a section on the patient report form where staff recorded an assessment of mental capacity if the patient refused treatment or transport. In one case, it was the patient's wish that they should not be taken to an A&E department; the process was observed and each step completed to ensure that they had capacity to make the decision before it was agreed.
- If staff needed support managing mental capacity concerns when dealing with some patients, they raised this with the advanced paramedic on duty.

Safeguarding

- All staff we spoke with were aware of the safeguarding policies and procedures. They were available on the intranet and were up to date.
- Staff had received training in safeguarding children and vulnerable adults.
- Staff reported any child or adult safeguarding concerns to a central reporting team based in Carlisle who then liaised with the appropriate authorities within agreed timescales.
- An electronic web based application was used to share information on vulnerable patients with key stakeholders in Manchester. The system supported the transfer of referral information to external organisations in the North West and provided a secure portal for organisations to inform the service of care planning arrangements for specific patient groups.
- We observed the transportation of a patient who had been sectioned under the Mental Health Act (1983). We spoke with a senior paramedic at the scene who told us the service did not have a specialist vehicle and explained that crews transported people as safely as possible given the limitations of the vehicle. We observed the patient was transported as safely as possible within the circumstances with the support of two police officers.
- Prevent is part of the UK government's counter-terrorism strategy known as CONTEST, which aims to reduce the risk to the UK and its interests overseas from terrorism. Prevent's objectives are to stop people becoming terrorists or supporting terrorism by protecting those who are vulnerable to exploitation from those who seek to enlist people to support or commit acts of violence. Healthcare staff are well placed to recognise individuals, whether patients or staff, both adults and children, who may be vulnerable and therefore more susceptible to radicalisation by extremists or terrorists. The trust had started to roll out training for staff and was encouraging them to follow the procedure to report any concerns they might have. Information relating to this was included in the March 2014 newsletter. By the end of March 2014, 38% of staff had completed their training.
- A flagging system was used to identify aggressive patients based on their address; however, it was not clear how this was kept up to date.

Assessing and responding to patient risk

- Ambulance crew told us that, if there was a concern about their own or anyone else's safety, then they would wait for the police to attend. We witnessed this on two occasions when the police arrived to help at a scene.

- The patient report form included a pre-hospital early warning score that could be used to inform the decision-making process and the urgency of the situation, particularly for staff working in the urgent care service.
- There were clear established clinical pathways for patients who had chest pain or were presenting with a suspected stroke.
- Patients who had experienced trauma were taken to one of the Manchester collaborative major trauma centres.

Staffing

- In the Department of Health NHS Staff Survey 2013, 90% of staff who responded to the survey said they worked extra hours.
- All staff reported that the service was challenged in meeting the increasing demand. In the Central sector, we looked at the rosters for two weeks and at no time had the road crews been staffed to capacity.
- Staff worked a regular shift pattern. Some had the role of what was referred to as the 'reserve' or 'relief shift' member, and they worked flexibly to cover planned absences. It was a requirement that they were informed of their shifts four weeks in advance. Staff also worked extra overtime shifts, and their hours worked were monitored by the electronic system.
- The trust aspired to have a paramedic on every vehicle. However at the time we inspected this was not always possible due to staff shortages. A single paramedic responded in the rapid response vehicle.
- Paramedics can only perform basic life support (BLS) when they are in attendance by themselves. Only when they are accompanied are they able to perform advanced life support (ALS).
- There was an on-call system at all times so that commanders at all levels were available if needed. These included operation managers and advanced paramedics.
- HART worked in teams of six, which included a team leader. When all six team members were on duty, two would work from a rapid response vehicle. These two vehicles were supposed to be in addition to the established resource. There was a mixed view on this with team members reporting that they were clearly considered as part of the resource and that they were not always released when HART was needed.
- Team leaders reported that if they were required then pressure would be applied and they would be released. The national models requires there to be a team of six HART available 98% of the time. The HART quality audit report 2013 found that "whilst the audit team were satisfied that there is a good level of understanding across the organisation of the need to prioritise the release of HART rapid response vehicles assets in response to a full HART deployment, however the organisation may benefit from a clear and codified procedure to avoid any subjective interpretations."
- Staff sickness absence rate was consistently above the England average for ambulance trusts between April 2013 and December 2013.
- Managerial staff were clear about their responsibilities to keep in contact with staff whilst they were on sick leave and to ensure that occupational health services were involved where required. Staff reported that they had to complete a back to work interview and we met several staff who were being supported through a phased return to work program.
- Driver training was managed centrally and the trust was in the process of completing the high speed driving register. Beforehand staff undertake a three week course and an additional one day course is required for rapid response vehicles driving. Some staff we spoke to had already completed the course.

Anticipated resources and capacity risks

- The trust had a Resource Escalation Action Plan, commonly known as the REAP. During our announced inspection the trust was operating at level 3 but had escalated to level 4 at the time of the unannounced inspection. The trust had responded by having two advanced paramedic (AP's) at the call centre to assist in filtering calls.
- We were told that different models of ambulances were used to prevent the whole fleet being taken off the road because of manufacturers re-calls.
- Staff talked about a 'procedure 44', which would be implemented if there was a resource issue. It was explained that this was a four step escalation procedure to gain access to a wider resource. Concerns were expressed by the HART that while they are fourth on the list as an available recourse the steps are not consistently followed. The decision to take the HART team off standby to support routine work should only

be made by the on-call control centre manager. It was felt by HART that, if this decision is made then the GOLD level commander on call should be informed because it would mean the loss of a national resource.
- HART reported that it was not always used effectively as an available resource and that it would find out about incidents after the event, when the team could have assisted at the time. HART felt there was inconsistency in the team being deployed even though there was a prompt on the control centre system to consider its deployment. This was now being tracked using the incident-reporting system.

Response to emergencies and major incidents

- 'Major incidents' or complicated incidents were planned and practised through table top exercises. Bronze, silver and gold commands attended calls depending on the severity of the incident. For example the bronze commander could attend calls such as road traffic accidents that required other emergency services. The bronze commander would support staff in their work by liaising and co-ordinating with the senior police and fire service department. When larger major incidents were declared bronze, silver and gold commands were instigated. Staff of all levels were able to explain the role in each.
- Senior staff were required to attend major incident training.
- Between July 2013 and March 2014, 141 Band 6 staff had completed the training in Greater Manchester. This was more staff than originally planned. A major incident pocket book had been distributed. Staff carried these with them to ensure that if such an event occurred there was clear accessible guidance on the action they were required to take depending on who was the first on scene. New staff reported that were waiting for their copy. A review and update on major incidents was included in the staff mandatory training programme.

Responsibilities under the Civil Contingencies Act 2004

- Special Operations was the operational arm of Resilience within the trust. It included two HARTs, the Special Operations Response Team and the specialist decontamination and mass casualty capability.
- The trust had a HART based in Greater Manchester. This was a team of staff who were specially recruited who provide the ambulance response to major incidents. These may involve chemical, biological, radiological, nuclear (CBRN) or other hazardous materials, or incidents such as train crashes, large-scale motorway accidents, building collapses or significant fires. These incidents could be the result of an accident or caused deliberately. HART would work alongside fire and rescue services within the 'inner cordon' (or 'hot zone') of a major incident. Their job was to triage and treat casualties and to save lives in very difficult circumstances. They were also there to look after other emergency personnel who may be injured while attending such incidents.
- Exercises took place at local resilience forum level with the other responder organisations.
- A liaison officer from Greater Manchester fire and rescue service confirmed there was a good working relationship with the local HART. They also confirmed that they often held multi-agency training and that this enhanced interservice cooperation.
- HART was on standby and available seven days a week, 24 hours a day, 365 days a year.
- HART had taken part in emergency plans and rehearsals under the Civil Contingencies Act 2004 requirements.

Cheshire and Merseyside

There were systems in place for reporting and managing risk but front-line ambulance staff did not perceive these tasks as important parts of their role. The way in which some minor incidents was reported was inconsistent, making it difficult to analyse trends. There was no effective system in place for ensuring that important safety information was received by the appropriate staff.

Front-line ambulance staff were not given sufficient time off the road during their shifts to clean emergency vehicles and access important safety related information electronically. Some infection control and manual handling practices were unsafe and the storage of patient and staff records in ambulance stations was unsatisfactory. In some cases the triage system used to initiate a pre-alert to A&E departments differed from the triage system within the hospitals, meaning that the teams in hospitals were sometimes either over or under prepared to receive patients.

Incidents

- Front-line ambulance staff were aware of the organisation's electronic reporting system, but some were unclear about what should be reported as an

incident, other than episodes of violence and aggression. Staff we spoke with did not perceive the reporting of incidents as an important part of their role. Feedback from incidents was reported by staff as inconsistent unless the incident was of a serious nature, when feedback was generally good.

- Staff told us of four ways in which they reported minor incidents. These included the use of the electronic incident-reporting system, directly reporting an incident verbally to their line manager, entering the incident in the station register at their base ambulance station and, in the case of equipment failure, entering it in the record book located in each ambulance. This meant that some incidents were reported more than once in different places and some of the less serious incidents did not get reported via the incident-reporting system. This made it difficult to analyse trends and learn from minor incidents.
- There was a system in place for the dissemination of important safety information to the appropriate staff, such as Medicines and Healthcare Products Regulatory Agency (MHRA) alerts. This system relied predominantly on an email alert to staff and access to a weekly online bulletin. All front-line ambulance staff we spoke with informed us that they did not have time to access their emails each day and that checking of emails once each week was normal. This meant that important safety information could be missed, particularly if staff had returned from leave and did not have time to access their emails before commencing their shift. We spoke with 17 front-line ambulance staff with responsibility for checking equipment on ambulances. None of them knew about a potential safety issue regarding the battery life of a defibrillator commonly known as the AED. The information had been disseminated to all staff via an 'Operational Information Bulletin' dated 12 August 2014 (1 week before the inspection).
- Each ambulance station we visited displayed graphs indicating the station's response performance. This initiative was of limited benefit to staff because the information contained on the graphs was open to misinterpretation and did not give any indication of the station's performance against other stations within the area or the trust.

Cleanliness, infection control and hygiene

- Front-line ambulance staff were allocated a period of time at the beginning of each shift to check and clean their vehicles. Often, staff were dispatched to an emergency call before they had had time to clean the vehicles. Checking of medicines and equipment was prioritised by staff over cleaning.
- We observed poor infection control practice by some ambulance staff in A&E departments. This included a lack of hand washing and the changing of sheets on trolleys without cleaning the trolley between patients.
- Storage of mops in ambulance stations represented an infection control risk because the mops used to clean the floors of ambulances were stored in a rack touching those used to clean kitchens. Mops were stored correctly, with the head down, in the racks we viewed; however, the notices in all the ambulance stations we visited gave incorrect instructions to store mops with the heads uppermost.
- The trust procedure was to change mop heads once a month, unless otherwise indicated, and a log was kept in each of the ambulance stations we visited indicating that this was the case. Replacing mop heads on a monthly basis is not sufficient to maintain effective infection control.
- Mop buckets were all stored incorrectly in the upright position in every ambulance station we visited, in some cases next to a notice informing staff that they should be stored upside down.
- In one ambulance station (Ellesmere Port), we noted that the sluice area was located close to the storage racks for patient consumables and without any partitioning of the two areas. This represented a risk of contamination to these supplies.
- Although vaccination against hepatitis B was offered to all volunteer community first responders, one we spoke with had volunteered for several years and had not been vaccinated against hepatitis B, despite being at an increased risk of contracting the virus.
- Suitable arrangements for the handling, storage and disposal of clinical waste, including sharps, were in place. However, although the clinical waste bins were locked and located within a secure area, in several ambulance stations the keys were observed dangling from the bins.
- We looked at 2 rapid response cars and 18 ambulances. They were clean, but surfaces in some vehicles were dusty. The trust had cleaning schedules that required flat surfaces in vehicles to be wiped down between

patient journeys. We did not observe any front-line staff cleaning surfaces between patient journeys and, when questioned, they all told us this was never done because of time constraints between calls.
  - Hand-sanitising facilities including gel were available throughout the vehicles with some staff having small bottles in their pockets.
  - Staff wore personal protective equipment, such as gloves and aprons, while delivering care.
  - There were suitable arrangements for the handling, storage and disposal of clinical waste, including sharps.
  - Cleaning schedules were in place and displayed in manuals in the vehicles.
  - There were defined roles and responsibilities for cleaning the environment and decontaminating equipment.
  - Staff were generally following hand hygiene and 'bare below the elbow' (BBE) guidance. However, we saw five staff wearing watches while delivering care.
  - Staff told us there was a lack of uniforms and that; ideally, they needed four to five sets for a full week. However, most staff had only two sets, which meant it was sometimes hard to wash them and get them ready between shifts.
- We saw that the trust had conducted several quality impact assessments for rolling out uniforms, and a uniform working group had been set up.
- All the vehicles we observed had a sticker to denote when the next 'deep clean' was due, which was every 6weeks. A deep clean meant that a vehicle went out of service and was cleaned by a central team who also checked the stocks of consumables (single-use items such as airway tubes, syringes and bandages), and restocked when required.
- Staff told us they would go back to the base to clean the vehicles themselves when they had carried a patient who may have had an infection or if there was bodily matter that needed cleaning.

Environment and equipment

- There were plentiful supplies of personal protective equipment available. However, staff did not always use the equipment provided for tasks such as cleaning the outside of vehicles. There was therefore a risk of infection being transferred to patients via staff uniforms.
- Poor manual handling practices were observed throughout the inspection. Patients were often transferred from an ambulance trolley to a hospital trolley in A&E by being lifted on a sheet.
- Staff told us that they "manhandled" heavier patients in wheelchairs up the ramp rather than transferring them to a trolley and winching them into the ambulance, because this was less time- consuming and more dignified for the patients.
- Emergency equipment was stored in the same place in ambulances but patient consumables, such as suction tubing and vomit bowls, were not. Staff reported wasting time searching for them if they were working in an ambulance they were unfamiliar with.
- There was an effective system in place for the maintenance of medical devices. Staff reported swift and efficient replacement of faulty equipment.
- Equipment was generally available for adults and children and fit for purpose on the vehicles we inspected. Equipment was checked and serviced regularly and the vehicles were on a planned maintenance schedule. This allowed staff to make alternative arrangements in advance to minimise disruption to services.
- Staff could replenish vehicle stocks, such as consumables, at the ambulance stations, and some A&E departments had specific cupboards for the trust staff to replace higher-used supplies such as linen.
- We were told there was no system in place for A&E staff to put the equipment in a designated place for trust staff to collect as they passed by that hospital or department.
- Staff told us equipment that was faulty or needed decontamination was taken off the vehicle and left at ambulance stations to be collected. If there were no spares or replacements, they would try and get items from other vehicles not in use.
- Staff confirmed this was escalated to managers and the equipment provided, but not always promptly. One vehicle was missing equipment on 18 August 2014 and it had not been replaced 3 days later.
- All vehicles carried log books for daily, weekly and monthly checks for equipment and medication, in order of priority. We saw these were completed and checked on a monthly basis by management at ambulance stations. However, some staff told us they did not always

have time to do all the checks before they went on the road because they were so busy, but they would do any outstanding checks when they got the opportunity while out on shift.

Medicines

- Controlled drugs within the trust were managed safely.
- Supplies of controlled drugs were obtained from a chain of high-street pharmacies, which meant that supplies could not be accessed when the pharmacies were closed. We reviewed the availability of one controlled drug, morphine, by examining the controlled drug supply order books in five ambulances over several months. We found that only one vehicle had run out of morphine completely and had been re-stocked the same day.
- One front-line ambulance crew we spoke with told us they had a 40-mile round trip to the nearest designated pharmacy to collect supplies of controlled drugs, but this was unusual.
- Stocks of other drugs were kept in designated cupboards within A&E departments throughout the region. This system generally worked well.
- We reviewed six ambulance record books for two vehicles over a 4-month period between April and July 2014. We found that, with very few exceptions, the daily records of medicines checks were well completed. The monthly records, however, which provided additional checks of the way in which medicines were managed within the organisation, had been completed in only two of the six we reviewed. In one of them, a discrepancy was found and the manager had recommended closer monitoring for the next month; however, the next monthly checklist had not been completed.
- Paramedics carried "Clear vision" booklets that were issued by the trust and contained doses of medicines to be administered to adults and children.
- Staff were aware of the medicines management policy and only paramedics or their seniors administered any medications. Paramedics told us they had received the relevant training and felt competent to administer medications.
- Medicines and controlled drugs were stored in the vehicles in a safe and appropriate manner, with only the paramedics having access to the keys.
- Controlled drugs were not stored at all the stations we visited. At Northwich Ambulance station, we looked at the storage of controlled drugs for vehicles that had been sent to the main dealer for repairs.
- The assistant operations manager told us that, when vehicles went for repair, their medicines and controlled drugs were removed and stored in a key-coded safe that only management could access. The storage facilities were safe, secure and suitable. The assistant operations manager confirmed that key codes were changed every 6 months or if any violations were suspected.
- We looked at three sets of drugs from three different vehicles and saw that the actual stock corresponded with that recorded in the paperwork, and that all the drugs were within their expiry dates.
- The assistant operations manager explained that paramedics had to call the control room and request more controlled drugs, such as morphine. They were then given a reference number to collect the drugs from the nearest chain of a high-street pharmacy by showing their badge.
- Paramedics confirmed this and told us it was a secure system and the pharmacy staff would only give the drugs to the named person from the trust.

Records

- Records in Cheshire and Merseyside were in a paper format. We looked at 27 records of care and treatment provided by front-line ambulance staff and found them to be comprehensive and well completed. Staff we spoke with in A&E departments confirmed this. The records were in three parts, with the middle and bottom copies being a carbon copy of the original top copy. The top and middle copies were clear and legible, but many of the bottom copies were unreadable.
- Storage of records in one ambulance station we visited (Bebington) was poor. Patient records were stored in locked post boxes fixed to filing cabinets and were so overfilled that the inspection team could access the records through the posting slot. One post box was not fixed and could have been carried away. Ten patient records were observed in staff pigeon holes in the hallway.
- Confidential waste, including confidential patient information, was found in an open bag in an unlocked office and staff appraisal records were stored in an unlocked filing cabinet in an unlocked office.

- Patient records were kept securely in the ambulances and at the stations we inspected. Staff transferred the patient transfer forms to secure locked filing cabinets split between the different teams to allow for traceability and audit purposes.
- However, storage of records in one ambulance station we visited (Bebington) was poor. Patient records were stored in locked post boxes fixed to filing cabinets and were so overfilled that the inspection team could access the records through the posting slot. One post box was not fixed and could have been carried away. Ten patient records were observed in staff pigeon holes in the hallway.
- We reviewed 10 patient records. We were able to follow and track patient care and treatment easily. Observations were well recorded when undertaken, and details such as the patient's history and agreed pathway were completed.
- We observed that the trust ambulance staff explained the information on the form to the staff at the hospital during the patient handover. The A&E nurses at all the hospitals we visited confirmed that this was very useful and helped them to better understand the patient's needs.
- We did not see any 'do not attempt cardio-pulmonary resuscitation **(DNA CPR)** forms because these did not apply to the patients being conveyed. All the staff we spoke with were aware of the purple standardised DNA CPR forms and would only not resuscitate when they had seen the appropriate documentation.

Safeguarding

- All front-line ambulance staff we spoke with had received safeguarding training and were aware of their individual responsibilities regarding the safeguarding of both children and vulnerable adults.
- Staff were aware of how to make a referral if they had any safeguarding concerns and described to us how the current system of referral to the centralised the trust safeguarding team worked well.
- The safeguarding work plan 2014/15 included a specific action for improving safeguarding processes in the Cheshire and Merseyside areas. This was to develop a network of 'Safeguarding champions'. Some of the actions in the work plan had been implemented and the outstanding actions were due for completion by December 2014.

Assessing and Responding to Patient Risk

- Paramedic Pathfinder was the system used by the trust to enable front-line ambulance staff to conduct a face-to-face assessment when they arrived at a scene and to determine the most appropriate care pathway for the individual patient. Use of the Pathfinder was restricted to staff grades of emergency medical technician 2 and above. The Pathfinder is designed to distinguish between patients who can be managed in the urgent care setting and those who need urgent transfer to an A&E department.
- The Pre-Hospital Early Warning (PHEW) score was used by front-line ambulance staff alongside the Pathfinder to identify those patients whose condition was deteriorating. They did this by undertaking a serious of patient observations, including blood pressure, heart rate and respiratory rate, and generating an indicative score based on those observations. The score determined whether a patient needed an urgent transfer to an A&E department.
- Staff we spoke with were very familiar with the pathways and the PHEW score and used them on a daily basis. Some staff felt that by following the pathways they were transferring some patients to hospital unnecessarily and that they should be able to use their clinical judgement. An example given was that all children under the age of 5 years had to be transferred, regardless of their clinical condition.
- Advice and support were available at all times to front-line ambulance staff from more senior paramedics with additional training. We observed this system in progress and it appeared to work well. However, advanced paramedics who provided this service told us that, if they were not in the operations centre at the time of the request, it was more difficult to provide advice and support because they did not have access to electronic guidelines and information.
- We spoke with four A&E consultants in three A&E departments about the pre-alert system used by the trust. A pre-alert is the system in place to convey details of a patient's condition to the receiving hospital to ensure that staff had all the appropriate equipment and personnel assembled and prepared. All the consultants expressed concern about the pre-alert system, which was not based on the same triage system as their own. This sometimes initiated unnecessary pre-alerts to their department that the patient's condition did not warrant

and therefore wasted their resources. Alternatively, they did not receive a pre-alert when they considered the patient's condition warranted one. We reviewed records for three patients whose condition was serious enough to warrant a pre-alert, but the hospital had not received one.

- Staff in A&E departments also expressed frustration that pre-alerts were given by ambulance control because this did not enable them to check details of a patient's condition with the ambulance crew treating them.
- We observed comprehensive, concise and effective handovers taking place between ambulance crews and staff in A&E departments.

Staffing

- Staffing levels had been established on historic demand. However, the trust had experienced a significant increase in demand during this year, with an increase in activity in Cheshire and Merseyside of 19.3% since the end of June 2014. All staff we spoke with felt the service provided to those with emergency life-threatening conditions was understaffed. The impact on staff was that they were frequently dispatched to emergency calls within a few minutes of starting their shifts, leaving little if any time for essential checks and cleaning of equipment and vehicles. They were also dispatched to emergency calls less than 5 minutes before the end of their shift, which meant they worked overtime to complete the call.
- Records we reviewed indicated that only 39% of staff responding to calls from people who may have a life-threatening condition had received an appraisal during the past year. The trust target for completed appraisals was 85%.
- We spoke to 17 front-line ambulance staff, across all grades, about the appraisal process and received mixed views. Six found it a highly personalised and valuable process and 11 described it using terms such as "a tick-box exercise" and "going through the motions".
- The ambulance service was aware of, and had made provision for, forthcoming changes in driving regulations under section 19 of the Road Traffic Act 1988. These required that anyone driving using blue lights and claiming an exemption from the speed limit, when justified, must be on a national high speed register. To become registered, the driver must have attended an approved high speed driving course and be reassessed every 5 years. Staff were aware of the change in regulations. None of the staff we spoke with had received their driving assessments at the time of our inspection.
- The dispatch team was aware of the skill mix within teams and worked effectively with the managers across Cheshire and Merseyside in the redeployment of staff to ensure that the best available skill mix within teams was dispatched to each emergency call.
- Staff rotas were prepared by the team leaders at 4-weekly intervals and the service was able to cover for staff shortfalls by using bank staff and allowing existing staff to work extra hours.
- Staff were confident that the right number of staff was employed for urgent care calls; however, they felt at times that they would benefit from increasing the number of paramedics by training the emergency medical technicians. This was because the emergency medical technicians could not work alone (for example, in the first responder vehicles) or administer medications. This meant that only the paramedics could access the drugs and this might cause delays when out in the field.
- Although it was rare, if an ambulance was staffed with two emergency medical technicians only, they would call another vehicle with a paramedic to assist in administering medication. The dispatch team were aware of this issue and sometimes it was necessary for them to organise the redeployment of some staff to ensure an appropriate skill mix within teams.

Anticipated resource and capacity risks

- The trust had resourcing escalatory action plans (REAPs) in place to manage demand. The REAP level changed in response to changes in demand, such as adverse weather conditions or when hospitals within the region were on divert.
- There was a central resource unit to manage shortfalls in staffing. It was only staffed during office hours, with the management team managing any staffing shortfalls that occurred out of hours. This meant there was a risk that the skill mix was inappropriate in some areas, such as the rapid response car and ambulance all being staffed by personnel unable to administer controlled drugs. The dispatch team was aware of this issue and sometimes it was necessary for them to organise the redeployment of some staff to ensure an appropriate skill mix within teams.

- The REAP level changed in response to changes in demand, such as adverse weather conditions or when hospitals within the region were on divert.
- When capacity issues relating to staffing and vehicle availability were identified, the control room staff were able to make alternative arrangements, such as using the rapid response car to assess the situation before an ambulance was sent.

Response to emergencies and major incidents

- The trust had a resilience business plan in place that was reviewed regularly.
- There were major incident plans that were updated regularly. We saw copies of these plans in ambulance stations we visited. Training exercises and table-top exercises had taken place as required, so that front-line ambulance staff were prepared to deal with a major incident anywhere within the Cheshire and Merseyside area.
- Operational staff were issued with a pocket, major incident 'aide memoire', which included a set of action cards and other useful information for incident management. This had recently been updated in advance of a new version to be issued early in 2015.
- We visited HART and reviewed its systems, processes and training, which were comprehensive and up to date.
- All staff we spoke to were aware of the plans and described the action they would take appropriately. They told us they could access the plan via the intranet.
- All the vehicles we looked at contained major trauma packs in the event of being the first responding vehicle at any major incident. Vehicles also carried spill kits (to absorb chemicals and oils), triage packs (equipment to assist with trauma, such as bandages and slings) and maternity packs in case of emergencies.
- Staff were aware of the Joint Emergency Services Interoperability Programme **(**JESIP**),** which was a two-year programme that aimed to improve the ways in which police, fire and ambulance services worked together at major and complex incidents to bring their combined expertise to the situation.
- Staff could also explain and show the steps in the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidance booklets the paramedics carried.
- Not all the staff had attended major incident rehearsals but they had received training about major incidents and were aware of business contingency plans.
- The service report dated 9 June 2014 showed that only 121 (38%) of 349 operations staff had received this training, while 22 tactical staff (53%) of the required 44 staff had attended training on JESIP.

Responsibilities under the Civil Contingencies Act 2004

- The trust is a Category 1 responder under the Civil Contingencies Act 2004. This requires the undertaking of risk assessments and emergency planning, in cooperation with other agencies, on high-risk locations throughout Cheshire and Merseyside. The trust had undertaken the appropriate risk assessments and had emergency plans in place, as required in the legislation.
- The CRR dated from 2010 and provided the basis for the responder agencies to develop emergency plans. The register outlined the areas of potential risk to the population and infrastructure, and the nature of that risk.
- The REAP gave the trust a structured set of considerations and arrangements to assist in business continuity management.

Are emergency and urgent care services effective?

(for example, treatment is effective)

Cumbria and Lancashire

We accompanied ambulance paramedics to observe how patients were being assessed, cared for and treated. Our observations and discussions with the paramedics showed that national and local guidelines were available and used to support patient care and treatment. Staff had the necessary skills and knowledge to deliver care to patients of all ages, including children.

Staff had access to and made good use of clinical advice from advanced paramedics. However, large number of ambulance staff told us that, while they could access clinical advice, there was a lack of sufficient direct clinical supervision or observation on the road to support them.

In Cumbria and Lancashire between 1 April and 19 August 2014, the service was performing below the national average for response time targets.

Emergency and urgent care

Hospital staff commented positively on the quality of the service provided by the ambulance trust and the information given when patients were handed over.

Evidence-based care and treatment

Mental health teams at district general hospitals told us that the service demonstrated an understanding of the requirements around the transportation of patients detained under the Mental Health Act 2005 and, in particular, the requirements of Section 136. Ambulance staff showed an appropriate level of knowledge to support this.

Clinical staff were issued with the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines, and these were also available at the ambulance stations that we visited.

The trust had also issued its own guidance to help staff, and we observed that staff referred to this and relied on it in preference to the JRCALC guidelines.

Ambulance crews used the Paramedic Pathfinder tool to inform the appropriate care and treatment pathway for each patient.

In Cumbria and Lancashire, we accompanied a number of front-line ambulance paramedics to observe how patients were being assessed, cared for and treated. Our observations and discussions with the paramedics showed that and local guidelines were available and used to support patients.

Assessment and planning of care

Staff used the Paramedic Pathfinder as part of the assessment process. They assessed patients at the point of contact, and recorded any identified risks at this stage. Records we looked at showed a detailed history was taken, including any known allergies and prescribed medications.

Staff had access to and made good use of clinical advice from both the specialist and advanced paramedics which meant they had support to manage the deteriorating patient.

There was a clear pathway for staff to follow when making clinical decisions, whether this is transporting a patient to the most appropriate care centre or providing a 'see and treat' service.

Records showed the relevant pathway had been followed and any treatment administered by the ambulance crews was evident. There was therefore a clear process for auditing purposes. The pathfinder ensured the needs of patients were considered and responded to.

Staff told us that at times following the documentation did not always lead to the best outcome. For example, if a patient had dementia, Paramedic Pathfinder would lead them to A&E, which might not always be the best option. We were told this was currently under review.

Response times

Staff told us that response times were good in towns and urban areas because they travelled shorter distances when conveying patients. However, in the rural areas, meeting response time targets was more challenging.

Examples of strategies in place to manage this included first response schemes, automated external defibrillators in GP surgeries and rapid response vehicles being moved to remote areas.

The ambulance crews logged in to A&E when they arrived and when they were leaving. This enabled both response and waiting times to be monitored.

We observed staff using the checking-in systems at A&E departments when they brought patients in.

Patients we spoke with told us the ambulances arrived rapidly after their calls and they were satisfied with the service they had received.

NHS England collect data on key performance indicators for all 10 ambulance service providers:

Category A (Red 1) incidents, which relate to presenting conditions that may be immediately life threatening. The national target is for attendance at 75% of all incidents within 8 minutes. In Cumbria and Lancashire between 1 April and 19 August 2014 the service has responded within 8 minutes 71.08% of the time. The England average for the year 2013/14 was 75.6%.

Category A (Red 2) incidents, which relate to conditions that may be life threatening but are less time critical. Again, the national target was for attendance at 75% of all incidents within 8 minutes. In Cumbria and Lancashire between 1 April and 19 August 2014 the service has responded within 8 minutes 71.12% of the time. The England average for the year 2013/14 was 74.8%.

Emergency and urgent care

Category A (Red 1 and Red 2) incidents, which relate to the requirement that a vehicle capable of transporting the patient should arrive at the scene of the incident within 19 minutes. The national target is 95%. In Cumbria and Lancashire between 1 April and 19 August 2014 the service met this target 92.46% of the time. The England average for the year 2013/14 was 96.1%.

In January 2014, the data showed that out of the 10 trusts, North West Ambulance Service ranked fourth on Red 1 response times, third on Red 2 response times and fifth on the 19-minute target, and the data equated to an average wait for an ambulance of 13 minutes and 51 seconds.

Care delivery

We saw that staff had the necessary skills and knowledge to deliver care to patients of all ages, including children.

Clinical staff who had the qualifications to prescribe and administer medication did so following national guidance and legislation.

All medication before administration was explained to the patient who made an informed decision as to whether to take the medication offered.

Ambulance staff used national tools to assess pain, including in children and vulnerable adults. They followed guidelines as appropriate.

Paramedics used specific guidance when administering pain relief including charts to guide them according to the height and weight of children.

At ambulance stations, several staff reported they would feel more confident in dealing with maternity patients if they had more training, particularly around childbirth.

We observed staff conveying a patient to an A&E department. The patient had learning difficulties, which had an impact on their mental capacity and communication with the crew. The patient was accompanied by a carer who told us how they felt listened to. They were pleased with how the patient was treated, communicated with and involved in their care.

Patient outcomes

There are 10 ambulance trusts in England. When measured against NHS England ambulance quality indicators, the trust performed:

Fourth best for the return of spontaneous circulation at the time of arrival at hospital and fifth best for cardiac survival on discharge;

Fourth best for the direct transfer of patients suffering a certain type of heart attack - ST segment elevation myocardial infarction - to a centre capable of delivering the most appropriate treatment;

Best out of all 10 trusts for indicators which measured the transport of patients suspected of having a stroke, to a stroke centre and for stroke patients receiving appropriate care bundles. A care bundle is a group of interventions related to a condition that when delivered together result in better outcomes than when implemented in isolation; and

Worst for calls managed without transport to A&E.

Competent staff

Three ambulance staff told us they had recently attended a high speed training course, the 'blue light driver training'. New legislation specified that anyone driving using blue lights, who was claiming an exemption from the speed limit, when justified, must be on a national high speed register.

The trust had a procedure for checking the registration of clinical staff. This ensured that all clinical staff (temporary, permanent and voluntary) continued to be registered with the appropriate professional body.

The trust provided induction, mandatory training and professional development training to enable staff to maintain and develop the necessary skills to assess, care for and treat patients.

We spoke with many ambulance crews, their immediate local managers, senior managers, and support staff in Cumbria and Lancashire. They confirmed that training was provided. However, a number of staff said that training was difficult to access at times because of increasing operational demands and having to cover for absent colleagues or unfilled vacancies.

A large number of ambulance staff told us that, while they could access clinical advice, there was a lack of sufficient direct clinical supervision or observation on the road to support them.

Although the training needs analysis for mandatory training includes refresher training on obstetrics and gynaecology,

on a two year cycle and this has been delivered in the current programme, several ambulance staff told us they felt they did not always receive the training they needed, particularly around childbirth.

Accessibility to training varied within each area. In Carlisle, there were two places a month allocated for a week's midwifery course, 'Practical obstetric multi-professional training'. We spoke with a staff member who had attended this and found it invaluable. However, they had to attend in their own time. .

We spoke with three recently recruited members of staff who told us they had received a detailed induction to the service; they felt well supported and confident to ask for any support and advice they needed.

A student nurse on a placement told us they felt they had received a thorough induction. This had included an explanation about roles and expectations, the vehicle, the crew, equipment available, stocks and supplies, and medicines.

We spoke with staff who told us they completed continuous professional development where they recorded their learning, subscribed to the Journal of Paramedic Services, carried out online modules and found the emails they received regarding clinical updates "informative and valuable" as ways of maintaining their professional registration.

Additional training support was provided in some areas. We spoke with a senior paediatric A&E lead who had provided training to local ambulance staff on paediatric resuscitation, trauma and child protection.

Working with other providers

Staff told us they worked well with partner agencies including the police and fire service.

Three police officers we spoke with, who escorted ambulance crews to A&E departments said they felt the local emergency services worked well together.

Discussions with managerial staff revealed that there were regular formal contacts and meetings with other providers, including clinical commissioning groups, hospital trusts and local authorities.

From observations we saw that trust staff worked effectively with external organisations, such as the A&E departments we visited. We saw several handovers where information relevant to the patient, including any special notes, was explained in detail.

The trust employed, as extra staff, hospital ambulance liaison officers (HALOs) who triaged patients in A&E to support the throughput of patients. HALOs addressed capacity issues in A&E and helped in transporting patients out as necessary.

We visited several hospitals in Cumbria and Lancashire where patients had been taken after transfer requests.

Hospital staff commented positively on the quality of the service provided by the ambulance trust and the information given when patients were handed over. Patients commented positively on their satisfaction with the transfer process.

We observed ambulance staff giving detailed and timely handovers to other providers, such as A&E and ward staff.

We visited a percutaneous coronary intervention centre, where patients were treated for obstructed coronary arteries. We spoke with the senior nurse at the unit who said that handovers from paramedics were appropriate when patients were brought to them in an emergency.

Greater Manchester

Overall response times were close to the national average. The care being delivered was effective, however the service took a high number of patients to hospital when alternative services may have been more appropriate in meeting patients' needs. Staff were well-trained and competent in performing their roles. They were supported by the trust to access learning and development. The service worked in collaboration with other emergency services and providers.

Evidence-based care and treatment

NICE Clinical guidelines were followed.

Clinical Performance Indicators (CPI) was used to ensure that evidenced based care and treatment were being practiced. At A&E departments we saw CPIs for specific clinical conditions. These covered specific clinical conditions: hypoglycaemia, trauma care, stroke care, cardiac chest pain, paediatric patients, patient report completion, patient pathways and asthma. These conditions were mapped to patient report forms. Situations where the crew may deviate from CPIs (termed

'exceptions') were clearly described. We observed that the crew recorded exceptions and shared those exceptions at handover with A&E staff. As an example, with one patient, the crew did not give aspirin to a patient with suspected cardiac chest pain as the patient had previously experienced an asthmatic attack with aspirin.

The Joint Royal Colleges Ambulance Liaison Committee (JRCALC) develops and reviews national clinical practice guidelines for NHS paramedics. Paramedic Staff had been provided with a hand book on JRCALC guidelines dated 2013.

Staff were kept up to date through regular bulletins. These were distributed electronically, however not all staff had regular access to their works emails, as some were only able to access them at a station. To ensure that staff had access bulletins were printed off and made available to staff to read. We saw these displayed at some station on noticeboards.

Patients detained under Section 136 of the Mental Health Act 1983 were transported in line with appropriate codes of practice or professional guidance.

We observed staff working collaboratively, putting the patient first with hospital staff and the police. We saw that all staff prioritised patients' safety and treated them with dignity and respect.

There were clear lines of responsibility for transfer and retrieval teams. The service provided transport with specialist staff being made available by receiving organisations, such as St Mary's Hospital, Manchester, that would provide care for neonatal transfers.

Assessment and planning of care

The trust performed well below the England average in managing patients without the need for transport to an A&E department. It managed 25.2% of such patients during the year to March 2014 against an England average of 35%. It had the lowest figure of all ambulance trusts, with the others ranging from 29.2% to 51%.

We observed that staff undertook very thorough patient assessments, and monitored patient's wellbeing throughout their journey to hospital.

A&E staff told us that assessments of patients carried out by ambulance staff were thorough and gave them the information they needed.

The clinical practice for adults and children who were critically ill or injured were followed and A&E staff were alerted prior to arrival to ensure that staff were assembled and available to deliver care.

Response times

NHS England collected data on three key performance indicators for England's ambulance services in 2013/14. These were:

Category A (Red 1) incidents, which related to presenting conditions that may be immediately life threatening. The national target was for attendance at 75% of all incidents within 8 minutes. Between 1 April and 19 August 2014, Greater Manchester averaged meeting this target 72.64%.

Category A (Red 2) incidents, which related to conditions that may be life threatening, but were less time critical. The national target was for attendance at 75% of all incidents within 8 minutes. Between 1 April and 19 August 2014, Greater Manchester averaged meeting this target 74.06%.

Trusts are supposed to get an ambulance to 95% of the most urgent cases within 19 minutes as part of government targets. Between 1 April and 19 August 2014, Greater Manchester averaged meeting this target 96.85%.

Care delivery

We observed many positive occurrences of care and treatment being delivered.

Patients and their families told us they were happy with the care that had been delivered. They reported that their pain had been managed and quickly addressed.

We checked over 10 patient report forms which had been completed in detail and clearly documented the patient's details, their medical history, presenting symptoms, vital signs and any treatment that had been administered by the ambulance staff. This ensured that the hospital staff had the information they needed to take over the person's care.

Patient outcomes

There are 10 ambulance trusts in England. When measured against seven NHS England ambulance quality indicators, The trust performed much better than expected on one (stroke patients who had received appropriate care bundles), similar on four, and worse and much worse on two (calls closed with telephone advice (worse) and calls managed without transport to A&E (much worse).

Emergency and urgent care

The trust performed fourth best for the return of spontaneous circulation at the time of arrival at hospital and fifth best for cardiac survival on discharge.

The trust performed fourth best for the direct transfer of patients suffering a certain type of heart attack (ST segment elevation myocardial infarction [STEMI]) to a centre capable of delivering the most appropriate treatment.

The trust performed best of all the ambulance trusts for transport of patients, suspected of having a stroke, to a stroke centre, and for stroke patients receiving appropriate care bundles. A care bundle is a group of interventions related to a condition that when delivered together result in better outcomes than when implemented individually.

Competent staff

Driver ability was assessed regularly. New laws are coming into effect with regards to 'blue Light' training and the trust was ahead of target in staff completing the driver training.

There were mixed views from staff, depending on their role and length of service in the role, on the support and training they had received. They highlighted that newer employees were trained to a higher educational level than existing employees.

Student paramedics described the training as excellent and effective in equipping them to fulfil their role once in post. We saw many out in ambulances receiving on-the-job training with crews.

Between September 2012 and July 2014, 78.28% of paramedic emergency service staff had completed their mandatory training. Mandatory training included 16 modules such as infection control, safeguarding, Mental Capacity Act, conflict resolution, trauma and driving standards.

Most Assistant operation managers had completed Chartered Management Institute training.

Additional online training was available. However, staff reported that this was difficult to access during work time because you needed to be at an ambulance station to access a computer. We saw staff off duty at ambulance stations completing their e-learning.

Emergency Medical Technicians 1 had completed basic training to undertake their role. Until recently, there had been little support for them to further their career. However, a trial was taking place to offer a course that would enable them to raise their level of education in order to gain access to further courses. Most Emergency Medical Technicians 1 we spoke with felt there was a lack of career progression opportunities available.

Staff who drove a vehicle had attended driver training at least once. Some reported that they had not been required to undertake refresher training.

Senior paramedics had a clinical skill responsibility for a team of front-line staff. To assist them in this role, they had three non-clinical days a month. Teams could be as large as 30 people.

There was an intention that a senior paramedic would accompany other ambulance staff on calls to observe practice on a yearly basis. In reality, this varied.

All paramedic staff were aware of their responsibility to maintain their registration and that a yearly review of their performance was required.

Key Skill Framework reviews and appraisals were conducted.

Patient report forms were also reviewed and used to inform performance and appraisal reviews.

Advanced paramedics were accessible and able to give support to staff. Staff were positive about this as a resource and said they could seek advice over the phone; in some cases the advanced paramedics would attend.

HART had a strict roster that included dedicated training time in order for team members to maintain the specific set of competencies required for their role. Attendance was monitored through an electronic system, as were appraisals

Some staff expressed concerns that they had not received the training they needed to manage obstetric emergencies. Mandatory training included an obstetric update but staff felt their training did not cover how to deal with an emergency. The paramedic training now included time in a maternity unit and some staff had taken the opportunity to spend time with a local midwife in a local maternity unit.

Staff reported the trauma pathway training as "excellent"

There was protected time for mandatory training and staff were rostered to complete it.

Volunteer community first responders received a comprehensive six month package of training, mandatory

training included oxygen therapy, dementia awareness and infection control, diabetes and patient communication and confidentiality. Additional e-learning was available for all community first responders to their professional development.

Coordination with other emergency services

There were hospital ambulance liaison officers at each location to manage turnaround time for ambulances at busy times. They liaised with A&E staff and the bed management teams to speed up admissions and decrease the amount of time ambulances and staff were held at hospitals.

Hospital staff had never witnessed any poor or concerning practice by ambulance staff. However on occasion they felt crews brought in patients unnecessarily, especially from care and nursing homes.

We observed several handovers between ambulance crews and hospital staff. All ambulance staff gave good information about patients' history, including results of observations undertaken and treatment given.

Hospital staff at all the hospitals we visited spoke positively about the professional behaviour of the ambulance staff. They reported the handover of patients and the information they were given were detailed and ensured that they could continue to care for the patient.

Police staff commented on the reliability, professionalism and calmness of the ambulance staff in reassuring a patient in a crisis.

Cheshire and Merseyside

National guidelines were used to treat patients and pathways were in place to provide the most effective care to patients with life-threatening conditions. Performance standards were monitored and outcomes were mixed when compared with other ambulance trusts, with the trust performing better than other ambulance trusts in some areas and worse in others.

Evidence-based care and treatment

- Operations managers and paramedics told us they provided care in line with the National Institute for Health and Care Excellence (NICE) clinical guidelines whenever possible, and the pathways outlined in the patient transfer form followed relevant professional guidance such as The Mental Capacity Act 2005. Our review of records showed that staff had completed the appropriate pathways for the patients they had conveyed.
- Clinical information bulletins were released via the trust intranet, when appropriate, in order to provide updates to clinical practice. Details of these were also given in the weekly general staff bulletins. Dissemination of this information to front-line ambulance staff relied on their having the opportunity to access the trust intranet and read the information posted there. This proved challenging for all the staff we spoke with because of constant deployment to emergency calls throughout the whole of their shift.
- Standards from the Royal College of Psychiatrists (July 2011) recommend that transport of patients detained under Section 136 of the Mental Health Act 1983 "should be prioritised by the ambulance service, even where the clinical situation does not represent an emergency, so as to reduce the distress and embarrassment to the patient. For Section 136 cases the standard ambulance service response is proposed as up to 30 minutes." Senior medical and nursing staff in all the A&E departments we visited expressed concern at the response times for transport of these patients and reported waiting times of up to 5 hours.
- Paramedics referred to the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) booklets, which provided clinical specialty advice to ambulance services. JRCALC had been a focus for clinical matters of ambulance relevance from a wide variety of sources. It worked closely alongside the directors of clinical care of all UK ambulance services, local Ambulance Paramedic Steering Committees, the British Paramedic Association and other interested groups. Staff also carried 'Clear vision' booklets distributed by the trust; these were part of the medicines management policy and contained information about administering drugs to adults and children.
- Clinical performance indicators are available for the 11 ambulance trusts in England and are linked to care bundles (a group of interventions related to a condition that, when delivered together, result in better outcomes than when implemented individually).
- Trust data from May 2013 to April 2014 for Cheshire and Merseyside showed that, out of eight care bundles, the area had only achieved the target for meeting the pain management care bundle by 0.6%, and had failed to

meet the asthma, trauma care below the knee and paediatric care (febrile convulsion) bundles by 8.1%, 12.9% and 18.1%, respectively. Cheshire and Merseyside had only marginally missed the targets for the remaining four care bundles.

Assessment and planning of care

- The trust has teams of community first responders throughout Cheshire and Merseyside. They are volunteers trained in the treatment and control of a wide range of potentially life-threatening conditions. They provide support to the trust by attending 999 calls in and around their communities. We spoke with two first responders during our inspection who spoke enthusiastically about the training and support they received, as volunteers, from the trust. One volunteered their availability for approximately 100 hours each week and the other for approximately 50–60 hours each week. They described a programme of continuing professional development, regular team meetings and team leader meetings attended by a member of the trust management team. They described the trust as being "like one big family".
- In Cheshire, first responder cars were used, usually staffed by an assistant operations manager and senior paramedics, to attend a patient before an ambulance to assess whether an ambulance was needed. This worked well in rural areas because it reduced ambulance call-outs if 'see and treat' was more appropriate. This was when less serious calls could receive face-to-face advice or be referred to other healthcare providers, such as a GP or walk-in centre. The A&E department was not always the right place for all patients so, by offering face-to-face advice, this procedure reduced the number of ambulance journeys, which in turn freed up vehicles to attend people with more serious life-threatening conditions.
- Staff used their training, skills and knowledge as well as Paramedic Pathfinder to assess patients against protocols and administer appropriate care and treatment. (Pathfinder allowed staff to transfer patients to the correct pathways using known clinical guidance to determine the correct treatment (for example, an out-of-hours GP service rather than conveying a patient to A&E).
- We saw one paramedic who had used Pathfinder to arrange GP visits to two patients. This meant they received the most appropriate care and did not have to be conveyed to an A&E department. However, the paramedic told us that a problem was that the GP out-of-hours service was limited to some areas and not always available at weekends.
- Staff told us they always gave children the care that was most appropriate to them and that in Merseyside they would try and convey children to Alder Hey Hospital, which is a specialist children's hospital.

Response times

- NHS England collected data on three key performance indicators for England's ambulance services in 2013/14. These were:
- Category A (Red 1) incidents, which related to presenting conditions that may be immediately life threatening. The national target was for attendance at 75% of all incidents within 8 minutes. The trust achieved this target 8 months out of 12 in 2013/14 and achieved an overall performance for the year of 75.9%, compared with an England average performance of 75.6%.
- Cheshire and Merseyside response times were as follows (with trust target in brackets): Emergency response times within 8 minutes (R1) 73.4 % (75%); within 19 minutes (R2) 73.8% (75%); and patient conveyance time within target 96% (95%).

Care delivery

- Staff we spoke with were confident and knowledgeable about the administration of pain relief.
- Patients we spoke with reported pain as being well controlled by ambulance staff. Staff in A&E departments confirmed this.
- Paramedics followed specific guidance on the administration of pain relief.
- Vehicles were equipped with items for adults and children. Staff told us infants and babies would be held on the lap of their parent or guardian, who would be strapped in.

Patient outcomes

- There are 10 ambulance trusts in England (with separate ambulance management arrangements on the Isle of Wight). When measured against seven NHS England ambulance quality indicators, the trust performed much better than expected on one (stroke patients who had

received appropriate care bundles), similar on four, and worse and much worse on two (calls closed with telephone advice (worse) and calls managed without transport to A&E (much worse).
- The trust performed fourth best for the return of spontaneous circulation at the time of arrival at hospital and fifth best for cardiac survival on discharge.
- The trust performed fourth best for the direct transfer of patients suffering a certain type of heart attack (ST segment elevation myocardial infarction [STEMI]) to a centre capable of delivering the most appropriate treatment.
- The trust performed best of all the ambulance trusts for transport of patients, suspected of having a stroke, to a stroke centre, and for stroke patients receiving appropriate care bundles. A care bundle is a group of interventions related to a condition that when delivered together result in better outcomes than when implemented individually.

Competent staff

- Staff satisfaction with training and development opportunities was dependent on their roles within the trust. A new scheme to support emergency medical technicians to undertake diploma-level study was seen as a positive move by emergency medical technicians, although they expressed concern regarding the limited number of training places available. They were also concerned that there was no guarantee of a job as a paramedic within the trust once they had gained the diploma.
- Paramedics who qualified without the diploma did not feel supported to undertake diploma-level study.
- Paramedics who had already gained the diploma generally felt well supported to achieve further qualifications.
- We spoke with several front-line ambulance staff who were either being supported or had been supported by the trust to achieve further academic qualifications.
- One of the duties of front-line ambulance staff was to wash the outside of their vehicles. The skills and experience of these highly trained people could have been better used.
- Induction, training and the programme of continuing professional development for community first responders was reported to be of a high standard.
- Newly appointed staff underwent an induction process and worked a number of shifts, during which time they were supernumerary and their competency was assessed before they worked unsupervised.
- Staff had the skills to deliver care to patients of all ages. They felt competent when dealing with and treating patients because they considered their induction and training had been effective. This was particularly the case for the graduate paramedics, most of whom had undertaken training and study at universities and had gained paramedic degrees.
- Staff told us they were given support for mandatory training. However**,** there was uncertainty among those we spoke to as to whether staff received this every 2 years or yearly. Most staff undertook mandatory training in 1 week every year via the trust headquarters. There had been a recent change from 1 year to 2 years, hence a reduction in compliance.
- There were also differences between trained staff, such as paramedics and emergency medical technicians. The paramedics had a structured programme, while the emergency medical technicians felt they were not always given the support to progress to become paramedics and missed out on training opportunities because they were overworked. Some emergency medical technicians, who had been employed for 5 years, had been told they would be trained to become paramedics but had not been given this opportunity.
- Staff told us there was no time to look at policies and procedures during working hours because they spent a lot of time attending calls and very little time at the ambulance stations**.**
- One paramedic told us teams could arrange specific training. An example of this was training about epilepsy that was planned at the Crewe Ambulance Station.

Working with other providers

- The trust worked with partners, such as St John's Ambulance, to respond to emergency and urgent calls, as well as to provide cover for special events.
- There was a range of specialist clinical networks in Cheshire and Merseyside, such as those for critical care, cardiac and stroke, and cancer. Each of these networks had links with The trust that resulted in projects such as piloting rapid discharge for end of life patients in the Southport area in 2009 and an interhospital transfers meeting in 2011.

- A January 2014 peer review of the major trauma centre (MTC) in North Staffordshire highlighted that staff reported "poor engagement from the North West Ambulance Service" despite their "working hard to improve a collaborative structure."
- Trust managers said that their staff repatriated "a lot" of patients into and from East Midlands. They said that hospital staff in Staffordshire were not always aware of the services offered at the two local hospitals in East Cheshire. This sometimes resulted in requests for a second transfer to the right hospital, such as from Cheshire to Manchester.
- Some senior staff complained that the trust did not challenge inappropriate referrals from HCPs as often as necessary.
- One paramedic shared examples of two calls where the local police and fire services did not share relevant information in advance. This resulted in ambulance staff attending calls where they were not needed or were not safe.
- Staff said that police in different local authorities had different protocols for working with ambulance services, particularly about how to manage patients who were declared dead on arrival. This caused some confusion because staff worked across multiple areas on occasion. They believed these differences were due to the areas having different coroners.
- One staff member said they were challenged by other providers, but felt "backed up" by the trust.
- The trust's Making Experiences Count team reviewed and managed concerns raised by HCPs about the trust staff. We observed trust staff engaging with other providers in a positive way. For example, a paramedic shared information with the dispatcher who alerted a local hospital regarding the needs of an incoming patient. This transfer of information was managed carefully, to ensure it was accurate and the patient safe. Feedback about pre-alerts varied among ambulance and hospital staff and seemed to depend on local agreements.
- We also observed a paramedic serving as an intermediary, requesting information from dispatch on behalf of the police. This request did not relate to clinical care or treatment and meant that the paramedic was delayed in becoming available for the next call. The EOC staff confirmed that there was no system to ensure that requests from the police for information did not disrupt the trust's responsiveness.

Are emergency and urgent care services caring?

Cumbria and Lancashire

We observed many examples of where ambulance staff demonstrated an awareness of patient need and provided the appropriate caring response to meet that need. Staff displayed compassion and kindness and provided reassurance to patients and relatives.

We received overwhelmingly positive feedback from patients about the care they received.

Staff were able to communicate effectively and had tools to aid communication to make sure patients understood and were involved in their care and treatment. We observed staff explaining what was going to happen next to patients.

Staff provided emotional support for patients and in doing so, they showed that they cared about people's emotional wellbeing.

Compassionate care

- We observed positive interactions with patients; reassurance was caring and empathetic.
- We observed staff conveying a patient to an A&E department. The patient was covered with a blanket to maintain their dignity and we observed that one crew member remained with them, giving verbal reassurance while the other undertook a confidential handover.
- We observed one-to-one care while patients were in the vehicle. One example included a patient who had sustained a leg injury being transferred from the ambulance to the A&E department and the awaiting triage nurse. The patient was reassured constantly by ambulance staff.
- A student nurse on a placement with the ambulance crew told us, "I have witnessed really good empathy and communication skills from ambulance staff."
- We observed staff who were sensitive to a patient's mental health needs and supported them appropriately.
- Many A&E staff told us that they felt that ambulance crews cared well for patients and their relatives.

Emergency and urgent care

Patient understanding and involvement

- Treatment was explained before it was administered and, whenever possible, it was administered with the patient's consent. Patients had proposed treatment options explained to them that took into consideration their cultural needs.
- We observed a paramedic talking to a patient who needed reassurance about how they were going to be transferred from the trolley to an A&E trolley. They listened attentively and repeated the information sympathetically so that the patient understood. The patient's next of kin needed further reassurance, which was given in a kind and sympathetic manner.
- We observed positive interactions between staff, patients and their relatives when staff were performing handovers in the areas we inspected.
- We discussed communication with people whose first language was not English. Staff told us they had the use of multilingual phrase books and visual communication aids. We were given an example of when staff had used a large-print questionnaire to establish a person's pain score.

Emotional support

- It was evident that all the ambulance staff we observed and spoke with were dedicated to providing the best care possible.
- The trust had a policy and protocol in place to support patients who died in their care, their family members and its own staff.
- Information was available for staff to pass on to family members about what happens next when someone dies.
- Staff gave examples of when they had supported grieving relatives and how they had taken into account the family's needs at these times.
- A member of staff gave us an example of how they had recently stayed with a relative in a distressing situation until the police arrived. They said this would be usual practice. During the inspection, we observed staff giving emotional support to patients, offering reassurance and comfort as necessary.

Greater Manchester

We saw and heard of numerous examples of patients being cared for with compassion and kindness. Staff were reassuring and provided patients, families and other members of the public who maybe bystanders with emotional support and information. All patients felt involved in the treatment, and the majority of the 65 patients we spoke with were positive about the caring nature of staff.

Compassionate care

We observed many interactions of staff treating patients with compassion. One example was a distressed older female who had driven to A&E, because she had been told by a GP to go there immediately. She was confused and couldn't find a parking space. A paramedic gave her detailed directions about parking but the woman was too upset to understand. The paramedic escorted her to the A&E reception, parked the car himself and paid for the parking.

Patients and family members described ambulance staff positively, for example they were "very caring", "helpful" and "reassuring". They described the service offered as "absolutely marvellous" and "very fast."

We observed care, treatment and support provided by ambulance staff in people's homes, in ambulances and at hospitals. In all cases patients were treated with patience, dignity and respect even in challenging situations. For example when one member of the ambulance staff carried out an ECG which meant exposing a female's chest, the other members of the crew were asked to stand behind the patient to maintain their dignity.

Ambulance doors were always closed during any examinations in the vehicle.

We heard ambulance staff explaining any course of action to patients.

We saw ambulance staff treating challenging patients in a professional and kind way.

Patient understanding and involvement

Patients told us they were involved in their care and treatment.

Staff took the time to explain what they were doing and to ensure that patients understood what they were planning to do before there was any intervention.

While observing in ambulances, we saw staff discussing with patients the next steps to take and whether or not to take them to the A&E department. In each case, staff took the time to explain their reasoning and involved the patient

in the final decision. When one person declined to go to the A&E department, this was respected. The correct procedure was followed, including an assessment of their capacity to make the decision.

Emotional Support

We saw, and patients and relatives told us, that staff provided them with emotional care and support.

Patients near the end of their life were treated with dignity and respect. We saw relatives being supported, kept informed and looked after.

Cheshire and Merseyside

Patient care at the trust was delivered by hard-working, caring and compassionate staff. We observed that staff treated people of all ages, and their families and carers, with dignity and respect. Care was delivered in a way that took their wishes into account. Emotional support was provided by front-line ambulance staff and was also available for them following a difficult call.

Compassionate care

- All the patients and relatives we spoke to said that they felt well cared for and that they thought the staff were kind and caring. We saw many examples of this during our visit.
- We observed ambulance crews preserving the dignity of patients at all times, particularly when they were transferred on and off trolleys and in and out of emergency vehicles.
- All the patients, relatives and representatives we spoke with were positive about the care and treatment provided.
- Patients told us, “The staff were very prompt to arrive” and “They were excellent, it couldn’t have been better”, and a relative told us, “The staff have treated my partner very well and the care has been good throughout the journey to A&E.”
- An elderly patient with a head injury and his wife were very complimentary and told us, “The ambulance arrived in less than 5 minutes” and that they “couldn’t praise the effectiveness and pleasant manner of the crew enough”.
- Staff in A&E told us, “Ambulance crews are always friendly and helpful. They will assist when needed.”
- Staff told us they made provisions for a patient’s privacy and dignity when they arrived on the scene by making ample space around the patient and using blankets to shield any who were receiving treatment. One paramedic told us that some places, such as shops and cinemas, would often clear the area around the patient of any members of the public before the ambulance arrived, which ensured further privacy.
- During the inspection, we saw that patients were treated with dignity, compassion and empathy. We observed staff providing care in a respectful manner and, when required, staying with anxious or worried patients until nursing staff took over their care.
- A patient experience survey undertaken by the trust for 2013/14 indicated that 97.1% of patients felt they had been cared for with dignity, compassion and respect by ambulance staff providing emergency care and treatment; 36% of the respondents were from Cheshire and Merseyside.

Patient understanding and involvement

- The patient experience survey undertaken by the trust for 2013/14 indicated that 97.8% of ambulance staff providing emergency care communicated in a way that was clear and easily understood.
- The survey found that 86.5% of ambulance staff agreed that the patient was involved in decisions about their care and treatment options. Patients and relatives we spoke with throughout Cheshire and Merseyside confirmed this.
- We observed positive interactions between staff, patients and their relatives when seeking verbal consent. The patients we spoke with confirmed that their consent had been sought before care and treatment were delivered.
- We observed a paramedic speak to a patient with dementia in a caring and understanding manner. The paramedic knew and had recorded the history of the patient, and handed over verbally to the A&E staff to ensure that they were aware of the patient’s condition.
- The patient handover forms we reviewed contained appropriate signatures, and when the patient was under 16 we saw appropriate signatures from their parents or guardians.
- On admission to the A&E departments, we saw the trust staff work with the hospital staff to make sure that all the information about the patient was handed over, thereby ensuring continuity of care.

- The patient transfer form had a section that was completed and handed to the patient or their representative if they were not conveyed or if they refused to be conveyed. Patients were asked to sign to say they agreed with the advice given.
- The patients we spoke with told us the ambulance staff explained information to them clearly.
- We observed positive interactions between staff, patients and their relatives when staff were performing handovers in the A&E areas we inspected.

Emotional support

- We observed that ambulance crews supported patients and their relatives well throughout their contact with the service and particularly during handover to the A&E department.
- Emotional support was provided to front-line ambulance staff, should they need it, via their immediate line manager and the counselling service commissioned by the trust Staff were aware of how to access this service. One staff member told us how well they had been supported by their line manager and how this enhanced level of support had enabled them to return to work earlier than originally planned.
- Staff could also request a break after attendance at a particularly distressing call. This did not happen often, but staff told us that the dispatch team respected and complied with such requests.

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

Cumbria and Lancashire

The trust employed increased numbers of volunteer drivers across Cumbria and Lancashire and we found that the service used these response vehicles appropriately to respond to patient need.

Ambulance staff were able to respond to the individual needs of patients, including the needs of patients with dementia and bariatric patients. Staff assessed mental capacity and obtained consent before treating patients

Paramedics used to phone through to the A&E department to alert staff about the patient. This communication is now made by call handlers through the emergency operations centre. There are criteria for alerts, and concerns were raised by ambulance staff that operations centre (non-clinical) staff were alerting for instances outside of the criteria. Hospital staff told us that the quality of information they received had been downgraded since non-clinical staff made the alert.

Service planning and delivery to meet the needs of local people

- In September 2013, the trust introduced a team of specialist paramedics to support frequent callers to the trust's operations centres. This team worked with patients, when they gave consent, on an individual basis.
- The purpose of the team was to support, enable and signpost these patients to access health and social care services to address their needs. The team liaised closely with local providers, as well as their own safeguarding team, to respond to the needs of these patients.
- This team also worked with local providers of health and social care, such as nursing homes, to support their residents to access the appropriate care.
- The trust employed increased numbers of volunteer drivers across Cumbria and Lancashire. This is a particularly important service in these areas where there are rural communities spread over large areas, and we found that the service used these response vehicles appropriately to respond to patient need.
- We spoke with staff who had to access the more remote areas and might be called upon to drive long distances in response to calls. They told us that the service used rapid response vehicles to attend Red calls in remote areas.
- Staff within the trust had received training in providing care to patients with dementia and learning disabilities. Staff told us that this training had helped them to provide appropriate care for this patient group.
- We observed positive interactions of an ambulance crew in supporting a patient with dementia in a caring and understanding manner. The paramedic included a detailed explanation of the social circumstances of the patient, which was important for the A&E staff.
- The trust had a policy for the management of supporting bariatric patients - bariatric is the branch of medicine that deals with the causes, prevention and treatment of obesity. When staff attended a call from a bariatric patient, they would be able to request extra staff and appropriate vehicles and equipment to support the moving and handling of the patient.

Emergency and urgent care

Access and flow

- We spoke with a paramedic working on a rapid response vehicle who told us that there were often instances when "response cars were being unable to clear because there are no ambulances to attend." This meant that response cars couldn't leave the scene to attend elsewhere as ambulance support wasn't available to take over.
- A&E staff and paramedics mentioned 'pre-alerting' as a cause for concern. The paramedics used to phone through to the A&E department to alert staff about the patient. This communication is now made by call handlers through the emergency operations centre. There are criteria for alerts, and concerns were raised by ambulance staff that operations centre (non-clinical) staff were alerting for instances outside of the criteria.
- Some A&E staff raised concerns that the quality of the information received from ambulance control was questionable. They said there had been a downgrading of information, which meant there was the potential for patients not to receive the level of care appropriate to their need.
- We noted two incidents where trust procedure and pathways guidance directed the patient to an A&E department, when the crew felt this was neither appropriate nor necessary.

Consent & Mental Capacity Act

- The documentation of mental capacity within the trust's written patient clinical record was appropriate.
- From a review of a sample of records and our observations, we considered that staff undertook appropriate mental capacity assessments and that patients were asked for their consent to treatment appropriately.
- Staff assessed mental capacity and obtained consent before treating patients. We saw that patients were involved in decisions about their care and treatment. Ambulance staff told us how they would involve partner services (the police, for example), if a patient showed challenging behaviour or refused assistance.
- The trust had taken steps to agree local protocols with other emergency services in Cumbria and Lancashire. These partner agreements to support patients were coordinated and collaborative.
- Operational front-line staff were able to phone an advanced paramedic if they had concerns about specific mental capacity issues and needed support.

Learning from complaints and concerns

- The trust had a 'Making Experiences Count' team to support people with complaints, provide further advice and a response as needed.
- Meetings were regularly held between the complainant and the trust's complaints team known as the making experiences count team.
- There was a section on how to complain on the trust's website. The trust had also produced a 'Making experiences count' leaflet.
- Mandatory training included customer services training. Staff told us they would direct people to the trust's website if they were asked about making a complaint.
- The trust looked at trends with regard to complaints. These were analysed and an action plan produced to address the concerns. Key complaints were reported in the annual quality report under the 'Lessons learned' section.

Greater Manchester

Services were planned and delivered to meet the needs of local people. Hospital ambulance liaison officers managed the access and flow of the ambulances at some hospitals during peak times to predict busy patterns and manage any potential diverts. Translation services were available for patients whose first language was not English, and ambulance staff carried communication books that included easy-to-follow visual prompts. The trust sought feedback from patients by encouraging comments, complaints and patient engagement, and then used this information to look for ways to improve the service.

Service planning and delivery to meet the needs of people

When a 999 call is made, it is triaged and assigned a category, which determines the response that is made. The response times for the two red categories, Red 1 response in eight minutes for a patient who has suffered cardiac arrest or stopped breathing and Red 2 response in eight minutes for all other life threatening emergencies are the national standards.

Staff understood the needs of treating patients with dementia. However most had not received any specific training.

Emergency and urgent care

We observed many interactions with patient who had a mental illness and were in crisis. Staff put their safety first and worked with others to ensure the best possible outcome for the patient.

There were two dedicated vehicles for transporting of bariatric patients. If the vehicles were not available, extra support from staff, equipment and other stakeholders was used.

This had recently been re-equipped with a dedicated stretcher and staff had received training in the use of these. The general ambulances were also able to accommodate larger people, but different pieces of equipment had different weight limits and it was not clear what the agreed upper limit for these vehicles should be.

The HART supported the road crews when it was necessary to move a heavier patients and a more detailed assessment or risk assessment on how to manage the patient might be required.

Access and flow

Once a patient had been identified as an emergency or urgent patient a rapid response vehicles or ambulance was sent to them. Their presenting symptoms determined how quickly they would be seen.

At ambulance stations managers have access to live electronic boards so they knew where their staff were, where the demand was and how many patients were waiting for an ambulance.

Performance data was available for managers to monitor trends of the demand on the service.

Between 4 November 2013 and 30 March 2014 at the University Hospital of South Manchester NHS Foundation Trust 1,666 ambulance delayed handovers over 30 minutes were reported. We discussed these with hospital staff and observed the improvements that had been made to reduce delayed handover times. A three bedded ambulance bay had been set up with two dedicated triage nurses to work with ambulance staff. Ambulance staff reported that they felt like it had reduced the handover times but they were not aware of any data to support this.

Learning from complaints and concerns

Complaints were looked into by the 'Making Experiences Count' team. All complaints were graded according to their seriousness. Senior staff responsible for the location or staff complained about were involved in any investigation. Outcomes and learning were shared with the individual concerned.

We saw outcomes displayed at some ambulance stations. Some examples of lessons learned we noted included staff reminders and bulletins about application of spinal immobilisation, differential diagnosis for hyperventilation, the importance of completing an appropriate patient assessments, and completion of detailed and accurate patient report forms.

There was no information on how to make a complaint in the vehicles used to transport patients, and none in the A&E or hospital departments visited.

Staff reported that some members of the public visited the ambulance stations if they had a complaint.

We spoke with over 65 patients. They were clear that they did not want to complain but, if they needed to, they would find out how.

Information on how to make a complaint was on the trust's website. The website also included information on how to find an advocate if needed.

At ambulance stations, we saw many 'thank you' cards and letters praising staff for their help.

Cheshire and Merseyside

There were initiatives regarding engagement with the public and effective action taken regarding frequent callers. The number of emergency calls audited each month was too low to assure the management team that the trust was providing a consistently effective service to those who contacted them in an emergency.

All patients were treated equally with paramedics conducting assessments for those with impairments. Services were planned and delivered to meet the needs of local people. Ambulance liaison officers managed the access and flow of the ambulances at hospitals during peak times to predict busy patterns and manage any potential diverts. Translation services were available for patients whose first language was not English, and ambulance staff also had access to communication books that included easy-to-follow visual prompts. The trust sought feedback from patients by encouraging comments, complaints and patient engagement, and then used this information to look for ways to improve the service. However, staff did not have any written information to give patients who wished to make a complaint.

Emergency and urgent care

Service planning and delivery to meet the needs of local people

- The trust had a policy and procedures in place for addressing the issue of frequent callers, while ensuring that their safety and welfare were safeguarded.
- Front-line ambulance staff were able to access appropriate vehicles and equipment to support the moving and handling of bariatric patients, when necessary.
- Staff told us they treated all patients equally regardless of any impairment. Paramedics told us that, if necessary, they conducted assessments and completed checklists for patients with mental health issues, dementia and or learning difficulties. There was a specific section in the patient record form to prompt this.
- The trust had a policy and procedures in place for addressing frequent attenders; staff were aware of these people in their areas and told us the most common reason for patients attending frequently was alcohol or drug use.
- Staff told us they would treat and assess each incident individually to ensure that patient safety and welfare were safeguarded. One paramedic, who had conveyed an elderly man who had fallen, explained that he repeatedly fell and injured himself, but ambulance staff always made sure his injuries were appropriately checked each time.
- The organisation had a policy for the management of bariatric patients (bariatric is the branch of medicine that deals with the causes, prevention and treatment of obesity). When staff attended a call involving a bariatric patient, they could request extra staff and appropriate vehicles and equipment to support the moving and handling of bariatric patients.
- The trust performed well below the England average in managing patients without the need for transport to an A&E department. It managed 25.2% of such patients during the year to March 2014 against an England average of 35%. It had the lowest figure of all ambulance trusts, with the others ranging from 29.2% to 51%.

Access and flow

- the trust had a higher percentage of calls abandoned before being answered than most other ambulance trusts in England. the trust was ranked ninth worst in the year to March 2014, with an average of 2% of calls abandoned, compared with an England average of 1.2%.
- Emergency calls to the trust were audited for quality purposes. We found that the audit team could only review, on average, two calls a month for staff who worked full time. This was too small a number to provide an assurance that these emergency calls were being managed in the most appropriate way.
- Ambulance liaison officers had been employed to manage the access and flow of the ambulances at the hospitals during peak times. They worked with the hospital staff in A&E to ensure patient handovers were efficient. When hospitals were reaching full capacity, they also attended hospital bed management meetings to find where the pressures were in the Cheshire and Merseyside area. This helped to predict busy patterns and manage any diverts to other appropriate A&E departments.

Staff told us they were not always able to meet the target for journey times in the more rural areas because of the nature of the roads and the location of the A&E departments or other services.

Consent & Mental Capacity Act

- A policy was in place that outlined how staff should obtain consent from patients and the trust's safeguarding policy also referenced the Mental Capacity Act 2005.
- Staff received mandatory training in mental health awareness and understood how to obtain consent appropriately and correctly. The staff we spoke with understood the legal requirements of the Mental Capacity Act 2005. They were skilled in explaining the benefits, side effects and complications of proposed treatments and procedures to patients.
- Staff told us that they were comfortable and competent in seeking consent from patients.
- We saw examples of patients being conveyed by ambulance who did not have the capacity to consent to treatment. However, in all cases they were accompanied by a family member and appropriate consent was obtained from them and noted on the patient transfer forms. We also saw that the trust staff had recorded this in the 'notes' section.

- The patient transfer form had an assessment section in accordance with the Mental Capacity Act 2005. We saw that this was completed for all patients when it was required in accordance with the policy.
- Although staff were confident about completing this, they had some concerns that the judgement needed clinical and ethical input, and they would benefit from more training in this area.
- We observed verbal consent being requested and recorded appropriately by front-line ambulance staff.
- All staff we spoke with had received training in the Mental Capacity Act 2005 and could describe how it related to their work. Immediate advice and support were available from more senior staff at all hours if front-line ambulance staff felt this was necessary.

Learning from complaints and concerns

- None of the front-line ambulance staff we spoke with had any information about how to make a complaint that they could give to patients or relatives. They told us they would advise people to contact the Cheshire and Merseyside EOC, or The trust Patient Advice and Liaison Service (PALS). Staff were not familiar with the contact details and did not always have paper on which to write them down.
- Trends relating to complaints were analysed and an action plan produced to address the key issues; this was reported in the annual Quality Report. However, there was no information about how the action plan from the previous year had been monitored and whether any improvements had been achieved as a result of the actions taken.
- Staff told us they felt the trust culture was not to encourage complaints, and the general consensus was to try and discourage people from making complaints.
- On one occasion, a paramedic told us they were over 4 hours late for a call and the patient was upset. The paramedic told us they calmed the patient down and persuaded them not to make a complaint.
- Complaints were recorded on a centralised trust-wide system. There was a centralised team that managed complaints.

Are emergency and urgent care services well-led?

Cumbria and Lancashire

The trust's vision, "we aim to deliver a high quality service to patients by ensuring we deliver the right care, at the right time and in the right place", was visible throughout the stations we inspected.

A number of clinical front-line paramedics and their local managers in Cumbria were concerned about a risk to patients as they were often unable to replenish stocks of morphine readily. Pocket formulary books said that Codeine Linctus could be given to children under 12 years of age, but this has been stopped as a clinical practice and had been referred to in several incident report forms.

A model of clinical leadership was evident and distributed, but many paramedics told us that they did not receive regular clinical supervision.

Staffing levels were determined in terms of numbers and skill mix, and monitored to ensure the quality of the service provided and to minimise risk to patients.

We were told by staff of different grades and from various parts of the organisation that staff sickness levels and recruiting difficulties posed particular challenges and pressures to those managing and delivering services locally.

Recent starters confirmed they had had a year of preceptorship in which they were supported by a mentor to gain confidence in the role and learn necessary skills for their new profession. Many of the crews we spoke with told us the organisation was good to work for and they felt supported by the service; however they thought staff morale was low.

Vision and strategy for this service

- We spoke with a wide range of front-line ambulance crews, their immediate local managers, and senior managers in Cumbria and Lancashire. They demonstrated awareness and understanding of the vision and values of the trust. They were also aware of and understood the strategies employed that sought to

deliver high-quality care and promote good outcomes for people. Some felt they were engaged with the strategy, vision and values of the service, but others felt less engaged.
- The trust's vision, "we aim to deliver a high quality service to patients by ensuring we deliver the right care, at the right time and in the right place", was visible throughout the stations we inspected.
- The trust's core objectives were focused on patient safety, clinical effectiveness and patient-centred care.
- We observed these displayed on noticeboards in ambulance stations we visited. There was also a weekly regional bulletin.

Governance, risk management and quality measurement

- We observed different working practices in Lancashire and Cumbria.
- Clinical staff in Cumbria showed that they used their clinical skills more often than their colleagues in the urban areas.
- Some staff working on rapid response vehicles told us that they often did not see a manager for weeks at a time.
- A number of clinical front-line paramedics and their local managers in Cumbria raised issues about the management of morphine. We were told that, to obtain supplies of morphine, staff had to go to a branch of a specified pharmacy chain. However, the geographical distances in Cumbria made obtaining supplies difficult at times.
- We were told by paramedics and local managers that these issues had been raised with senior managers of the trust but had not as yet been resolved.
- We looked at the guidelines and the pocket formulary books that were being used by operational crews. These said that Codeine Linctus could be given to children under 12 years of age. This has been stopped as a clinical practice and was referred to in several incident report forms we saw on medicines management.
- We heard and saw that some paramedics were concerned that Paramedic Pathfinder guidance sometimes conflicted with the patient's best interests.
- The trust's safeguarding lead had developed an online training module to meet the specific needs of its staff, but the trust was unable to monitor or evaluate how many people completed this training.

Leadership of service

- Staff we spoke with were able to identify and tell us about different leads, their roles and responsibilities.
- A model of clinical leadership was evident and distributed, but many paramedics told us that they did not receive regular clinical supervision.
- Paramedics said that they only received clinical supervision when a mistake had been made and it had been identified in an audit.
- One senior paramedic referred to themselves as an 'audit monkey', and said that they were not giving staff regular clinical supervision.
- Other senior paramedics said the job was not what they had thought it was going to be, in that it was audit driven and not about providing clinical supervision.
- Any concerns would be shared to establish whether there was a theme emerging across the service or if they were issues to be managed at local level.
- We were told by staff of different grades and from various parts of the organisation that staff sickness levels (in both Lancashire and Cumbria) and recruiting difficulties (especially in Cumbria) posed particular challenges and pressures to those managing and delivering services locally.
- Front-line ambulance staff told us they rarely got off on time and there was an expectation by senior managers that they would work extra shifts to cover absent colleagues or vacancies.

Culture within the service

- Six emergency medical technicians told us they felt there was no educational development pathway for them to train to become paramedics.
- There was evidence of little support for the personal development of Level 1 emergency medical technicians.
- New staff told us they felt well supported by senior, experienced staff.
- Three recent starters confirmed they had had a year of preceptorship in which they were supported by a mentor to gain confidence in the role and learn necessary skills for their new profession.
- Many of the crews we spoke with told us the organisation was good to work for and they felt supported by the service; however they thought staff morale was low.

- Staff told us they felt morale was low because of the extra hours they worked. They said they regularly worked beyond their finishing time because of the nature of the job.
- One ambulance crew member articulated the impact of this, telling us "you can never make personal or family plans because you will no doubt let them down due to the hours we have to work and the additional hours we work at short notice."
- Staff told us there was provision for access to a counselling service and they felt support was available from senior staff.
- There was a critical incident debriefing service available to staff if needed.
- The ambulance teams worked well together, and respected and valued each other.

Public engagement

- The service was using a variety of methods to engage with patients and the public.
- The trust's website contained detailed information about the services provided and actively encourage people to submit their views and feedback.
- A community strategy has also been developed to widen public engagement and identify ways to improve the quality of the services provided. An example of how the trust worked with local communities in 2012/13 included 300 members of the public attending an open day to hear about the service and its future plans.
- There was public consultation on a variety of trust policies, including the community strategy, communication and engagement, and equality and diversity.
- The trust engaged the public through social media and had more than 9,000 Twitter followers.
- The trust worked with other healthcare providers and a community group in Millom, in Cumbria, to coordinate a collaborative response to meet the healthcare needs of the people living in this community.

Greater Manchester

There were clear management structures in place for ensuring staff were supported to carry out their duties. Clinical leadership was seen on the frontline and most staff knew who to get contact if they needed to raise clinical concerns or operational issues such as annual leave. The culture of the teams differed across the sectors. Staff we spoke with were honest and committed to doing the right thing for people who accessed the service. They all recognised the increasing demand on the service and some were involved in trying to reduce this by new initiatives such as the GP referral scheme or having a liaison officer based at A&Es at peak times.

Vision and strategy for this service

- Staff freely quoted the trusts vision - Delivering the right care, at the right time in the right place.

Governance, risk management and quality measurement

- Performance was monitored and reported at station level and at sector level at the clinical quality improvement forum.
- The quality of the service was monitored by auditing of clinical pathways through the clinical performance indicators. The information was displayed.
- We were told there was no risk registers held at a local level to identify issues or concerns relating to their location. However operational managers monitored their risks through incident reporting and real-time data about demands on the service.
- The HART had its own risk registers that related to their role, dedicated station and equipment.
- Senior paramedics assessed ambulance crew's performance through the audits on the completed patient report forms as well as regularly accompanying paramedics on shift.
- We observed senior paramedics assessing staff during their shift. However this did not ensure that every member of staff went through a paper audit because they may not have attended a patient with a condition being audited, such as diabetes or asthma.

Leadership of service

- There were clear and separate management and clinical leadership structures in place.
- The management structure of operations managers and assistant operations managers ensured that paramedics' time was freed up to focus on clinical activity.
- Crews reported to assistant operations manager and a senior paramedic at a local level. Assistant operations manager were responsible for the day-to-day running of

the station and for ensuring crews had the equipment available to do their job. The senior paramedic was responsible for clinical matters such as advice, audits, and observing practice.
- The frontline staff knew which assistant operations manager and senior paramedic they reported to. Most staff reported that they felt supported at a local level.
- Most staff were aware of who their line manager was. Because of shift patterns staff did not always see their line manager but they knew there were managers on shift at the larger stations if they needed them.
- Visibility of managers varied across the area. Some staff at the smaller ambulance stations said they rarely saw them but could speak to them on the phone if necessary.
- Senior staff held 'hot debriefs' for staff immediately after a serious or difficult incident. This enabled staff to discuss their thoughts and feelings, and any outcomes that worked well or could have worked better.

Culture within the service

- Staff were passionate, calm and reassuring at all times. Staffs demeanour and relationships with patients were kind and friendly.
- Many staff groups had worked together for a number of years and socialised together.
- Staff were very aware of the targets they were meant to meet. They reported the workload intensity had risen, which meant they were working harder and longer hours; on occasions they felt the situation was unsafe because their health and wellbeing were not being considered.
- Staff were dedicated and regularly worked longer than contracted hours because of late finishes at locations out of their local area.
- Most staff we spoke with felt the organisation was too big and geographical areas were working in isolation and not sharing good practice and ideas. For example Central sector had a closed Facebook page to enhance communication. Some staff in the other sectors were not aware of this but thought it would be a good idea.
- Staff were encouraged to not tolerate colleagues' poor practice and there was a procedure for staff to report this. They were able to give us examples of when they had used this to report concerns.

Public engagement

- There were many examples of the service engaging with the public.
- There was a team at the call centre who attended events such as PRIDE, a local mosque's open day and universities.
- '#Team 999' is an education programme which has been in operation for over a year. It has produced 'You Tube' videos to educate the public in the work they do.
- The trust had have a FaceBook page https://www.facebook.com/nwasofficial
- The area had many public events such as those involving sport and music. Staff provided a service at these events as overtime, and used them to educate the public on different healthcare options.

Staff engagement

- Regular staff forum meetings were held at main ambulance stations and different levels of clinical and non-clinical staff were invited. However, staff told us these were not usually well attended because they had to attend in their own time and without pay.
- We joined a forum meeting. Many people attended in their own time because they were committed to sharing their views with us.
- Staff attended community events (for example, 'Freshers' week' for the new university students) to encourage students to register with a GP, and to educate them on healthcare issues and when an ambulance is needed

Innovation, improvement and sustainability

- A GP referral scheme was in operation in some sectors. If a patient was assessed by frontline staff as needing to see a GP, their GP was contacted and within a timescale the GP visited the patient. This ensured the right care was being provided and reduced avoidable admissions at A&E departments.
- Staff had been actively involved in a review of health and care in Greater Manchester called Healthier Together. The review's aim was looking at how to provide the best care for people and take out variations in the quality of care across Greater Manchester.

- To improve formal and informal communication a closed Facebook page had been created in the Central sector. It had over 100 members and was used for formal updates, to organise social activities and to say 'Happy Birthday' to staff.

Cheshire and Merseyside

There was little awareness of the vision and strategy for the organisation among those staff delivering care to patients with life-threatening conditions. Many staff felt the organisation was target driven, sometimes to the detriment of patient care, while others only felt connected with other staff within their immediate geographical area and not with the trust as a whole.

The organisation's vision and strategy had not been cascaded to all the staff we spoke with. Staff were proud of the work they did and the overall ethos was that patient safety came first with patient experience being seen as a priority and everyone's responsibility. However, certain staff felt undervalued and demotivated. Key risks and performance data were monitored but poorly communicated trust wide. There was clearly defined and visible leadership, and staff felt free to challenge any staff members who were seen to be unsupportive or acting inappropriately in carrying out their duties. Although systems were in place to engage staff and the public, they were not always effective.

We were told by managers that they did not have access to the corporate risk register and there was no effective mechanism to regularly assess and monitor the performance of front-line clinical staff.

The trust had several initiatives in place to improve the service provided to patients.

Vision and strategy for this service

- The trust had a vision and strategy for the organisation that had clear aims and objectives. However, there was little awareness among front-line ambulance staff of the vision and strategy for the trust, despite the fact that the vision for the service was reproduced on many of the trust documents.
- The trusts' core objectives were focused on patient safety, clinical effectiveness and patient-centred care and were displayed on noticeboards in ambulance stations. Other content included was the weekly regional bulletin, a special bulletin regarding the Care Quality Commission inspection and information about available training courses (in-house and external).
- The only part of the trust strategy that most front-line ambulance staff were familiar with was the application to become a foundation trust. This was viewed by many staff with concern because there was a perception that, if the trust became a foundation trust, it would be detrimental to their terms and conditions of service.
- Front-line ambulance staff were only engaged with issues that they perceived as having an immediate bearing on their day-to-day operational work.

Governance, risk management and quality measurement

- The trust was assessed and achieved Level 2 of the NHS Litigation Authority Risk Management Standards in November 2011. This was similar to other ambulance trusts.
- A risk register was maintained at trust level. Managers of ambulance stations could describe the key risks within their areas of responsibility and how they were managed, but they did not have access to the organisation's risk register. They did not know how their risks related to other risks within the organisation.
- There was no mechanism in place to regularly monitor and assess the clinical performance of front-line ambulance staff, other than by senior paramedics (Band 6) working on shift, in an ad hoc way, to observe the practice of other front-line ambulance staff. There was no structured programme to systematically observe each person's practice throughout the year. It was not usual to record observations on a staff member's file unless poor practice was noted, when action would be taken and recorded appropriately. This meant that staff members could be working independently for an indefinite length of time without an assessment of the quality of their service, unless concerns were raised regarding their abilities, when a senior staff member would arrange to work a shift with them. It also meant that staff that were performing satisfactorily, or well, did not have this recorded in their personal files.
- Staff told us risks were rated from low to high with the lower risks being managed at local station level and the higher risks being escalated to the main trust risk register. However, they did not know how their risks

related to other risks within the organisation and were not always aware of the performance activity reports, recent serious untoward incidents and other quality indicators, such as the number of complaints received.
- There were discrepancies as to how the local risks were being managed. Staff we spoke with had differing views as to the actual risks. One assistant operations manager told us there was a mismatch between management and front-line staff and what they did about the risks. We were told that risks were based on best guesses and not evidence. Another assistant operations manager told us their biggest risks were the cleanliness of vehicles, missing equipment, inappropriate crew skill mix and assaults on staff. One paramedic told us, "I don't look at the big risks but lots of little nuggets."
- We asked for the local risk registers but these could not be located at the stations.
- A governance system and board assurance framework was in place that allowed risks to be reviewed and escalated to directorate and trust board level. Key items such as performance against targets, audit findings, organisational issues and the risk register were reviewed regularly at meetings such as those of the Paramedic Emergency Service Quality Business Group.

Leadership of service

- Staff told us that their immediate line managers were accessible and approachable. They said they rarely, if ever, saw members of the executive team.
- Community first responders and the Hazardous Area Response team (HART) felt that their team leaders were particularly visible and that communication within their teams was good.
- There were no team meetings for front-line ambulance staff. Some staff we spoke with had been employed by the trust for over 7 years and had never attended a team meeting.
- There were clearly defined and visible leadership roles within the ambulance stations and staff had been split into distinct teams with clinical leads.
- The staff we spoke with told us they understood the reporting structures clearly and felt they were well led locally by the senior staff at the stations.
- Staff we spoke with felt free to challenge any staff members who were seen to be unsupportive or inappropriate in carrying out their duties.
- The paramedics and emergency medical technicians reported an improvement in the overall service over the past 2 years and said management was "getting there".
- The ambulance stations we inspected had noticeboards with information about performance data and policy updates for staff to read.
- Generally, the staff were positive about the leadership. However, a few ambulance staff felt there was little recognition from management when staff did a good job. One person said, "We know we are doing a good job when we are left alone."

Culture within the service

- Staff spoke positively about the morale within the local teams. One staff member spoke positively about their local manager; this varied around the region.
- Some staff, who had been working for the trust for many years, spoke negatively about the culture. They said they felt part of a local team but not the wider organisation. Some staff did not feel supported by trust-wide management. They said that trust-wide managers were not visible in the way that local managers were.
- A union representative described the morale at The trust as "awful" due to the pressures staff faced, citing "no significant increase in resources" at The trust to help them.
- Ambulance staff received a 30-minute unpaid meal break as well as a 20-minute paid refreshment break. If staff were unable to take their breaks in the relevant 'window', they received payment. We reviewed overtime and payment forms that showed that staff regularly missed taking breaks in the relevant window.
- Sometimes, managers had to make difficult decisions about when to stand someone down or send them on a call. This meant either that some staff missed their break or that some callers waited longer for an ambulance response.
- One staff member, who normally worked in a busy urban area, said it was much quieter in Cheshire. This meant it was easier for them to take breaks or stay longer at calls.
- Most staff said that their colleagues and managers were supportive during and after distressing calls, such as a traumatic death of a child. One staff member said that they had to escalate their request to stand down, after a particularly difficult call.

Emergency and urgent care

Public Engagement

- The service was using a variety of methods to engage with patients and the public.
- The trust website contained detailed information about the services that are provided and actively encourages people to submit their views and feedback.
- A communities strategy has also been developed to widen public engagement and identify ways to improve the quality of the services provided. Examples regarding how the trust worked with communities during 2012/13 included 300 members of the public attended an open day to hear about the service and its future plans.
- Consultation on a variety of trust policies including the communities strategy, communication & engagement and equality and diversity.
- The trust has reached its target to reach a membership of 8,000 people and has established a shadow council of governors.
- The trust engages the public through social media and has more than 9,000 twitter followers.
- The trust developed community responder and community defibrillation programmes; and has recognised the first 20 Cardiac smart communities with the British Heart Foundation.
- The trust has an award winning patient experience board game used with community groups to identify gaps in public perception, service quality and information as well as to involving them in service re-design.
- The trust has a dedicated patient experience team and making experiences count team tasked with listening and responding to the experiences of patients and others.

Innovation, improvement and sustainability

- In the Quality Account for 2013/14, the trust proposed five new working areas to concentrate on in 2014/15, including new clinical performance indicators for patients who self-harm or fall, a new dementia-themed quality improvement programme, and a new medical emergency response incident team (MERIT).
- The MERIT was specially funded to provide medical staff that could perform specialist surgical procedures in the field. This programme was highly welcomed by local clinical commissioning groups and should improve services for critical care patients.
- The air ambulance locations were changing to better meet the needs of the service. The trust was working with the regional major trauma centres to improve air ambulance transfers. Currently, the helicopters land in local fields and require transport by ambulance, but in the future they will use a helipad at Aintree.

Patient transport services

Information about the service

Cumbria and Lancashire

The North West Ambulance Trust's patient transport services serve a population of about two million people across Cumbria and Lancashire.

The services are provided by 242 staff, based at 40 ambulance stations, and two control centres in Carlisle (Cumbria) and Broughton (Lancashire). The staff are supported by about 300 ambulance car service volunteer drivers.

Cheshire and Merseyside

The patient transport service provided transport for people who met the eligibility criteria for the population of Cheshire and Merseyside. These were people who did not need emergency conveyance to hospital. The service included the provision of transport for people who were unable to make their own way to hospital because of clinical or medical needs, such as needing minimal assistance from one person, and the use of intermediate ambulance vehicles to transport people on stretchers.

The patient transport service facilitated vital access for many patients with planned healthcare appointments, involving close to 1 million patient journeys every year. In order to comply with National Institute for Health and Care Excellence (NICE) transport standards, these patients should be dropped off and picked up within 30 minutes of their clinical treatment.

During our visit, we observed and spoke with 44 staff including control room staff managers and transport service crew. We also spoke with 15 patients and people who cared about them, such as friends, relatives or carers. We observed care to assess if patients had positive outcomes, and we looked at the care and treatment records for five patients.

We gathered further information from data that we had requested and received from The trust. We also reviewed information regarding their internal quality assurance and compared their performance against national data.

We also obtained information from stakeholders and community focus groups held before the inspection.

The service was managed through The trust divisional structure and led by a Head of Patient Transport Services across the trust.

During the inspection, we visited the ambulance stations at Anfield, Toxteth, Warrington and Newton le Willows. We visited the patient transport centre on the Countess of Chester Hospital site. In order to observe staff and speak with patients and people who cared about them, including the trust and hospital staff, we visited the Countess of Chester Hospital, Royal Liverpool University Hospital, Clatterbridge Cancer Centre and Warrington Hospital.

We also received information from other members of the team who visited Southport and Ormskirk, Whiston Arrowe Park and Leighton Hospitals.

We looked at the five transport service ambulances. Two members of the inspection team also joined staff in vehicles to observe practice and understand the role of the crews on the road.

Patient transport services

Summary of findings

Cumbria and Lancashire

Staff we spoke with were aware of how to identify abuse and report safeguarding concerns. Staff could raise safeguarding concerns through a support centre team based at Carlisle. Patients' needs were assessed by the control room staff as part of the booking process and the most suitable resources were deployed to meet patient's needs. As part of the booking process staff were able to identify patients with specific needs, such as learning disabilities, a mental health condition or dementia.

The service was supported by a team of volunteer drivers who were overseen by a delivery and performance manager based at Broughton in Lancashire. The volunteer drivers accounted for approximately 64% of all patient journeys in Cumbria and 22% of those in Lancashire.

There was an escalation process in place so key risks and capacity issues could be escalated to senior managers. When a patient or their representative made a request to use the service, they were assessed to determine their eligibility.

Between July 2013 and June 2014 local teams achieved or were slightly below the expected local targets for patient transport times. There were no significant differences in performance between the Lancashire and Cumbria teams.

Ambulance staff spoke positively about the mandatory training they had received and told us they felt it was sufficient for them to carry out their role effectively. Staff told us they had good working relationships with the police when escorting patients under Section 136 of the Mental Health Act 2005.

The general manager and team leaders attended routine engagement meetings with commissioners and hospitals to discuss key concerns and performance.

Patients were treated with dignity, compassion and empathy. We observed staff providing care in a respectful manner. Hospital staff we spoke with were positive about the attitude displayed by the ambulance staff. They told us the staff were friendly and had a good rapport with the patients. Patients gave positive feedback about the care they received.

Collection times were planned in advance for morning and afternoon collection slots across Cumbria to make efficient use of resources. This meant that some patients who had an appointment early in the morning or early in the afternoon might need to wait longer for collection.

Transport to appointments for haemodialysis patients was available up until 7.30pm with collection after appointments up to 1am, Monday to Saturday, including bank holidays. Transport was available for cancer patients from Monday to Friday, including bank holidays.

Key issues, such as performance against targets, audit findings, organisational issues and the PTS risk register, were reviewed at the PTS business group meetings that took place every two months. During the inspection, we looked at the PTS risk register and saw that key risks had been identified and assessed.

From July 2014, 32% of Lancashire PTS staff had had an appraisal within the last 12 months, but only 4% of PTS staff in Cumbria had received an appraisal in the last 12 months

There was a positive culture of reporting incidents and safeguarding concerns. However, the staff we spoke with were unable to describe how learning from incidents was shared to aid learning and improve the service. Ambulance staff told us they received good support from their team leaders but felt disengaged from the wider organisation.

Cheshire and Merseyside

There were systems for reporting actual and 'near miss' incidents across the patient transport service, and staff did report incidents. However, we found processes for feedback were poor and staff we spoke with were unaware of the key risks for the service.

Overall, we found that the service was compliant with infection prevention and control processes. However, we found that some stations were not fully adhering to specific infection prevention and control guidance.

Patient transport services

The trust had been issued with a contract query notice on 12 February 2014 because of non-achievement of the standards of performance expected to be delivered for access to the patient transport service. Service managers told us that they had invested in the introduction of mobile data terminals in vehicles. This had improved planning and communication, and contributed to improved performance. The inspection team noted that, although significant improvements had been made, The trust was still reporting below target on arrival within a 60-minute window and on passenger time on vehicle of less than 40 minutes.

Staff told us, and we observed that individual needs were taken into account when planning transport, such as a 54 year old patient needing an early appointment or a cancer patient needing a stretcher to make a hospital appointment.

Most patients we spoke with raised the issue of eligibility and the 10 questions they had to answer every time to prove they were eligible for transport, even if they were a regular user of the service.

We found that the patient transport service was delivered by committed and caring staff. We observed that all staff treated patients with dignity and respect. Most patients we spoke with were positive about the care they had received. Some told us they would have welcomed more information on the procedure for booking the patient transport service.

We did not see any evidence of a project plan or timelines for the delivery and implementation of a patient transport service strategy. We found that there appeared to be a disconnect in communication and understanding of key issues between managers and staff across the transport service. During discussions, the Head of Patient Transport Services acknowledged the challenges of working in such a huge geographical area and the need to increase the visibility of the senior management team.

Most staff at the control centre in Chester felt under pressure, and morale was low. Transport service staff also told us that they felt unsure and anxious for the future of the service, and that they were less patient focused since the new contract had come into force.

Are patient transport services safe?

Cumbria and Lancashire

Staff were aware of the process for reporting any identified risks to staff, patients and visitors. All incidents, accidents and 'near misses' were logged on the trust-wide electronic incident reporting system.

Daily and weekly safety and cleanliness checks on each vehicle and piece of equipment, are completed and recorded on infection control checklists. The checklists were complete and up to date.

Staff we spoke with were aware of how to identify abuse and report safeguarding concerns. Staff could raise safeguarding concerns through a support centre team based at Carlisle who recorded the information and coordinated the response.

Patients' needs were assessed by the control room staff as part of the booking process. This allowed the control room staff to deploy the most suitable resources. The service was supported by a team of volunteer drivers who were overseen by a delivery and performance manager based at Broughton in Lancashire. The volunteer drivers accounted for approximately 64% of all patient journeys in Cumbria and 22% of those in Lancashire.

There was an escalation process in place so key risks and capacity issues could be escalated to senior managers.

Incidents

- There were no Never Events (serious events that are preventable) for the patient transport services (PTS) between July 2012 and March 2014.
- The PTS ambulance staff we spoke with were aware of the process for reporting any identified risks to staff, patients and visitors. All incidents, accidents and 'near misses' were logged on the trust-wide electronic incident reporting system.
- Staff told us they were encouraged to report incidents and that they received direct feedback from incidents from their team leaders. However, the ambulance staff we spoke with were not able to provide any specific examples of how practice had changed as a result of an incident being reporting and investigated.
- All staff had access to the electronic incident reporting system.

- Staff could only access the system themselves at an ambulance station. However, ambulance staff told us they could report incidents by notifying the control room staff or by completing a paper-based incident form that was available in each PTS ambulance vehicle.
- Incidents logged on the system were reviewed and investigated by a team leader.
- The general manager told us there were three serious incidents reported by the trust to the National Reporting and Learning System and the Strategic Executive Information System that were directly related to PTS during the 12 months before our inspection.
- Serious incidents were investigated by a general manager or other staff with an appropriate level of seniority.
- We looked at a report for a serious incident in June 2014 and saw that a root cause investigation had been carried out to minimise the risk of a recurrence. We also looked at three routine incident reports on the electronic reporting system and saw that these had been reviewed and investigated appropriately.
- The general manager told us that all incidents were analysed for trends. They said that improvements in staff practice were made through changes to policies and procedures to ensure consistency across teams.

Cleanliness, infection control and hygiene

- Ambulance staff were aware of current infection prevention and control guidelines and had clear instructions for cleaning ambulance vehicles, and for cleaning and decontaminating equipment, such as chairs, stretchers and wheelchairs.
- Ambulance vehicles were clean and tidy. Staff told us they cleaned the vehicles and equipment on a daily basis using disinfectant wipes.
- Staff completed daily and weekly safety and cleanliness checks on each vehicle and piece of equipment, and recorded this information on infection control checklists. The checklists were complete and up to date for each vehicle we inspected.
- The ambulance vehicles were decontaminated and deep cleaned on a monthly basis. Each vehicle had a tax-style disc displayed on the windscreen showing when it was last cleaned and when the next deep clean was due. All the ambulance vehicles we inspected had been cleaned within the past month.
- The ambulance stations we inspected were clean, tidy and well maintained. There were arrangements in place for the handling, storage and the disposal of clinical waste.
- We observed staff following hand hygiene and 'bare below the elbow' guidance. Staff carried portable hand gels and personal protective equipment. Gloves and masks were readily available on each vehicle.
- The trust carried out routine cleanliness and infection control audits for vehicles, equipment and ambulance stations. The PTS business group had reviewed a 'Mind the Gap' report that included audit results for the management of equipment and infection control standards in PTS ambulance vehicles and at ambulance stations.
- The service had an action plan to address areas where concerns had been identified.

Environment and equipment

- The ambulance vehicles were on a planned maintenance schedule. This allowed staff to make alternative arrangements in advance to minimise disruption to the PTS.
- The trust used two types of PTS ambulance vehicles, one with a stretcher and one without. The vehicle fleet and equipment on each vehicle were standardised. We saw that equipment, such as chairs, stretchers and wheelchairs, were maintained.
- The staff we spoke with were aware of how to report faulty equipment and told us that was readily replaced. Consumable items, such as gloves and hand gels, were replenished each day from stock available at ambulance stations.
- Each vehicle had an emergency 'snatch bag' that included basic first-aid equipment, oxygen masks and single-use sterile items, such as airways tubes that were kept in their sterile packaging.
- These items were also checked routinely by staff to ensure they were within their expiry dates.
- The staff we spoke with told us they carried out visual checks on patients' own equipment (for example, wheelchairs) to ensure that they were safe to transport.
- Each ambulance vehicle we inspected was equipped with a wheelchair if needed.

Medicines

- The patient transport vehicles we inspected did not carry any medicines for emergency purposes.

- Ambulance staff told us that patients with specific medication needs were identified during the patient booking process. They said they did not administer any medication but would prompt patients to take their prescribed medicine if this had been identified during the patient booking process.
- Ambulance vehicles were equipped with oxygen, which was appropriately stored and maintained.
- Patients who needed oxygen during their journey were identified in advance and assigned to travel in vehicles staffed by two people.

Records

- The trust used an electronic booking system for patients. Patient information, such as personal details, journey times and specific needs, were stored electronically. The control room staff communicated this information electronically to hand-held devices carried by ambulance staff.
- Ambulance staff did not generate any specific patient records for planned journeys. Information such as journey start and end times were recorded electronically. Staff told us they would only use paper records if the electronic system was unavailable.
- The staff completed a paper record when oxygen was administered to a patient. The completed records were placed in a locked container in the ambulance station, and then sent to a centralised team within the trust for review and archiving.
- Ambulance staff told us that most patients took responsibility for their own records when travelling. When this was not possible, they would help the patient to ensure that their accompanying records were handed over to the relevant healthcare professionals at the end of the patient's journey.

Safeguarding

- Staff we spoke with were aware of how to identify abuse and report safeguarding concerns.
- Staff could raise safeguarding concerns through a support centre team based at Carlisle who recorded the information on the trust's electronic referral information sharing system.
- This system automatically notified the relevant local authority based on the patient's address details.
- We looked at the records for two safeguarding incidents raised by PTS staff in Cumbria and Lancashire. These had been recorded and referred correctly.
- Support centre staff told us that if the local authority did not accept a referral, the trust's safeguarding team would review and investigate the incident in order to improve the service.
- Trust data showed that between April 2014 and July 2014 there had been 33 adult safeguarding referrals and no child safeguarding referrals made by PTS staff. This accounted for less than 1% of all referrals made by staff across the trust during that period.
- The safeguarding manager acknowledged that the level of reporting of safeguarding incidents by PTS staff needed improving and there was an action plan in place to address this.
- The safeguarding work plan 2014 to 2015 included specific actions for improving safeguarding processes for PTS staff across Cumbria and Lancashire.
- These included monthly PTS reports to monitor the level of reporting by staff, improving staff awareness, encouraging the use of crib sheets, guidance and instructions on how to identify and report concerns, increasing staff awareness through local engagement, introducing safeguarding champions and increasing training for PTS supervisors.
- Some of the actions in the work plan had been implemented and the outstanding actions were due for completion by December 2014.

Assessing and responding to patient risk

- Patients' needs were assessed by the control room staff as part of the booking process. This allowed the control room staff to deploy the most suitable resources (for example, vehicle type and number of staff) to meet the needs of the patient.
- If a patient was identified with complex health needs during the booking process, they would be referred to the emergency ambulance service.
- Ambulance staff received mandatory training in basic life support and choking. Ambulance vehicles were not equipped with defibrillators for use during cardiac arrest.
- Staff told us that, if a patient's health deteriorated during the journey, they would take the patient to the nearest acute hospital for treatment or request an emergency ambulance if the patient was in a critical condition.
- Staff said they rarely attempted to resuscitate a patient themselves unless a patient was critical and an emergency ambulance would not reach them in time.

They also told us they would confirm patient-specific information, such as 'Do not attempt cardio-pulmonary resuscitation' status, with the control room staff before attempting to resuscitate a patient.
- Staff told us that, if they had concerns relating to vulnerable patients at home, they would carry out environment and health and safety assessments to determine if it was safe to access the patient, and transfer them to the vehicle.

Staffing

- Trust data for July 2014 showed that PTS staffing levels in Cumbria and Lancashire were 13.85% below the expected level. The General Manager for the area told us that recruitment was ongoing for both Cumbria and Lancashire for 32 permanent positions and also bank positions.
- We did not identify concerns relating to staffing levels. The service was able to cover for staff shortfalls with the use of bank staff and by allowing existing staff to work extra hours.
- The PTS was supported by a team of volunteer drivers who were overseen by a delivery and performance manager based at Broughton in Lancashire. The volunteer drivers accounted for approximately 64% of all patient journeys in Cumbria and 22% of those in Lancashire.
- The PTS ambulance staff were supported by the PTS control room staff up until 8pm.
- Staff told us that they could contact their team leader or rely on the emergency services if extra support was needed out-of-hours.
- There was a lone worker policy that provided guidance to staff. The staff we spoke with were aware of this policy and understood the risks associated with lone working.
- Patient journeys were tracked by control room staff and so the location of lone drivers was known.
- Patient journeys were planned with two members of staff when patients were assessed to need that level of support.
- Staff had access to radios so they could contact the control room if they needed guidance or support.

Anticipated resource and capacity risks

- The trust had a documented resilience business plan that outlined how key risks that could affect the provision of services would be managed.
- The key risks included the potential impact of major incidents, a surge in demand, adverse weather conditions and disruption to staffing levels.
- There was an escalation process in place so key risks and capacity issues could be escalated to senior managers.
- When capacity issues relating to staffing and vehicle availability were identified, the control room staff were able to make alternative arrangements, such as sourcing taxis or external ambulance contractors to minimise the impact on patients.
- The trust carried out service development risk assessments that included an assessment of the impact on patient safety.

Cheshire and Merseyside

There were systems for reporting actual and 'near miss' incidents across the patient transport service, and staff did report incidents. We found that across the service different methods of reporting incidents had been used. Some staff had received feedback about a specific incident but not as part of a structured framework of feedback.

Staff we spoke with at different levels of the service were unaware of the risk register and were unable to tell us the key risks for the service.

Overall, we found that the service was compliant with infection prevention and control processes. However, we found that it was variable in that some stations were not fully adhering to the specific guidance.

An external audit had been carried out to audit the process for safeguarding, and this had identified under-reporting in the patient transport service. As a result, the service had introduced safeguarding crib sheets, which we found in safeguarding folders in the transport service vehicles.

All the vehicles we saw had a tax disc-type sticker to denote when they had last been cleaned and the date of the next 'deep clean' that was done every 6 weeks. This was considered to be good practice.

Incidents

There were systems for reporting actual and 'near miss' incidents across the patient transport service. Staff told us they reported incidents, although one person said, "I don't bother raising them as you don't get any feedback." They told us that they knew what to report and were able to show us how they would do so by using the electronic reporting system. We noted that most staff were aware of

and used the system and the incident reporting forms. However, we found that across the service different methods of reporting incidents had been used. We were told, and records confirmed that some staff used the incident reporting forms; other staff told us they would report the incident to their supervisors, and others that they would record incidents in the station log book. The lack of absolute clarity around incident reporting may have had an impact on the trust's ability to ensure that all incidents were captured and acted upon in a timely manner.

Staff also told us they did not always get feedback from incidents they reported and we did not see evidence of formal feedback, such as at team meetings. Some staff had received feedback about a specific incident but not as part of a structured framework of feedback.

The data available from the trust showed that they had been reported a serious incident in November 2013 which had been investigated were a patient being conveyed had become unwell there had been problems contacting the control centre for support. As a result of this event we saw that the PTS service had revised how PTS staff access support for acutely unwell patients.

The area manager told us that they regularly updated the risk register for the service and this was reviewed by the senior management team. Staff we spoke with at different levels of the service were unaware of this risk register and were unable to tell us the key risks for the service.

The patient transport service monitored all its risks and had a local risk register. We reviewed the risks it had identified. The key risks it had identified in July 2014 were compliance with the contract performance targets, staff appraisals and training, and staff sickness. All the risks had action plans mitigate the risks to maintaining and improving patient care.

We were told that front-line staff would be made aware of changes in policy or procedures that had been made after safety incidents or alerts. Some staff told us that they had been asked to sign to say they had read a policy and others said that they had received an email. We were told that not all staff had access to email and we noted that at two locations there was only one PC terminal for the staff to access.

Cleanliness, infection control and hygiene

The trust had developed clinical safety indicator percentage scores to monitor compliance with regard to clinical quality. Infection prevention and control indicators measured compliance against cleanliness, sharps disposal, management of equipment, etc. The 2013/14 Quality Account showed that for infection prevention and control the compliance rate for the patient transport service was 91.6% and 90.1% for stations compared with a patient emergency service rate of 95.5%. The average trust compliance score was 92.4%. These figures were lower than the 2012/13 figures of 96.6% for the emergency service, 94.6% for the transport service and 91.6% for stations, with the average of 94.3%.

Staff told us that they completed their own checklists for cleaning schedules. We found that the standard of record keeping for vehicles was good, and that daily cleaning records had been completed. We saw examples of completed checklists for auditing the vehicles, including checking the use of protective equipment and single-use spill kits.

A service delivery infection prevention and control audit had been carried out in August 2014. Staff told us that they had not been told the outcome of this audit. In one vehicle, we found a manager's audit record sheet that had last been completed in September 2013. In two other vehicles, we found that the last audits had been completed in August 2014. We were told that it was part of the new transport service contract to complete service delivery Infection prevention and control audits.

Staff we spoke with were aware of current infection prevention and control guidelines. We observed good practices such as hand-sanitizing facilities (for example, gel) available throughout the vehicles with some staff having small bottles in their pockets. Staff were generally following hand hygiene and 'bare below the elbow' guidance.

There were suitable arrangements for the handling, storage and disposal of clinical waste, including sharps. We observed that staff had been able to dispose of clinical waste at the base ambulance stations. They understood the defined roles and responsibilities for cleaning the environment and decontaminating equipment.

Patient transport services

We noted that, at the Toxteth ambulance station, mops for cleaning ambulances were dirty and water, which was also dirty, had been left in buckets.

All the vehicles we saw had a tax disc-type sticker to denote when they had been last cleaned and the date of next 'deep clean', which was every 6 weeks. This deep clean meant the vehicle was taken out of service and, during this time, staff made sure it was fully stocked with equipment and patient areas clean and ready for use. This was considered good practice.

Environment and equipment

Compared with emergency vehicles, the patient transport service had minimal equipment in their vehicles, such as blankets, spill kits and first-aid kits. Staff told that any faulty equipment would be reported to their supervisor for maintenance.

Staff said they could replenish personal protective equipment if needed. Some staff told us that this had been an issue, but most did not have problems with equipment. They said that they would have preferred to have an automatic defibrillator on board because other emergency services had that equipment and they felt that members of the public would see them as an ambulance and expect them to have access to a defibrillator in an emergency.

Staff told us that they would accept people's wheelchairs in the vehicle if appropriate but would also use hospital chairs to safely transfer a patient to their appointment, depending on the space available in the vehicle.

Staff said, and we observed, that they undertook a dynamic risk assessment (with the patient present) while on site and/ or in the ambulance with patients and felt that they had access to the control room if further support was required.

Medicines

All the vehicles we looked at had oxygen cylinders available and in date.

The transport service vehicles did not have any emergency drugs and staff told us that they would contact control and ask for assistance from an emergency ambulance if needed.

Records

Transport service staff did not routinely complete patient care records. Staff told us, and we saw, that all the information needed about a patient was made available by using mobile data devices. The trust used an electronic booking system for patients. Patient information, such as personal details and patient-specific needs, were stored electronically. However, staff told us that the system had only gone live this year and there had been issues regarding the individual devices and the lack of signal in some areas. Staff told us that they often had to either print off their worksheets or phone into the control room to update information on patients.

Staff told us, and we observed that usually no records would be transferred with a patient using the transport service. Staff received information from the mobile data device in their vehicle to tell them the destination for each patient. The staff told us that they always carried out a verbal handover to clinical staff to ensure that they were aware that the patient had arrived in the department.

Staff did not have access to 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms but told us that they would always attempt resuscitation if they had any doubt whether or not to resuscitate.

If there was a change in a patient's clinical condition or an issue with a patient, the transport service crew completed a patient report form. This included specific patient details and a description of the issues. The form also indicated whether or not consent had been obtained from the patient and a description of any escalation for assistance if needed. The form was carbon copied and three copies were made each time it was completed. One copy was for the hospital, one for the patient or their representative and one for the trust to store. We were told that patient records would be kept securely in the stations we inspected.

At Warrington ambulance station, we found a number of completed patient report forms on top of the secure box where they should have been stored and in an unsecured filing cabinet; others were overflowing from the secure container. We advised the assistant operational manager on duty at the time who assured us that immediate remedial action would be taken. We were told that a further lockable cabinet had been ordered.

Consent and Mental Capacity Act 2005

Staff understood how to obtain consent appropriately and correctly. We observed staff gaining consent during the

transport of patients. This was also confirmed in a record we reviewed of a patient. The patient report form asked, "Does the patient have capacity to consent?" and this had been ticked 'yes' on the record.

Staff received mandatory training in consent and safeguarding children and vulnerable adults that included aspects of the Mental Capacity Act 2005 and Deprivation of Liberties Safeguards (DoLS). Staff understood these requirements and were able to explain what they would do if the situation arose.

Safeguarding

We were told that in October 2013 the trust had started to use an electronic system to share safeguarding referral information with children's and adults' social care teams. Staff we spoke with were aware of the processes and understood that they could ring a central number for advice. We were told that 100% of safeguarding referrals generated by the transport service now gave feedback to staff.

An external audit had been carried out to audit the process for safeguarding, and this had identified under-reporting in the patient transport service. As a result, the service had introduced the safeguarding prompt sheets that we found in the vehicles.

We looked at the safeguarding folders kept in the transport service vehicles. They were not always standardised across the vehicles but they all contained the prompt sheets and safeguarding procedures to follow in the event of concerns about a vulnerable person. We recognised that the local teams had worked to develop the folder and this was considered good practice by the specialist adviser.

Transport service managers received Level 2 safeguarding training and the trust's mandatory training work book had a section on safeguarding. Staff confirmed that safeguarding had been included as part of staff induction. The safeguarding lead told us that they had reviewed the mandatory training that was now going to include yearly safeguarding training. Voluntary car drivers also had safeguarding information as part of their induction.

We were told that sometimes the safeguarding team had to rely on the operational managers to distribute information or provide access to policies. Staff told us that they had little time to access this information via email or bulletin boards. The lack of timely access to appropriate policies and procedures may impact on the ability of the service to deliver a safe quality service.

Assessing and responding to patient risk

Staff told us, and we witnessed, that they carried out dynamic risk assessments on patients when they arrived to transport them to their appointments. Staff confirmed that they had access to the control centre if they had issues or concerns at a patient's house.

Staff had been trained to respond to basic emergencies and understood the process for calling emergency assistance if a patient deteriorated. Some staff told us that they would prefer more training in responding to emergencies and would be willing to be trained to use automatic emergency defibrillators, although they currently did not carry them in their vehicles.

Staffing

The NHS staff survey (2013) reported that more staff at this trust than at other ambulance trusts nationally said that they worked extra hours (90% of staff against 85% nationally).

Observations and discussions showed there was a sufficient number of trained and support staff with an appropriate skills mix to ensure that patients were safe and received the right level of care. However, we noted that The trust's own risk register, updated in July 2014, outlined a risk as 'Failure to deliver PTS [patient transport service] contract standards due to high rates of sickness and absenteeism within PTS operations and control resulting in detrimental patients' care and potential reputational damage to The trust.'

The high sickness rate presented a risk to the trust in regard to maintaining a safe staffing level needs to be addressed by the provider to ensure the continuous provision and safe delivery of care.

We were told, and records showed, that the service was able to use third-party providers to help them with service delivery.

Some staff we spoke with told us that they had requested access to senior staff outside normal working hours, but

currently there was no system for support from senior transport service staff out of hours. Any request for support would need to be escalated though to the emergency services team.

We spoke with two new members of staff who confirmed that they had received an induction as part of their introduction to the service and felt confident to ask for support and advice from their immediate team supervisor.

Anticipated resource and capacity risks

The trust had employed ambulance liaison assistants to engage with the discharge departments and wards at local hospitals. Staff told us that they had recently removed an assistant from one trust and another assistant told us they were at the trust on a temporary basis.

Staff members told us that shifts had been changed at short notice and one supervisor said they had been informed on a Friday that a new member of staff was starting on Monday. This meant that they had not been able to plan induction or workload in a timely manner.

Staff told us that there had been an issue with the new contract and how the service worked with third-party providers. Although they welcomed the ability to use third-party providers, they were still unsure as to how the resources could best be used as part of the overall capacity.

We saw copies of a staff communication indicating that the current escalation level had changed from Resource Escalation Action Plan (REAP) Level 2 in June in response to a review of performance and system pressures. The REAP system was in operation at all times and enabled The trust to ensure that its service could be maintained if any challenges occurred, such as increased activity or significant loss of staff.

Are patient transport services effective?

Cumbria and Lancashire

When a patient or their representative made a request to use the service, they were assessed to determine their eligibility. The eligibility criteria were established by the CCG and based on national guidelines for the non-emergency transport of patients. Patients with specific medical conditions, such as haemodialysis and cancer patients, were given priority and eligibility to use the service.

Between July 2013 and June 2014 local teams achieved or were slightly below the expected targets for patient transport times. There were no significant differences in performance between the Lancashire and Cumbria teams.

Ambulance staff spoke positively about the mandatory training they had received and told us they felt it was sufficient for them to carry out their role effectively.

Staff told us they had good working relationships with the police when escorting patients under Section 136 of the Mental Health Act 2005. The general manager and team leaders for PTS in Cumbria and Lancashire attended routine engagement meeting with NHS commissioners and local NHS hospitals to discuss key concerns, such as performance targets and patient access to the service.

Evidence-based care and treatment

- The trust had a service contract with the local clinical commissioning group (CCG), led by Blackpool CCG, to provide patient transport services (PTS) in Cumbria and Lancashire. The contractual arrangements specified how the PTS should assess patients' needs and their eligibility for the service.
- When a patient or their representative made a request to use the service, they were assessed to determine their eligibility.
- The eligibility criteria were established by the CCG and based on national guidelines for the non-emergency transport of patients.
- For example, patients with specific medical conditions, such as haemodialysis and cancer patients, were given priority and eligibility to use the service.
- The eligibility assessment also took into account whether patients needed oxygen treatment during their journey, as well as their level of mobility.
- The head and the general manager of PTS in Cumbria and Lancashire told us they did not carry out any specific clinical audits because of the nature of the service.
- Most patients who used the service were deemed low risk and non-emergency, in other words, people who needed limited clinical or medical support during their journey.
- The trust's clinical audit plan 2013 to 2014 included two specific clinical performance indicators for PTS that were under development, and for which a clinical audit had not yet taken place.

- These were to monitor patients who needed oxygen treatment and to monitor the completion and data quality of the 'patient report form'.
- The PTS had also recently started to collate Commissioning for Quality and Innovation data for patient mobility.
- There was limited data available at the time of our inspection; however, the data was being collated to review the accuracy of bookings for patients with mobility needs.

Patient outcomes

- The PTS had performance targets that had been agreed as part of the service contract with the CCG.
- One performance target was that patients arrived no more than 45 minutes before or 15 minutes after their appointment time on 90% of occasions.
- For haemodialysis or cancer patients, the target was to arrive within 30 minutes of the appointment time on 90% of occasions.
- Trust performance data between July 2013 and June 2014 showed that the local teams achieved or were slightly below the expected targets.
- The performance data showed that there were no significant differences in performance between the Lancashire and Cumbria teams.
- When arrival targets were not achieved, most patients arrived earlier than their expected time rather than after their appointment time, which meant that they were still able to attend their appointments.
- The trust target for collection of routine patients was to collect them within 60 minutes of their scheduled collection time on 80% of occasions, and within 60 minutes of the scheduled time on the patient readiness notification (the time they would be ready for collection) on 85% of occasions for patients having haemodialysis or cancer treatment.
- The data showed that the local teams consistently achieved these targets between July 2013 and June 2014.

Competent staff

- Staff underwent an induction process when they began employment, and attended two days of mandatory training on an annual basis.
- The mandatory training covered key topics including safeguarding, infection control, health and safety, fire safety, customer service, oxygen therapy and mental health awareness.
- Trust data up to July 2014 showed that 88% of PTS staff in Lancashire had completed the mandatory training. However, only 51% of PTS staff in Cumbria had done so during the current period.
- Ambulance staff spoke positively about the mandatory training they had received and told us they felt it was sufficient for them to carry out their role effectively. However, they also told us they did not receive any on-the-job supervision or competency-based assessment or training.
- The general manager told us the trust had developed additional training for staff in specific patient conditions such as dialysis and blood pressure. This training had not yet been rolled out to all staff.
- The volunteer drivers received mandatory training as part of their induction process.
- Trust audit data for August 2014 showed that the vast majority of volunteer car drivers had completed disclosure and barring Service checks**.** Volunteer drivers were not deployed until the relevant checks had taken place.

Working with other providers

- Staff told us they had good working relationships with the police when escorting patients under Section 136 of the Mental Health Act 2005.
- We received a mixed response from the hospital discharge staff we spoke with during the inspection.
- NHS bed bureau staff at Royal Preston Hospital told us they had a good working relationship with the PTS liaison officers based at the hospital.
- Staff at Furness and Westmoreland Hospitals told us they sometimes experienced communication difficulties when trying to resolve queries with the PTS control room staff, because there were no dedicated PTS staff based at these hospitals.
- Furness Hospital accident and emergency staff told us they had a good relationship with the PTS ambulance staff and that they provided good information during patient handover.
- The general manager and team leaders for PTS in Cumbria and Lancashire attended routine engagement meetings.

- They met with NHS commissioners and local NHS hospitals to discuss key concerns, such as performance targets and patient access to the service.

Cheshire and Merseyside

The delivery of care for transport services was based on guidance in contract standards issued by service commissioners. In order to comply with these standards, patients had to be dropped off and picked up within 30 minutes of their clinical treatment. We were told that the patient transport service did not give any clinical intervention, other than oxygen.

The coordinating commissioner had served a contract query notice on the trust in February 2014 on all four contracts for failure to achieve various standards of performance. The inspection team noted that, although significant improvements had been made, the service was still reporting below target on arrival within a 60-minute window and on passenger time on vehicle of less than 40 minutes.

Evidence-based care and treatment

We reviewed the service for any applicable NICE guidance. We identified one relevant quality standard (NICE Quality Standard 55). It outlined that people with chronic kidney disease, receiving haemodialysis or training for home therapies and who are eligible for transport, should have access to an effective and efficient transport service.

We found that this patient group had been identified and access to the service was being provided and monitored in terms of responsiveness through the main transport service contract. The service covered four counties and third-party providers were used; this adhered to the trust transport service standards. The service also completed a performance dashboard to monitor key contract indicators. The trust had been experiencing some challenging performance targets agreed with commissioners regarding the transport service. We saw that they had a key performance indicator matrix with exception reporting outside the targets

The coordinating commissioner had served a contract query notice on the trust in February 2014 on three out of four contracts for failure to achieve various standards of performance. The inspection team noted that, although significant improvements had been made, the service was still reporting below target on arrival within a 60-minute window and on passenger time on vehicle of less than 40 minutes.

Throughout the inspection, we observed, and staff reported, considerable time wasted while waiting in their vehicles for patients. At least 10 staff told us that they spent a lot of time waiting to be able to transport patients to meet the contract target times. We observed that one person had been sitting in an ambulance for 2 hours waiting to be released to another transport vehicle. The inspector who rode in the vehicle found that the staff picked up three patients during an 8-hour shift and felt that they could have completed a greater number of journeys. It was noted at two hospitals that several members of the transport service crew were waiting to be allocated work. We found this to be a lack of review of the use of transport service resources.

We were told by staff that they had arrived for duty at a particular time to find that the first planned journey has already passed so they had missed their performance target. We noted that a paper had been presented to the general manager for Cheshire and Merseyside in July that highlighted the need to further review the planning processes to effectively manage resources. The paper also highlighted significant unproductive time when runs had commenced after the shift start times to meet the 60 minutes' time window requirements of the contract, lessening the opportunity to meet the target time.

Patient outcomes

We were not able to compare the local transport service contract with that of another provider but we were able to review the one contract across the trust's two areas. While both areas had problems delivering the patient outcomes specified in the contract, discussions with the Head of Patient Transport Services confirmed that some of the key challenges had been in Cheshire and Merseyside.

Staff described how they planned transport to meet the needs of patients. However, we saw an example of one complaint about the service sending an incorrect vehicle to meet an individual's needs on six occasions.

In discussions with managers, we were told that the transport service was reviewing its current fleet requirements in line with activity demands to ensure that

patients' outcomes were met and that the most appropriate transport vehicle was dispatched to meet a patient's needs. We found this to be confirmed on the risk register.

The trust's clinical audit plan 2013/14 included two specific clinical performance indicators for the transport service. These were still in draft and an audit had not yet taken place. They related to the monitoring of patients who required oxygen treatment and the monitoring of transport service patient report forms.

Competent staff

We spoke with senior managers of the service who told us that they currently did not assess staff competency for patient transport service roles. However, they had recently reviewed the delivery of mandatory training and plans were in place to do practical sessions on resuscitation and the administration of oxygen.

We asked one manager for a copy of a training needs analysis in line with the scope of practice for transport service staff. The manager was unaware of the existence of a training needs analysis and was not up to date with the scope of practice. Staff told us that they did not feel there was any clear direction regarding scope of practice for non-qualified staff.

The transport service road crew told us that they had attended mandatory training. However, control centre staff felt that they had been unable to access training adequately and some staff had been told to complete e-learning in between calls. We noted that one person was interrupted 17 times while trying to complete the e-learning. We were not assured that this was an appropriate way for staff to undertake mandatory training.

Staff confirmed that newly appointed staff underwent an induction process .We found that the service had a range of training opportunities to ensure that training needs were met.

Mandatory training was available and included various modules such as infection prevention and control, equality, diversity, dementia, risk management and manual handling.

Although we met with senior managers who felt that staff development interviews and appraisals were not a problem, we identified that the lack of completion of performance or NHS Knowledge and Skills Framework (KSF) reviews had been highlighted as a risk on the risk register. The weekly performance review record from 12 August 2014 indicated that in Cheshire 59% of staff had completed a KSF interview and 89% in Merseyside. In Cheshire, nearly all staff had completed mandatory training but in Merseyside 89% had done so. It was also highlighted in Cheshire that only 41% of staff had completed driving licence checks compared with 93% in Merseyside. Staff we spoke with confirmed that performance review meetings had been ad hoc and some staff had not had a review in 2 years; others felt it was a tick-box exercise.

We were told, and records showed that limited training was available for voluntary car drivers and there was a handbook with information on safeguarding, conduct and escalation procedures.

Working with other providers

We observed the trust staff working with external organisations such as local hospitals' discharge suites to improve patient response times.

We saw an example of good practice at the Royal Liverpool University Hospital. Staff had worked jointly to introduce the use of an orange sticker that identified to hospital staff that a patient was an ambulance patient and considered a priority.

Are patient transport services caring?

Cumbria and Lancashire

Patients were treated with dignity, compassion and empathy. We observed staff providing care in a respectful manner.

Hospital staff we spoke with were positive about the attitude displayed by the ambulance staff. They told us the staff were friendly and had a good rapport with the patients. Patients gave positive feedback about the care they received.

Patients also told us the PTS ambulance staff explained information to them clearly during their journeys, and supported them fully. However, they were not always told how long they would have to wait for collection if there had been a delay.

Patient transport services

Compassionate care

- During the inspection, we saw that patients were treated with dignity, compassion and empathy. We observed staff providing care in a respectful manner.
- All the patients and relatives we spoke with said they thought staff were kind and caring. They gave us positive feedback about how staff showed them respect and ensured that their dignity was maintained.
- The comments received from patients included, "very helpful. I feel safe while with the crew", "they are nice, friendly and help to take me inside my home and check if I am OK" and "the staff are excellent. I feel well looked after".
- All the hospital staff we spoke with were positive about the attitude displayed by the ambulance staff. They told us the staff were friendly and had a good rapport with the patients.
- Patent Transport Services (PTS) staff told us they tried to accommodate patients' preferences. However, it was not always possible to maintain continuity of staff for regular patients.
- Ambulance staff told us they respected patients' privacy and dignity. Patients were helped with their toileting needs and the staff could make stops during the journey if needed.
- Ambulance vehicles were also equipped with drinking water bottles for patients who wanted them.

Patient understanding and involvement

- Patients who might be eligible to use the service were made aware of it through various sources, such as information leaflets or referral by other healthcare professionals. For example, GPs or hospital-based staff.
- Patients told us the PTS ambulance staff explained information to them clearly during their journeys, and supported them fully. However, they were not always told how long they would have to wait for collection if there had been a delay.
- The trust had produced a patient charter that included key information, such as contact details and what patients should expect before and during their journey. The patient charter was available on the trust's website but was not displayed in any of the areas we inspected.
- The trust had identified through their engagement with patients that information about waiting times and awareness of the patient charter needed improvement.

Cheshire and Merseyside

We found that the patient transport service was delivered by committed and caring staff. We observed that all staff treated patients with dignity and respect. Most patients we spoke with were positive about the care they had received. Some people told us they would have welcomed more information on the procedure for ordering the patient transport service.

Compassionate care

- We found that the patient transport service was delivered by committed and compassionate staff.
- The 2013/14 Quality Account reported that for the patient transport service 91% of patients surveyed confirmed that their call into the control room(s) was handled politely and respectfully: "I have always been spoken to politely and understandingly." "Always the call is efficient, polite and compassionate."
- A transport service patient had contacted the trust to express his thanks to the crew who were professional, caring and compassionate.
- We observed that all staff treated patients with dignity and respect.
- We spoke with 15 patients and overwhelmingly the comments were positive about the staff and their attitude towards patients. Some comments made were: "Staff are always so friendly and professional" and "They always look after me and I feel safe."
- We observed examples of staff ensuring that people were comfortable in the transport service ambulance and were treated with dignity. We saw patients being appropriately supported to access the vehicle, such as being helped to walk and transfer to a seat.
- Staff were aware of particularly vulnerable patients and understood the need to communicate in a way that was supportive and respected their privacy and dignity. Blankets were provided for both warmth and privacy if needed. Staff told us that they had received awareness training for dementia and the trust was aiming to be recognised as a dementia friendly organisation.

Patient understanding and involvement

- We saw staff obtaining verbal consent when helping patients with care.
- Staff told us that patients liked to see a (regular) member of staff with whom they were familiar and this was confirmed by the patients we spoke with. We did not see formal mechanisms for ensuring the continuity

of staff for regular patients but the planning team told us that they had tried to factor this into the planning process. Staff confirmed they were assigned to (regular) patients they had previously transported.
- We were told, and records showed, that a range of community engagement activities had involved the development of pictorial handbooks for transport service patient information. We did not see any of these in the vehicles we looked at or in any of the hospital trusts we visited. We did see that small credit card-sized leaflets were available but we did not see any literature in large format for visually impaired patients or in different languages for people whose first language was not English. There was therefore potential for staff to be unable to communicate effectively with some patients.
- Some patients we spoke with said that they found the system for booking transport confusing and needed help to phone the contact centre.

Are patient transport services responsive?

Cumbria and Lancashire

As part of the booking process staff were able to identify patients with specific needs, such as learning disabilities, a mental health condition or dementia. They then planned to meet specific patients' needs by allocating the most suitable type of transport vehicle, mobility equipment or by ensuring vehicles were staffed by two people for patients with greater dependency. Ambulance staff had a good understanding of individual patients' needs.

Patient-specific information, such as their level of mobility, advanced decisions and mental health needs, were identified during the booking process and communicated to the ambulance staff.

The electronic patient booking system did not identify a patient's history of using the service. The eligibility assessments were carried out for each booking so that a patient's needs could be assessed in real time and were specific to each booking.

Collection times were planned in advance for morning and afternoon collection slots across Cumbria to make efficient use of resources. This meant that some patients who had an appointment early in the morning or early in the afternoon might need to wait longer for collection.

Transport to appointments for haemodialysis patients was available up until 7.30pm with collection after appointments up to 1am, Monday to Saturday, including bank holidays. Transport was available for cancer patients from Monday to Friday, including bank holidays.

Staff received mandatory training in mental health awareness. Ambulance staff we spoke with understood the legal requirements of the Mental Capacity Act 2005.

Service planning and delivery to meet the needs of local people

- Staff had a good understanding of the needs of the local communities in Cumbria and Lancashire.
- They worked in multidisciplinary teams and routinely engaged with local NHS commissioners, other healthcare providers and other professionals involved in the care of patients to ensure that the service met patients' needs.
- Control room staff planned most patient journeys one day in advance so that staff and vehicles could be allocated effectively.
- As part of the booking process staff were able to identify patients with specific needs, such as learning disabilities, a mental health condition or dementia. They then planned to meet specific patients' needs by allocating the most suitable type of transport vehicle, the right mobility equipment or by ensuring vehicles were staffed by two people for patients with greater dependency.
- The service had a dedicated patient transport ambulance vehicle based at Broughton, Preston, that could be used for transporting bariatric patients. Bariatric is the branch of medicine that deals with the causes, prevention and treatment of obesity.
- Ambulance staff told us that, if they identified a patient needing bariatric support, they would contact the control room staff to access the specialist vehicle. The service could also source specialist bariatric vehicles from external ambulance contractors if needed.
- Ambulance staff had a good understanding of individual patients' needs. Patient-specific information, such as their level of mobility, advanced decisions and mental health needs, were identified during the booking process and communicated to the ambulance staff.

Patient transport services

- Ambulance staff in East Lancashire understood and respected the diverse population in the areas they served, and were able to accommodate patients' cultural needs.
- When patients were unable to speak English, an interpreter was arranged for the journey during the booking process.
- Ambulance staff had access to communication books that included easy-to-follow visual prompts. These were used when staff identified a patient who could not speak English or was unable to communicate for other reasons, such as a hearing impairment.

Access and flow

- The PTS could only be accessed by booking in advance. Transport journeys could be booked by the patient themselves or their representatives, and by other healthcare professionals, such as GPs or hospital outpatient department staff.
- Most bookings were made by hospital staff.
- Patients were asked to book each journey individually and an assessment to determine if a patient was eligible to use the service was carried out on each occasion.
- Three patients told us they often used the service and found the system repetitive and inconvenient because they were asked about the eligibility criteria each time they made a booking.
- The control room staff told us the electronic patient booking system did not identify a patient's history of using the service. The eligibility assessments were carried out for each booking so that a patient's needs could be assessed in real time and were specific to each booking.
- Patients could book routine journeys between 8am and 6pm, Monday to Friday, excluding bank holidays.
- PTS for haemodialysis patients were available up until 7.30pm with collection after appointments up to 1am, Monday to Saturday, including bank holidays.
- Transport was available for cancer patients from Monday to Friday, including bank holidays.
- The staff at Westmoreland and Furness Hospitals told us they had difficulties getting access to the trust's routine PTS during the evenings and at weekends.
- The risk to patients was minimised because the hospital staff were able to arrange alternative transport for patients by using a private ambulance contractor.
- The general manager for PTS in the area said they were aware of these concerns and had plans to install an extra patient transport ambulance for Furness Hospital to operate after 5pm.
- We did not observe any issues relating to patient delays during our inspection.
- Patients we spoke with at Preston Royal Hospital told us they did not experience long waits and rarely waited longer than one hour following their appointment.
- Patients at Furness Hospital told us they sometimes waited up to 4 hours for collection after their appointment.
- Ambulance staff told us that collection times were planned in advance for morning and afternoon collection slots across Cumbria to make efficient use of resources.
- This meant that some patients who had an appointment early in the morning or early in the afternoon might need to wait longer for collection.
- The trust target for the journey time a patient would spend on the vehicle was within 60 minutes on 80% of occasions. Trust data showed that the local teams consistently achieved this target between July 2013 and June 2014.
- The target for journey times for patients having haemodialysis or cancer treatment was within 40 minutes on 85% of occasions. Trust data showed that local teams consistently failed to achieve this target every month between July 2013 and June 2014.
- The Lancashire teams kept journey times below 40 minutes between 63% and 76% of occasions, and the Cumbria teams between 73% and 76% of occasions during the 12-month period.
- Ambulance staff told us they were not always able to meet the target for journey times because of the rural locality of some of the patients who used the service. They told us they were able to plan for longer journeys to ensure that patients' toileting and hydration needs were met.

Consent & Mental Capacity Act

- Staff received mandatory training in mental health awareness. Ambulance staff we spoke with understood the legal requirements of the Mental Capacity Act 2005.
- Ambulance staff were able to describe how patient consent was sought verbally during planned journeys, such as when assisting patients who were not able to move independently.

Patient transport services

- As part of the booking process, the control room staff identified patients who lacked the capacity to make their own decisions or had been sectioned under the Mental Health Act. When this was the case, the patients were accompanied by their own representatives or other health professionals.
- Staff told us there had been occasions when a patient with a mental health condition, such as dementia, had not been accompanied by a carer. When this happened, they ensured that two members of staff were present in the vehicle to observe the patient at all times, and to minimise the risks to staff and other patients.
- Staff told us they would also sometimes plan a single patient journey to minimise identified risks to other patients.
- Ambulance staff carried out mental capacity assessments to identify if a patient had the capacity to consent in specific circumstances, such as when refusing oxygen.

Learning from complaints and concerns

- The trust had produced 'Making experiences count' leaflets that gave information on how to make complaints. However, we found that only some of the PTS ambulance vehicles we inspected held stocks of these.
- Information on making complaints was neither visibly displayed nor readily available in the ambulance vehicles we inspected.
- Patients told us that, if they wanted to make a complaint, they would speak with the ambulance staff.
- The ambulance staff told us that, if a patient wanted to make a complaint, they would give them the contact details of the trust..
- There was a centralised team, the 'making experiences count' team that managed complaints. Trust data showed that there had been 289 complaints across the whole PTS, and that 231 of these (79.9%) had been categorised as relating to arrival and collection times.
- The trust's performance targets were to acknowledge 95% of complaints within 1 working day and to resolve 80% of them within 40 working days.
- Trust data between July 2013 and June 2014 showed that responses to complaints about the Cumbria and Lancashire PTS did not always achieve this 40-day target.
- The trust's patient experience annual report 2013/14 included an analysis of complaints about the PTS and listed actions to address the key concerns identified.
- For 2013/14 the PTS generated 47.3% of the complaints against the trust. Evidence we were given by the trust indicated that 82% of those complaints related to arrival and collection times and that Lancashire accounted for 17.2% of that figure.

Cheshire and Merseyside

We observed the control centre for the patient transport service and how the staff used the eligibility criteria to ensure that people who needed the service had access to it and that their specific needs were identified, such as learning disability or dementia. We were told that the transport service contract required the service to survey 1% of users each year to understand the experience of patients. In response to these surveys, The trust had published the priorities for the current year. These included more education on the eligibility assessment, and a marketing and awareness campaign.

Managers told us that they had invested in the introduction of mobile data terminals to vehicles. This had improved planning and communication, and contributed to improved performance.

Staff told us, and we observed that individual needs were taken into account when planning transport, such as a dialysis patient needing an early appointment or a cancer patient needing a stretcher to attend a hospital appointment.

We did not see any literature in large format for visually impaired patients or in different languages for people whose first language was not English.

Most patients we spoke with raised the issue of eligibility and the 10 questions they had to answer every time to prove they were eligible for transport. We found there appeared to be some confusion between responding to individual needs and applying the eligibility criteria because, for example, some people either under- or over-estimated their mobility problems.

The trust gained feedback from patients and their representatives through complaints data, focus groups with community organisations and public engagement events from which feedback had been collated.

Patient transport services

Service planning and delivery to meet the needs of local people

- The senior managers outlined how the service contract had been developed to respond to the needs of the local population. We were told that the trust had worked with patient groups such as haemodialysis and cancer patients to help influence the delivery of patient transport services.
- Staff told us, and we observed that individual needs were taken into account when planning transport, such as a dialysis patient needing an early appointment or a cancer patient needing a stretcher to attend a hospital appointment.
- We observed that the needs of patients were considered and that, although a ward had booked a journey for a single person, the crew had checked and the patient had required a stretcher.
- One patient reported that they had had 10 trips with the service between centres and on each occasion there had been little coordination about appointment times. Another told us that they had been away from their home for over 3 hours just for a 10-minute appointment.
- The eligibility checklist mentions the ability to walk but one person told us that the staff had not checked whether or not they could manage stairs. The service needs to ensure that they maintain current records to meet the individual needs of patients using the service.
- Specific transport was available for bariatric patients (patients living with obesity) by another provider to ensure that the patient's individual needs were met.
- In line with the service contract, journeys were clearly planned to reduce the amount of travel time in an ambulance and took account for a patient's hydration, feeding and toileting needs. We found that water was available in the vehicles if patients were thirsty.
- Staff told us they were not always able to meet the target for journey times because of the distance that some patients had to travel for their appointments.
- Some patients were unsure why they had to ring on a weekly basis for a planned series of appointments when there was no change in their condition, and then have to answer the same eligibility questions.
- Staff we spoke with in the control centre said that often older patients found it difficult to answer the eligibility questions over the phone. We were told that people could ring the local clinical commissioning group if they had been declined patient transport services. Staff reported that, if the clinical commissioning group thought someone was eligible, they would over-rule the transport service, and this had happened regularly.
- Staff we spoke with at two local hospital trusts said that standard patient transport was no longer booked by health professionals and that it was sometimes difficult for older people to access support to phone for an appointment. We found there appeared to be some confusion between responding to individual needs and applying the eligibility criteria because, for example, some people either under- or over-estimated their mobility problems.
- Staff told us about the new mobile data devices that contained up-to-date details of patients requiring transport. Any specific individual needs of patients could be identified though that system.
- There was potential for staff to be unable to communicate effectively with some patients as we did not see any literature in large format for visually impaired patients or in different languages for people whose first language was not English.

Access and flow

- We spoke with and observed the planning department at the Chester control centre and were shown how they planned the next day's activity. The service also had dispatch and control at this site to facilitate responsive working. We spoke with the planning team who told us that they only planned for the next day.
- We observed the control centre for the patient transport service and how the staff used the eligibility criteria to ensure that people who needed the service had access to it and that their specific needs were identified, such as learning disability or dementia. This allowed the service to plan and deliver patient transport journeys appropriately. The planners told us that they tried to allocate the vehicles that were manned by two members of staff for patients with higher dependency.
- The managers told us they had invested in the introduction of mobile data terminals to vehicles. This had improved planning and communication, and contributed to improved performance.
- The service accommodated appointments for patients between the hours of 8am and 6pm Monday to Friday, excluding bank holidays except for cancer patients.

Patient transport was also available for haemodialysis patients who had appointments from 7am to 7pm and needed to be collected up to 1am, including bank holidays Monday to Saturday.

- On the day of our visit, the control information system had gone down and staff had to divert calls to the other control centre near Preston. Staff did not have an alternative paper system in place. Staff reported that this had happened several times this year. The lack of clear business continuity plans may have an impact on the trust's ability to provide a responsive service.
- Clear targets were in place for the provider to comply with the contract. The key performance indicators were arrival to appointment time no more than 45 minutes before or 15 minutes after an appointment, and time spent on a vehicle to be no more than 60 minutes.
- All the managers we spoke with acknowledged the challenges of meeting the contract targets, improving access to the control centre and ensuring that patients arrived for their appointments within the identified 60-minute time window. The service was still missing its 90% target for arrival by 5%.

Learning from complaints and concerns

- Between April 2013 and March 2014, the trust reported receiving a total of 2078 complaints, 508 general enquiries (including comments) and 1073 compliments. The trust triaged complaints using a risk score that ranged from minimum to serious; 79.6% (1654) of the complaints were scored as minor or minimum risk.
- In 2013/14, the patient transport service generated 47.3% of the complaints against the trust. Evidence we were given from the provider highlighted that 82% of the complaints had been categorised as patient transport. Cheshire and Merseyside had 13% of the complaints compared with Lancashire, which had 17.2%.
- Patients we spoke with told us that if they wanted to make a complaint they would speak with the transport service ambulance staff. Staff told us that if a patient wanted to raise a complaint they would be supported to do so and given contact details for the complaints team.
- We were told that all complaints were managed by the Making Experiences Count team. The trust had produced 'Making experiences count' leaflets that provided information on how to raise complaints with the trust. We did not find any of these leaflets in the vehicles we inspected or at the local hospitals we visited.
- We did find copies of the PTS transport service description on the trust's dedicated transport service website. However, we did not find copies of either this or the transport service fact sheet at any of the hospitals we visited. However, we saw that one hospital trust had compiled its own leaflet for patients to explain the new transport service contract.
- In The trust's annual report on patient experience, the main areas of concern were about delays in arriving and leaving hospital, transport not arriving and the patient eligibility criteria for the transport service. From the lessons learned from complaints, the service had tried to improve records to ensure accurate notes for all patient journeys.
- The trust's performance targets were to acknowledge 95% of complaints within 1 working day and to resolve 80% of complaints within 40 working days. The Cheshire and Merseyside performance review meetings found that in August 2014 Cheshire and Merseyside had four complaints unresolved over the target response time and the control centre had seven.
- The 2013/14 Quality Account published by the trust showed examples of areas of improvement that had been identified following complaints. Improvements had been made to the processes for handling queries about the eligibility criteria and for raising awareness of the importance of robust patient notes.
- Further to individual patient assessments, transport arrangements for categories (for example, patients not suitable for taxis, patients who should travel in the front of cars), mobility assessments and bespoke contracted provider transport had been put in place to ensure that patients received the correct transport for their specific needs.

Are patient transport services well-led?

Cumbria and Lancashire

The trust's quality strategy 2011 to 2015 included key objectives to be met if Patient Transport Services (PTS) was to deliver the right care at the right time. These objectives had been incorporated across the service into measurable performance targets, such as measuring patient arrival and collection times as part of the 'right time' objective.

Key issues, such as performance against targets, audit findings, organisational issues and the PTS risk register,

were reviewed at the PTS business group meetings that took place every two months. During the inspection, we looked at the PTS risk register and saw that key risks had been identified and assessed.

There were clearly defined leadership roles across Cumbria and Lancashire. Teams in each ambulance station had separate reporting structures and worked independently of the emergency ambulance teams.

The ambulance stations we inspected had noticeboards with information about performance data, policy updates for staff to read. The trust collated performance data on a daily basis, and weekly and monthly reports were sent to PTS staff across the Cumbria and Lancashire teams.

From July 2014, 32% of Lancashire PTS staff had had an appraisal within the last 12 months, but only 4% of PTS staff in Cumbria had received an appraisal in the last 12 months.

There was a positive culture of reporting incidents and safeguarding concerns. However, the staff we spoke with were unable to describe how learning from incidents was shared to aid learning and improve the service. Ambulance staff told us they received good support from their team leaders but felt disengaged from the wider organisation.

The head and the general manager of PTS in Cumbria and Lancashire told us that the service was sustainable in the future because they had a stable workforce and an ambulance fleet that was less than seven years old.

Vision and strategy for this service

- The trust's vision, to 'deliver the right care, at the right time and in the right place', was visible in all the ambulance stations we inspected.
- Staff we spoke with knew what the trust vision was.
- The trust's quality strategy 2011 to 2015 included key objectives to be met if Patient Transport Services (PTS) was to deliver the right care at the right time.
- These objectives had been incorporated across the service into measurable performance targets, such as measuring patient arrival and collection times as part of the 'right time' objective.
- The trust did not have a formal documented strategy specifically for PTS.
- The head and general manager for PTS in Cumbria and Lancashire had identified what the key challenges to the service were in relation to patients' requirements and expectations, the marketplace, competition and organisational culture.
- They had also identified potential solutions to address these challenges, and how doing so would benefit the service.
- However, this information had not been formally documented and there were no timelines in place for implementing the proposed solutions.

Governance, risk management and quality measurement

- There was a governance system in place that allowed risks to be reviewed and escalated to directorate or trust board level.
- Key issues, such as performance against targets, audit findings, organisational issues and the PTS risk register, were reviewed at the PTS business group meetings that took place every two months.
- During the inspection, we looked at the PTS risk register and saw that key risks had been identified and assessed. These included staff sickness, control room staff morale, meeting vehicle cleanliness standards and failure to meet performance targets.
- We saw that routine audit and monitoring of key processes took place within PTS to monitor performance against quality and performance objectives.
- Ambulance staff we spoke with had limited knowledge of either the risk register or audit findings.
- The head of the service acknowledged that the trust needed to strengthen how key risks were shared with staff across the Lancashire and Cumbria teams.

Leadership of service

- PTS were incorporated into the finance directorate. The head of the service told us this was because the trust recognised the commercial and competitive aspects of the service.
- There were clearly defined leadership roles across Cumbria and Lancashire.
- Teams in each ambulance station had separate reporting structures and worked independently of the emergency ambulance teams.
- Staff told us they understood the reporting structures clearly, and that the first point of contact for any day to

day issues was the team leader. If they were unable to contact them, they notified the control room staff who would arrange for the next most appropriate person(s) to provide support.
- Ambulance staff told us they were in regular contact with their team leaders and received good support from them. They said the team leaders kept them up to date on issues that could affect the delivery of care, such as those relating to vehicles or staffing.
- The ambulance stations we inspected had noticeboards with information about performance data, policy updates for staff to read.
- The trust collated performance data on a daily basis, and weekly and monthly reports were sent to PTS staff across the Cumbria and Lancashire teams.
- Ambulance staff told us they were kept up to date with performance information, and that their team leader would regularly engage with them if performance fell below expected targets.
- From July 2014, 32% of Lancashire PTS staff had had an appraisal within the last 12 months, but only 4% of PTS staff in Cumbria had received an appraisal in the last 12 months. This meant that most staff were not being supported with their career progression or personal development needs.

Culture within the service

- Most staff we spoke with were motivated, proud and positive about their work.
- There was a positive culture of reporting incidents and safeguarding concerns. However, the staff we spoke with were unable to describe how learning from incidents was shared to aid learning and improve the service.
- Staff told us they were focused on meeting patients' needs and ensuring that patients received good care.
- There was a considerable focus on delivering performance targets, and staff performance against targets was monitored daily.
- Trust data from July 2013 to June 2014 showed that sickness levels for PTS staff in Cumbria ranged from 4.17% to 14.67%, with sickness levels above 10% between December 2013 and February 2014. Most staff on sick leave were on long term sickness absence.
- The general manager told us the trust had recently updated the staff sickness policy. This meant they now monitored staff sickness levels on a routine basis to minimise the impact on service delivery and to identify individuals who may be abusing the trust's sickness policy.

Public engagement

- The trust gained feedback from patients and their representatives through complaints data, survey questionnaires, focus groups with community organisations and public engagement events.
- The trust's patient experience annual report 2013/14 showed that 1,572 postal surveys were completed by patients who had used the service, and a further 470 surveys were returned from hospital-based ambulance liaison assistants who handed out surveys to patients in hospitals.
- Most patient responses were positive when asked about key areas, such as politeness by call-handling staff; privacy, dignity and compassion; patient safety; and whether patients were made aware of their arrival and collection times.
- The annual report showed that complaints and patient feedback data relating to the PTS had been analysed to look for improvements that could be made to the service.
- The trust had identified remedial actions to address key concerns highlighted from complaints and patient feedback. These included actions to increase patient awareness of PTS information leaflets and the patient charter; and those to address hospital staff's difficulties with the booking system, long waiting times after patients' appointments and issues such as the incorrect transport being provided.

Staff engagement

- Ambulance staff told us they received good support from their team leaders but felt disengaged from the wider organisation.
- They told us they had limited communication with any managers above team leader level, and limited contact and little direct communication with senior managers or trust executives.
- Ambulance teams across Cumbria and Lancashire did not routinely have team meetings.
- The staff we spoke with told us that ad hoc meetings within their teams had taken place but these were infrequent and not documented.

Patient transport services

- The trust was in the process of conducting focus groups, facilitated by external consultants, to discuss key issues such as culture, leadership and ways of working with PTS staff in Cumbria and Lancashire.

Innovation, improvement and sustainability

- PTS in Cumbria and Lancashire were not involved in any clinical studies or research and development activities at the time of our inspection. However, there were a number of ongoing projects to improve the service.
- The trust had introduced 'time window planning'. This gave staff a flexible 45 minute time window in which patients needed to be delivered in order to achieve performance targets. The head of the service told us this gave staff a visual prompt that made them more aware and had led to an improvement in performance.
- A report from the director of finance dated June 2014 highlighted that the service was overspending, and that extra funding was needed to maintain performance against delivery targets.
- The trust was contracted to provide PTS in Cumbria and Lancashire until April 2016, after which it would undergo a re-tendering process.
- The head and the general manager of PTS in Cumbria and Lancashire told us they needed to be both competitive against other service providers and financially viable in order to retain the contract after 2016.
- They told us that the service was sustainable in the future because they had a stable workforce and an ambulance fleet that was less than seven years old.
- They said they aimed to reduce costs through better planning and usage, such as reducing the use of taxis to transport patients in Lancashire and increasing the use of volunteer drivers.

Cheshire and Merseyside

The trust vision was available on each computer desktop and on literature in ambulance stations we visited as part of the inspection**:** "We aim to deliver a high quality service to patients by ensuring we deliver the right care, at the right time at the right place."

The trust monitored quality and safety through a set of clinical safety indicators, such as safeguarding services, infection prevention and control, medicines management and clinical risk.

Staff we spoke with were not always aware of the risk register, recent serious incidents or other quality indicators such as the number of complaints received. The lack of learning and feedback to the staff may have had an impact on the ability of The trust to be a learning organisation. The weekly performance review record from 12 August indicated that in Cheshire 59% of staff had completed a Knowledge and Skills Framework (KSF) interview and 89% in Merseyside. In Cheshire, nearly all staff had completed mandatory training but in Merseyside only 89%.

We did not see any evidence of a project plan or timelines for the delivery and implementation of a transport service strategy. We found that there appeared to be a disconnect in communication and understanding of key issues between managers and staff across the transport service. During discussions, the Head of Patient Transport Services acknowledged the challenges of working in such a huge geographical area and the need to increase the visibility of the senior management team.

Most staff at the control centre felt under pressure, and morale was low. Transport service crew staff also told us that they felt unsure and anxious for the future of the service and that they were less patient focused since the new contract had come into force.

Staff sickness rates were consistently above the England average of just above 6% between April 2013 and December 2013, and at the time of our inspection the rate was 14%.

Vision and strategy for this service

- The trust vision was available on each computer desktop and on literature in ambulance stations we visited as part of the inspection. "We aim to deliver a high quality service to patients by ensuring we deliver the right care, at the right time at the right place." However, when we asked people to explain the icons on the computer, not all of them had been able to do so. Staff we spoke with were unclear about the overall vision but understood there had been changes and a new transport service contract.
- In the 2013/14 Quality Account, The trust had proposed areas for development to help embed the vision for the trust. This included improving the experience for transport patients and establishing a transport service quality improvement team.

Patient transport services

- The service had had clear strategy objectives from 2011 to 2015, which it had translated into key performance targets for the patient transport service. The targets included arriving within a 60-minute window and reducing time spent in a vehicle. These targets aligned to the trust vision for "right care, right time". The trust's core objectives were focused on patient safety, clinical effectiveness and patient-centred care, and were displayed on noticeboards in ambulance stations.
- We met with the Head of Patient Transport Services and a general manager for the service who both outlined a draft strategy for the service. The Head of Patient Transport Services acknowledged that the strategy needed to be formalised and communicated to all staff. The draft strategy clearly identified the challenges to the service in relation to patient needs and expectations alongside business priorities and competition. We did not see any evidence of a project plan or timelines for the delivery of the final strategy and implementation of a transport service strategy.

Governance, risk management and quality measurement

- The trust monitored quality and safety through a set of clinical safety indicators, such as safeguarding services, infection prevention and control, medicines management and clinical risk.
- We were shown a copy of the transport service's quality assurance framework 2014/15.The framework outlined the management and governance arrangements applied by the trust to ensure the correct use of subcontractors or third parties in supporting delivery of the transport service contracts. The core issues included agreements on patient dignity, safeguarding, transportation of patients' possessions and other equipment, cleanliness and equipment, health and safety, and insurance. Transport service senior team leaders undertook infection prevention and control audits of third-party ambulances at least annually.
- The trust Patient Transport Service Quality Business Group was established in May 2013 to obtain assurance on all aspects of the service's performance dashboard. The contract was also monitored closely by the management team and at operational delivery level.
- In 2013/14 an external auditor reviewed the trust's safeguarding processes and found that the patient transport service made a lower number of referrals than expected. The trust acted on the findings of this review by developing an action plan to increase safeguarding awareness and facilitate referrals.
- Staff we spoke with were not always aware of the risk register, recent serious incidents or other quality indicators such as number of complaints received. Staff told us that a senior manager completed the updates to the risk register but they could not tell us what the top risks to the service were. The lack of learning and feedback to the staff may have had an impact on the ability of the provider to be a learning organisation.

Leadership of service

- There were clearly defined and visible leadership roles within the patient transport service. The service was incorporated into the finance directorate. The staff were well led locally by the senior staff at the stations and worked well together with good communication between all grades of staff. However, a number of front-line staff felt that there was little recognition from trust senior management.
- Most PTS staff we spoke with felt well supported by their immediate supervisor. However, we found that most staff we spoke with across the service felt that they were not supported by senior managers within the management structure. Four people we spoke with did not know the name of the Chief Executive Officer.
- We found that there appeared to be a disconnect between managers and staff across the transport service. During discussions, the Head of Patient Transport Services acknowledged the challenges of working in such a huge geographical area and the need to increase the visibility of the senior management team.
- Several people told us that they had not had feedback when they had reported issues and one person said, "Things never get done and no one will make a decision." Another said, "They are only interested in targets now."
- The service had clear processes for reporting contract performance data on a daily, weekly and monthly basis. Staff confirmed that they were kept up to date with performance against the contract targets and discussions with team leaders took place about how to improve target times.
- Most staff in the control centre at Chester told us their morale was very low because of their excessive

workload and pressure to delivery against the contract. Staff told us that they did not have regular team meetings and felt unable to provide a quality standard of care (for example, to an elderly caller when they had to finish the call within a set timescale). They told us they had tried to express their concerns to management but felt they were not listened to. We reported these concerns to the service manager who was aware that a meeting had been requested but then cancelled.

- The ambulance stations and offices we visited had noticeboards with information such as performance data and policy updates. The standard of information was inconsistent. For example, in two locations we found out-of-date memos going back 4 years with out-of-date information and procedures.

Culture within the service

- All the staff we spoke with were positive about the care they provided and proud of the quality of care. They felt well supported by immediate colleagues and supervisors. However, staff reported feelings of stress and anxiety about the current workload, and uncertainty about the future of the service.
- Transport service crew staff told us that they felt unsure and anxious for the future of the service, and that they were less patient focussed since the new contract had come into force. Staff described hanging around waiting to transport patients and felt that they were not part of the wider trust organisation.
- Staff said that they tried to report incidents and concerns but did not get feedback; there was no formal process for learning from issues raised. They felt the only focus was on meeting targets and that the monitoring of staff performance against the targets was intense and at times overwhelming.
- We were told that sickness levels were monitored routinely to minimise the impact on service delivery. We noted that several staff reported to us that they had experienced stress from work in the past 12 months.
- The trust was rated as worse than expected or tending towards worse than expected for 8 of the 28 NHS 2013 Staff Survey key findings. These included working extra hours, staff appraisals within the past 12 months and staff experiencing harassment, bullying or abuse from patients, relatives or the public in the past 12 months.
- The trust carried out annual staff appraisals using the KSF. The weekly performance review record from 12 August 2014 indicated that in Cheshire 59% had completed a KSF interview and 89% in Merseyside. In Cheshire, nearly all staff had completed mandatory training but in Merseyside only 89%.
- The transport service ambulance teams across Cheshire and Merseyside did not routinely have team meetings. We did see copies of a weekly regional bulletin. The staff we spoke with told us that ad hoc meetings within their teams had taken place but these were infrequent and not documented. This meant that transport service ambulance staff may not have received information in a consistent and structured manner.

Public Engagement

- We were told that the transport service contract required the service to survey 1% of users each year to understand the experience of patients. The survey was undertaken with patients who had used the transport service or attended outpatient or hospital appointments throughout the area. The trust's patient experience annual report 2013/14 showed that 1,572 postal surveys were completed by patients who used the service .The trust had used hospital-based ambulance liaison assistants to hand out surveys to patients in hospitals, although we noted that not all hospitals had a liaison assistant..
- Staff told us that they used to have liaison meetings but that they had not had contact with the provider for up to 12 months.
- The trust had appointed a clinical quality and innovation (CQUIN)-funded role of Health Watch Engagement Manager to improve their public engagement profile and drive service improvements.
- The trust used a range of methodologies to engage with people regarding their services. This included one-to-one interviews, focus groups, use of patient stories and a patient experience board game.
- The trust's webpage on NHS Choices had reviews with a total ranking of 4 out of 5 stars.
- The trust held focus groups for specific patient groups who used the patient transport service regularly, such as those undergoing haemodialysis or cancer treatment.

Staff Engagement

- The trust received feedback from staff through the incident-reporting system and a web-based platform called 'Talk to Us'.

Patient transport services

- We were told that managers held regular staff forums at different ambulance stations but that they were often poorly attended. Staff told us that there were very few face-to-face meetings and any meetings had to be attended in their own time. Many staff told us that, other than by union representatives, there was little engagement with the trust managers. However, some staff members told us that they had attended meetings in Bolton to discuss the implementation of the new mobile devices; they said this had been very useful and they had felt engaged in the project.
- The lack of supervision and regular one-to-one meetings with supervisors limited the engagement opportunities for staff to have with managers.
- We were told that only 90% of staff had access to email and staff told us that as they could no longer use their home computer it had been difficult to access emails in work as there weren't sufficient terminals in the stations for staff to access emails and ensure that they received updates in a timely manner. We raised this with the executive team at the end of the inspection and had confirmation that this had been resolved however staff were not aware.

Innovation, improvement and sustainability

- The trust had introduced new technologies and we were told that crews were now using mobile devices for the management of information.
- The trust had piloted the use of text reminders for appointments and was looking to develop the use of mobile phone technology for seeking patients' views and improving service delivery.
- We discussed with the Head of Patient Transport Services and a general manager for the service the future sustainability of the service and the need to ensure that The trust was able to retain the contract for patient transport services when it came up for renewal in 2016. They told us they aimed to reduce costs through better planning and usage, such as the more effective use of resources and application of the eligibility criteria.
- A report from the Director of Finance dated June 2014 highlighted that the service was overspending and that additional funding was needed to maintain performance against delivery targets. This financial risk was also on the service risk register.

Access to the service

Information about the service

Cumbria and Lancashire

The North West Ambulance Service has an emergency operations centre in Cumbria and Lancashire, which is located at Broughton, near Preston. There is also a support team based at Carlisle, which takes internal calls and referrals, including safeguarding referrals from crews and staff sickness calls.

The emergency operations centre receives all 999 calls for Cumbria and Lancashire, triages and handles these calls and dispatches vehicles and crews to patients.

The centre uses a call triaging system called the 'advanced medical priority dispatch system' (known as AMPDS), which is used by about 50% of ambulance services nationally.

Greater Manchester

Greater Manchester is an area covered by the trust and is led by the Head of Services. The area is divided into four sectors central, south, east and west. Each sector has a sector manager with a management reporting structure and clinical reporting structure in operation. Our inspection covered the whole of Greater Manchester.

The emergency operations centre is based at Parkway. It receives all 999 calls for the area, triages and handles these calls and dispatches vehicles and crews to patients. It has an urgent care desk where Senior Paramedics perform secondary triage and offer information about alternative care services that maybe required instead of an ambulance.

The centre uses a call triaging system called the 'advanced medical priority dispatch system' (known as AMPDS), which is used by about 50% of ambulance services nationally.

Cheshire and Merseyside

The trust handled emergency 999 calls via the Emergency Operations Centre (EOC) call centre at Elm House, Liverpool. This was one of three call centres which were linked so that if one call centre was fully at capacity a call would be re-routed to the other two to pick up. The trust also operated a system for healthcare professionals (HCPs), such as doctors, nurses, approved social workers, approved mental health workers, midwives, or dentists, to book transport through designated telephone numbers and referral forms.

All calls were triaged and coded under the advanced medical priority dispatch (AMPDS) system.

The initial response was determined by the needs of the patient. This could be despatch of a rapid response vehicle operated by a paramedic or an emergency ambulance or both.

Patients not requiring an emergency response would be booked onto the patient transport service. Patients typically included those transferred from one hospital to another for specialist treatment (for example, for heart attack, paediatrics, trauma or burns). Sometimes, patients were transferred for non-clinical reasons (for example, when a hospital did not have an appropriate bed available). The transport vehicle used depended on the patient's needs. For example, some independently mobile patients were transferred by taxi, whereas critical care patients were transferred with more equipment and highly qualified staff.

Access to the service

Summary of findings

Cumbria and Lancashire

Staff in the trust's Emergency Operations Centre in Broughton were proud to work for an ambulance service. The systems that call handlers and dispatchers used made sure that patient safety was a priority and that they maintained accurate and detailed records. Staff had received appropriate training and most staff felt confident they had been supported to gain the competencies for the role.

However, many call handling staff did not feel listened to or engaged by managers, and minutes of meetings showed that staff suggestions were not responded to or acted upon in a timely manner.

Systems and processes supported the responsive deployment of emergency vehicles and coordination with other emergency services.

Call handlers were compassionate, reassuring and gave people appropriate support and information.

While call handlers at one of the trust's other operations centres had regular input from clinicians, call handlers at Broughton did not. Non-clinical staff re-triaged calls with competing priorities.

Individual audit data for call handling staff was not available to support the effective performance management and development of staff.

Greater Manchester

The emergency operations centre was well-led, effective, responsive, and provided a caring and safe service to people accessing the service. The practices and environment at Parkway, Manchester enabled staff to provide access to the service.

Systems, processes and practices were used to keep people safe and safe from abuse. Staff learned when things went wrong and took steps to improve. Staff assessed and monitored safety in real time, reacting to changes in risk levels for individuals. Staff anticipated potential risks and planned for them in advance, working with a range of other providers to keep people safe.

The service was effective in ensuring people with healthcare needs could access the service. Staff used a internationally approved call triage system called the 'advanced medical priority dispatch system' (known as AMPDS) to triage the high volume of people attempting to access the service. Staff worked well with other emergency services and health and social care providers to ensure people's health and social care needs were met.

We saw several examples of call handlers and paramedics based at the emergency operations centre talking with people compassionately. They listened carefully to the patients details and asked clear questions to gather more information to ensure the right action was taken, whether that was an ambulance or a telephone conversation with another healthcare professional.

There were clear escalation protocols in place for increasing levels of demand. All staff were well equipped to provide care for people in consideration of their needs. Screens were visible to staff to make them aware of the demands on the service and the flow.

Staff were proud of their roles and felt supported and well-led. Their health and well-being was considered and there was a 'no blame' culture within the team.

Cheshire and Merseyside

The concept of safety was embedded into clinical practice throughout the service. There were systems, processes and practices in place to keep people safe from abuse.

Access to the service

Is access to the service safe?

Cumbria and Lancashire

It had been recognised in departmental minutes that not all staff in the operations centre were routinely reporting incidents. However, learning from incidents that had been reported was shared.

The triage system that call handlers used made sure that patient safety was paramount, that an appropriate vehicle was dispatched in response to calls, and that the service was able to appropriately respond to support patients whose condition deteriorated.

Staff had a good awareness of how to make sure that vulnerable patients were safeguarded and there was a dedicated team in Carlisle that made sure all safeguarding referrals were appropriately made.

There were contingency plans to manage the demand on the call centre such as support for taking calls from other operations centres and an urgent disconnect policy which enabled staff to prioritise urgent calls and drop non-urgent calls. However, there was confusion as to how this policy worked in practice and how it should be implemented.

Unlike the trust's operations centre at Manchester, the call handlers did not access clinical advice when responding to calls.

Incidents

Staff in the emergency operations centre were not routinely reporting incidents.

We asked staff if they were able to report an incident; they told us that they were, but that they usually deferred to the road crews to do so.

The triage system the centre used sent a vehicle for every call, and so a crew on the road would always attend the patient.

Minutes from a recent sector partnership meeting in May 2014 acknowledged that more work needed to be done to encourage operations centre staff to raise incident report forms. However, the minutes also reflected an increase in incidents being raised by staff who had experienced verbal abuse from callers.

Staff received feedback from incidents in bulletins, and all call handlers were asked to sign to say they had seen this information.

Cleanliness, infection control and hygiene

Staff raised concerns about the cleanliness of the environment they worked in, but during our inspection the operations centre was visibly clean and stations were kept clean and tidy.

No hand gels were readily available for staff at the operations centre in Broughton.

Environment and equipment

Equipment was appropriate for the centre's function and adequately maintained.

Minutes from a sector partnership meeting in May 2014 showed that maintenance and repairs were being discussed and generally acted on, as and when issues were highlighted.

A member of the dispatch staff reported that there were loose wires in the operations centre, and that this was a potential health and safety concern. We saw that this had been reported to the appropriate department for their attention.

Medicines

The service uses a triage system known as the 'advanced medical priority dispatch system' (AMPDS).

The way AMPDS guides call-handling staff means that they do not give advice to callers about giving medicines or injections in any circumstances.

Call handlers and dispatchers in the Broughton operations centre did not seek clinical input, and operations staff did not access clinical advice when triaging calls.

If a caller asked staff whether they could still take a certain medicine, a call handler would not be clinically trained or supported to advise.

The trust has an urgent care desk in Manchester. This is run by clinical operations staff and the call handlers in the operations centre can use instant messaging or call these clinicians for advice. There was no similar communication channel being used by staff in the Lancashire and Cumbria operations centre for clinical support.

Access to the service

Records
We observed that staff taking calls made accurate and complete records, making sure they obtained all the necessary information for colleagues in dispatch and on the road.

Team leaders and duty managers produced detailed shift summaries.

AMPDS, which sits alongside the computer-aided dispatch system known as 'C3', provides prompts for call handlers to ask the relevant questions and record the necessary information.

Safeguarding
Operations centre staff told us that they did not routinely make safeguarding referrals, but instead would rely on the road crews to do this.

We visited the support centre in Carlisle that had a team dedicated to receiving and handling safeguarding referrals from operations centre staff in Cumbria and Lancashire.

This support team took information from colleagues, including over the telephone from front-line staff, recorded it, and made the appropriate referrals to local authorities and other relevant agencies.

Operations centre staff contacted the team appropriately and we saw that the support centre appropriately discharged its, and the trust's responsibility to ensure that patients and others were safeguarded.

Mandatory training
Operations centre staff told us that they were up to date with their mandatory training.

The trust gave staff 5 days' mandatory training every 2 years.

This training had been delivered by the trust for slightly over 85% of its staff that worked in emergency services in Cumbria & Lancashire, 88% of patient transport services staff in Lancashire and 51% of patient transport services staff in Cumbria.

Assessing and responding to patient risk
Patient calls were initially triaged through a series of standard questions. Access to the service was prioritised, with the call handler providing advice and reassurance as necessary until an ambulance arrived.

The trust provided a service to healthcare professionals when they needed an ambulance for their patients. This provision, known as 'clinically required' services, included carrying out high dependency and intensive care transfers between hospitals. It also included the urgent transfer of patients to hospital on the request of a healthcare professional such as a doctor, nurse or midwife.

To ensure that patients were transferred safely and appropriately, the trust had published details of the process on its website. It had also given the relevant professionals information on how to access the services and the assessment criteria.

We observed Cumbria and Lancashire operations centre staff receiving and assessing requests from GPs for their patients.

Staff dealt with these calls courteously and worked through the prescribed process to determine the most appropriate response; this included agreeing the level of urgency with the GP.

Flags were placed on addresses to highlight identified risks (for example, to highlight issues relating to access, specific risks to the patient or risks to ambulance service staff).

The use of AMPDS meant that many of the risks to patients were mitigated because the operations centre always dispatched a crew to the caller.

We observed a call involving a patient whose condition had deteriorated before the rapid response crew reached them; the crew was able to assess the patient's change in condition and the associated risks, and then immediately call on a paramedic crew to help.

Ambulance service staff grade calls into categories to denote their priority, and there are target times for the responding attached to each category of call.

Often, various categories of call will be in the queue waiting for crews to be dispatched to them.

At Manchester Parkway emergency operations centre, there was clinical support available to assess and re-prioritise calls as necessary. If there were two calls with the same level of priority and only one available vehicle, a clinical member of staff would use their judgement to re-prioritise one call over the other.

Access to the service

In the Cumbria and Lancashire operations centre, this clinical support was not available and a non-clinical operations staff member was re-prioritising calls with the same level of priority.

This person was known as a critical incident manager and the trust had a policy to outline and support their role.

Staffing

Staffing numbers were sufficient to manage the demand for response to calls made to the emergency operations centre.

A team at the centre, known as the 'Purple Team', was without a dedicated supervisor and was therefore sharing a supervisor with another team. The service had plans to appoint to the post.

Each day staff could choose the time they would take their breaks by booking slots when they came on shift.

We saw that shift leaders ensured that staff left their workstations and took their planned breaks when they were due.

Planning for variation in demand

The service used a virtual telephony system that could route calls to other operations centres when demand was unmanageable. On an unannounced inspection on a Friday evening, we visited a team in Manchester Parkway operations centre that was under-staffed for that shift. The team at Broughton was making calls to people that required call backs for the Manchester team, to help meet the demand.

The system is designed to route calls to any of the three operations centres when demand was high to help with downtime.

Call handlers can also invoke an urgent disconnect policy when non-life-threatening calls and high-priority calls queue up. This enables them to drop a call when certain criteria are met, so that they can take and respond to the high-priority call.

Greater Manchester

Systems, processes and practices were used to keep people safe and safe from abuse. Staff learned when things went wrong and took steps to improve. Staff at the emergency operations centre assessed and monitored safety in real time, reacting to changes in risk levels for individuals. Staff anticipated potential risks and planned for them in advance, working with other a range of other providers to keep people safe.

Incidents

Staff knew how to report incidents using the trust's electronic reporting system. There were standalone computers for staff to access to complete incidents reports. However there was some concern that staff did not always get the opportunity or time to complete reports resulting in under reporting.

Some staff reported that they did not receive feedback after reporting an incident. However staff received individual feedback by email and clinical bulletins about wider organisational changes following incidents.

Staff were aware of changes resulting from local incidents, for example the urgent control desk could no longer offer medical advice to children under the age of 11.

Cleanliness, infection control and hygiene

The call centre was clean and tidy.

Cleaning products and hand gels were readily available.

Infection control was considered important within the call centre where people worked closely together.

There was good station hygiene to prevent the spread of infection.

Environment and equipment

The call centre at Parkway was a new build and staff found it a positive environment to work in.

It was spacious, areas were zoned for Emergency call takers and urgent care call handlers, and the dispatch desks were in a different room. Although staff were busy the atmosphere was calm and quiet.

Staff showed us the equipment and computer systems they used to take calls, prioritise callers and dispatch the nearest available vehicle if needed.

Staff had been trained in how to use the equipment and were competent in doing so.

If the computer systems failed the staff had a manual symptom checker to follow in order to triage calls.

Staff told us the IT equipment and IT support was good and fit for the role they performed.

Access to the service

Medicines
The service uses a triage system known as the 'advanced medical priority dispatch system' (AMPDS).

The way AMPDS guides call-handling staff means that they do not give advice to callers about giving medicines or injections in any circumstances.

Clinical staff were available to call handlers and dispatchers at Parkway, and assisted call handlers when triaging calls or responding to medication queries.

The urgent care desk was run by clinical operations staff and the call handlers in the operations centre used instant messaging or call these clinicians for advice. Similar communication channels were available to staff in the Cumbria and Lancashire or Cheshire and Merseyside operations centres for clinical support but they were not utilised.

Records
All contacts to the call centre were recorded on an electronic system.

In the event that the contact centre reverted to paper records due to the electronic systems failing any written information was transferred to the electronic system as soon as practicable.

Call takers marked records to identify a possible persistent caller or perhaps an address where the occupants were violent, and therefore requires police attendance prior to ambulance entering. There was a system to ensure the records were kept up-to-date and staff who attended the calls could directly update the system, for example if the previous violent occupant had moved.

The records were audited regularly as an incorrect marker could delay an ambulance response.

Safeguarding
All staff we spoke with were aware of the safeguarding policies and procedures. These were available on the intranet and were up to date.

Some staff told us about safeguarding champions whose roles were to advise, communicate and disseminate information to colleagues about safeguarding issues.

Most staff had received training in safeguarding children and vulnerable adults.

Staff reported any child or adult safeguarding concerns to a central reporting team based in Carlisle which then liaised with the appropriate authorities within agreed timescales. An electronic web based application was used to share information on vulnerable patients with key stakeholders in Manchester. The system supported the transfer of referral information to external organisations in the North West and provided a secure portal for organisations to inform the service of care planning arrangements for specific patient groups.

Assessing and responding to patient risk
Call centre staff and urgent care staff escalated or deescalated the response time to a patient through a triage system if the patient's medical responses changed.

The call centre had processes to trace calls placed through BT lines to specific locations when a person would not or could not disclose their location. If the tracing system was unable to identify the location of the caller the call handler stayed on the line until the caller disconnected. There were strict protocols for call handlers to disconnect phone calls and it was usually only in cases of extreme pressure.

Special notes were kept on the call centre's computer system for people who were known to have a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) order or who were flagged as a vulnerable person, bariatric patient or child. Bariatric is the branch of medicine that deals with the causes, prevention, and treatment of obesity.

Call handlers referred callers refusing an ambulance to a clinician to make a further assessment of the caller's needs and to assess their safety.

Staffing
In May 2014, there were no gaps in the rota for the emergency operations centre.

Staffing issues were raised with the inspection team. During known busy times such as Christmas and New Year staff felt extra support was not always made available but recognised that managers provided cover to maintain performance.

All grades of call centre staff were clear about their role and responsibilities, and who to escalate anything to if it fell

outside of the boundaries of their role. For example, an initial call handler may decide after the triage process that a caller requires clinical advice and therefore transfer the call to the urgent care desk to follow up.

Planning for variation in demand

Staff told us the demand for the ambulance service was steady throughout most of the week and there was not a rise in demand particularly at weekends or during the evening. All staff we spoke with told us any peaks were usually on Friday afternoons and Monday mornings due to transferring patients in and out of hospital either side of the weekend.

There were comprehensive escalation procedures for all call centre staff to follow in the event of major incidents, such as chemical spills, explosions or bomb threats. All grades of staff in the control centre felt confident and trained in following the procedures.

The Regional Operational Co-ordinating Centre (ROCC) worked closely with the senior operations management team. They had regular daily communications with bronze, silver and gold commands regarding requests for diversion or deflection of services due to local stresses, such as the demand for A&E or hospital bed pressures.

Control centre staff were clear about the paper process to follow in the event that computer systems failed.

There was a procedure to deal with multiple calls about the same incident. Supervisors and staff were aware of how this should be implemented.

Cheshire and Merseyside

There were systems, processes and practices in place to keep people safe and safe from abuse. Staff learned when things went wrong and took steps to improve safety standards. The provider assessed and monitored safety in real time, reacting to changes in risk levels for individuals. Staff anticipated potential risks and planned for them in advance, working with other providers to keep people safe.

Incidents

- Staff reported incidents by completing an incident record form that was then allocated to a member of staff to investigate. All incidents were reported to both the Clinical Governance Management Group (clinical patient safety) and the Health and Safety Management Group (non-clinical/staff safety) The trust's Incident Learning Forum scrutinised any trends and sought assurance, when appropriate.
- Staff told us that, in the past, people "never reported issues" because there was a "blame culture". Most people noted that this culture had been changing, as the trust promoted duty of candour. Some staff said there was more openness now.
- We found that not all incidents were reported in the trust's incident database. This was corroborated by staff. We observed that incidents, such as scheduling problems or surges in demand, were reported in an 'occurrence log' within the emergency operation centre (EOC), but few actions were taken to manage these incidents.

Cleanliness, infection control and hygiene

- The call centre was clean and tidy with cleaning products and hand gels available.

Environment and equipment

- The Liverpool EOC facilities included a call-handling room, a dispatch room and an urgent care desk. The dispatch and call-handling room were on two floors connected by a staircase. The space was cramped and the trust acknowledged that the environment was not ideal with staff working in close quarters with each other and with little space around desks. The trust had plans to build a new call centre but local staff were not clear on how far advanced these were.
- The IT systems used by the EOC enabled the call handlers and dispatchers to perform their duties safely. The trust had systems in place to alert staff to safety concerns that might require operational staff to implement additional safeguards.
- Staff said that, when the IT system went down, the trust operated on a 'paper system' that resulted in 'chaos'. The trust had planned downtime from 7am to 2pm for several days in July 2014. We saw that this had resulted in incidents due to errors made by dispatch and call-handling staff while the system was down. The trust had not yet investigated these incidents because of staff workloads. The trust stated that arrangements are practised for when the IT system is down, either on a planned or unplanned basis.

Access to the service

Medicines

- The trust monitored medicines management through clinical safety indicators that were regularly audited.
- We observed that on-duty paramedics, called the dispatch team at the EOC to request controlled medications when stocks were low; these medications were ordered promptly and the paramedics experienced minimal delay in re-stocking the medication while on the road. The Liverpool EOC was trialling a new daytime dispatch support worker, whose responsibilities included ordering the controlled medications.

Records

- The trust recorded most information on its electronic system, including recordings of calls. Call-taking and dispatch staff received extensive training to use the system accurately and efficiently. We observed that some of the dispatch staff knew the system better than their supervisors or managers.
- At the urgent care desk, staff recorded notes about patients in several locations. One staff member recorded notes in a personal notebook because they did not trust the existing records system. This increased the risk that important information about a patient might not be accessible to others.

Safeguarding

- The trust had clinical safety indicators for safeguarding, which measured the quality and timeliness of referrals of vulnerable people to the safeguarding authority.

Mandatory training

- New call handlers took part in an induction that included 4 weeks of classroom learning. When they showed the necessary competencies, they moved to the EOC, working with a mentor for a minimum of 100 hours until the mentor signed them off, which generally took 4 weeks.
- The manager explained how they extended probation for call handlers who had not been signed off by their mentor within 3 months, and offered a second period of mentorship to a prospective call handler who left after failing to achieve the necessary competencies and then asked to try again.

Assessing and responding to patient risk

- We reviewed paper record forms that showed staff awareness of vulnerable patients. One senior paramedic, who was acting as a mentor for junior staff, gave an example of staff approaching them with queries about a vulnerable patient. A senior manager said that staff regularly called the advanced paramedics requesting advice on managing a challenging vulnerable patient.
- The trust stated that it did have protocols that specified clear lines of responsibility and accountability for their staff and those of a hospital transfer or retrieval team. However staff we spoke to were not fully aware of these. This caused difficulty for both the call handlers, who were unable to adequately triage the patients, and the hospital staff, who said they were unsure how to engage with the ambulance staff.

Staffing

- The trust had about 150 staff in the Liverpool EOC. The contact centre manager said that the numbers on shift at a given time fluctuated depending on demand. The centre used staggered starts on their core 12-hour shift, with some flexibility for individual needs (such as limiting unsociable hours). The deputy manager worked with staff individually, with colleagues from human resources, to agree shifts.
- The trust did not use agency or bank staff in the dispatch or call-taking rooms because staff needed extensive training to become competent in the role and maintain their skills.
- The trust obtained 'buddy support' from two local ambulance trusts when demand outstripped capacity.
- The next recruitment drive for call-takers was planned for September and October 2014. This followed the last recruitment drive in October and November 2013. Since then, the EOC had promoted two managers and several supervisors. We observed some call-takers training as dispatchers in order to become qualified to apply for the dispatch roles.
- Clinicians' banding ranged from Band 2 (patient transport drivers) to Band 7 (advanced paramedics), with emergency medical technicians at Bands 4 or 5 and paramedics at bands 5 or 6.
- Many staff had over 10 years' experience working at the trust. A union representative raised concerns about the number of staff who were due for retirement, stating

that the current recruitment and training plans were not enough to fill the gap in the numbers of paramedics needed. The trust had made a number of emergency medical technicians redundant in the past few years. Staff described a 'progression ceiling' for these staff. The trust subsequently stated that a small number of staff were allowed to take redundancy in order to enable skill mix changes within the workforce.

- A team based at the EOC used Excel-based tools to estimate how many staff were needed for a given shift. This tool used data from past years to estimate demand. EOC managers then re-allocated staff to different stations to ensure vehicles were fully staffed, before sending out requests for overtime.
- Staff said the trust was "frequently down" and could not fill the core shifts from the existing numbers. We reviewed the overtime records for staff at the Macclesfield station and saw that most staff were working significant amounts of overtime, on top of a full working week. This resulted in extra payments for missed breaks, or extended shifts, as well as overtime pay for taking on other shifts. Several staff spoke positively about doing overtime shifts, but there was no system to check whether they were fit to work these extra hours.

Planning for variation in demand

- The trust had a clinical escalation plan that specified that HCP referrals would be triaged as normal until the trust reached Level D, when HCP referrals would receive ring-backs in order to prioritise patients by clinical need. At Levels E and F, the patient transport service took over HCP referrals and staff had the authority to refuse bookings. During the inspection, the trust operated at Level C and Resource Escalatory Action Plan (REAP) Level 3.
- Some managers and supervisors in the EOC did not show an adequate understanding of the escalation plan.
- The dispatch and call-taking rooms in the EOC at Elm House were not co-located but were on different floors connected by a staircase. This made it difficult for managers and supervisors to oversee both operations. The trust had drawn up plans to house the EOC in a new building on site. Staff looked forward to these changes although at the time of the inspection the date of completion was not confirmed.

Is access to the service effective?

Cumbria and Lancashire

In the emergency operations centre we observed staff making assessments of emergency 999 calls, and calls from GPs and other health professionals. The call triage system used by the service provided guidance for dispatchers to provide deploy an appropriate response vehicle. The service worked with community first responders (local trained volunteers) across Cumbria and Lancashire to help meet the immediate needs of patients.

In 2013/14, the operations centre did not meet several of the trust's own targets including for call pick-up times or first allocation of a dispatch vehicle. The trust was also performing worse than expected in comparison with other ambulance trusts for the number of calls they resolved with telephone advice alone.

Staff competency in using the triage system was assessed every two years.

Evidence-based care and treatment

- The service used a medically approved call triage system called the 'advanced medical priority dispatch system' (known as AMPDS).

Assessment and planning of care

- Assessment systems were in operation to ensure the effective care and treatment of patients.
- The assessment determined whether they would send a rapid response vehicle equipped to provide treatment at the scene of an accident, or an ambulance and crew if it was likely the patient would need to be taken to a hospital for further treatment.
- The service also used community first responders to assist with responding to calls if appropriate.
- Community first responders are volunteers who live and work in the local community. They are recruited, managed, trained and used by the ambulance service to attend certain emergency calls, to minimise risks to a patient's health.
- The responder would provide care until the ambulance arrived, usually only a few minutes later.
- The ambulance service controller sends responders to appropriate category A (immediately life-threatening)

medical calls; they are dispatched at the same time as the ambulance crews because local community first responders in cars can often arrive more quickly than the ambulance.

Patient outcomes

- The triage script used by the operations centre staff was automated through AMPDS.
- Built into this system were tools to ensure good patient outcomes for callers being advised by non-clinical staff.
- These included a metronome for call handlers to advise third parties on the speed at which to carry out cardiopulmonary resuscitation, and a tool to measure the contractions of a woman in labour.
- For the period from 1 April 2013 to 31 March 2014 operations staff in Cumbria and Lancashire were tasked with meeting trust call response targets:
- Against a target to pick-up 95% of calls within five seconds, 91.6% of calls for Cumbria and Lancashire were answered in this time frame. For the first two quarters of 2014/15, this percentage had fallen to 85%.
- Against a target to confirm the location to arrive at within 30 seconds for 80% of calls, this was achieved for 78.6% of calls. For the first two quarters of 2014/15, the trust performed similarly at 78.7%.
- Against a target to dispatch a vehicle (known as first allocation) within 30 seconds in 40% of cases, Cumbria and Lancashire achieved this 33.7% of the time. For the first two quarters of 2014/15, this percentage had fallen to 20.8%.
- Against a target for 'best allocation' - getting the right/most appropriate vehicle to the patient in 40% of cases, Cumbria and Lancashire achieved this 58.5% of the time. For the first two quarters of 2014/15, this percentage had fallen slightly to 57.2% but remained above the local target.
- The percentage of 999 calls resolved through telephone advice alone by the trust had reduced each year for the past 2 years. In 2013/14, the trust resolved 2.32% of emergency calls through telephone advice alone.
- The trust was performing much worse than expected against a national annual quality indicator (data collated for 2013/14) for the proportion of calls closed with telephone advice only when clinically appropriate.

Competent staff

- New staff told us they felt their induction had adequately prepared them for their role.
- More established operations centre staff told us they thought the mandatory training they received was beneficial and appropriate to their role.
- The competency of all staff who used AMPDS was assessed every two years through an exam.
- The operations centre leadership at Broughton was unable to assess many aspects of individual call handling performance.
- We asked for a breakdown of data for individual call handlers but the service was unable to provide this.
- This meant that call handler performance could not be qualitatively assessed and benchmarked against other call handlers.
- The trust was 5% below its own target for making sure that 85% of staff appraisal reviews were up-to-date across all staff groups.

Coordination with other emergency services

- We listened to several calls where the police were, or needed to be involved, and we observed that the response to these calls was well coordinated.

Greater Manchester

The service was effective in ensuring people with healthcare needs could access the service. Staff required used a medically approved call triage system called the 'advanced medical priority dispatch system' (known as AMPDS) to triage the high volume of people attempting to access the service. Staff worked well with other emergency services and health and social care providers to ensure people's health and social care needs were met.

Evidence-based care and treatment

The service used a internationally approved call triage system called the 'advanced medical priority dispatch system' (known as AMPDS).

Staff followed evidenced based care guidance in assessing callers' symptoms and ensuring they were referred to the appropriate healthcare professional.

The Joint Royal Colleges Ambulance Liaison Committee (JRCALC) develops and reviews national clinical practice guidelines for NHS paramedics. Staff had been given a hand book on JRCALC guidelines dated 2013.

Assessment and response of care

Call centre staff followed a script to triage patients to assess the appropriate response from the ambulance service.

Access to the service

Staff used a decision making tool called Paramedic Pathfinder to assess and identify the most appropriate place to take the patient to. It helps staff determine the most appropriate care and treatment needed. It is a consistent and clinically safe triage and evidence-based process designed to enable accurate face-to-face assessment of individual patient needs, on scene**.** Pathfinder generates key outcomes, all of which are aimed at accurate streaming and direction of patients to the most appropriate care for their needs; these are A&E departments, urgent care centres or Kite-marked equivalents, community or primary care pathways or self-care pathways.

We observed senior paramedics carrying out secondary triage for patients who had been categorised as non-urgent by call handlers.

The paramedics used the Manchester Triage System (MTS). There was a target of deflecting callers to ensure the ambulance service was providing the right care at the right time in the right place. Staff told us they did not feel pressured to meet the target. There would be days when the seriousness of calls meant that most had their response times upgraded rather than downgraded or deflected. The paramedics told us they felt empowered to use professional judgement as clinicians.

We saw senior paramedics supporting each other and being supported by more qualified advanced paramedics.

Non-urgent patients were triaged and monitored by the urgent care team at the call centre. The team called patients waiting for non-urgent ambulance services to ascertain the most appropriate course of action for their needs. For example some patients may not require an ambulance and would be treated more effectively at a local walk-in centre or GP surgery.

When appropriate patients were transported to the most appropriate A&E, specialist unit or trauma centre for their needs.

The 2013/14 Hear and Treat Survey contacted adult callers who had received telephone triage and advice when calling 999 in December 2013. The survey consisted of 26 questions relating to the call handler, clinical adviser, outcome and overall impression of the service provided. The trust performed, on average, the same as other ambulance trusts for 23 questions, worse than other trusts for 1 question and better than other trusts for 2 questions.

Patient outcomes

The emergency call centre and urgent care desk performance was measured against a number of targets such as, time respond to a call, time to obtain an address, and use of the triage script.

In 2013/14 the trust aimed to pick up 95% of calls within five seconds. Greater Manchester picked up 94.07% of calls within five seconds.

In 2013/14 the trust aimed to have the location confirmed within 30 seconds in 80% of calls. Greater Manchester achieved this with 78.57% of calls.

In 2013/14 the trust aimed to dispatch a vehicle (known as (first allocation) within 30 seconds in 65% of cases. Greater Manchester achieved this 39.46%. In quarter 2 of 2014/15, this had fallen to 21.39%. Staff told us this was due to the increasing demands on the service and there not being enough staff and vehicles to meet the demands.

In 2013/14 the trust target for 'best allocation' - getting the right/most appropriate vehicle to the patient happened in 41.29% of cases. The trust aimed for 60% of cases. In quarter 2 of 2014/15 there was an increase to 42.45% of cases.

Competent staff

Staff in the call centre felt supported by their teams and managers and equipped to carry out their duties.

They had regular one to one and yearly appraisals.

It was recognised that staff worked in a high-intensity and stressful environment and felt supported to take breaks and discuss work when they needed.

New senior paramedics were mentored for one month by more experienced paramedics. After that, the new senior paramedics continued working alongside the mentor senior paramedic at adjacent desks so that the mentor was available to answer any clinical questions.

Managers listened to call handlers telephone conversations on a regular basis to ascertain their competency. Any issues, such as following protocols or their verbal communication was discussed with the call handler.

The specialist paramedics on the urgent care desk peer reviewed each other in order to ascertain correct protocols

were followed and advice given. Any concerns were discussed and any major concerns were overseen by an advanced paramedic to ensure a fair assessment was made.

We heard staff in the call centre and urgent care desk speak with more experienced colleagues or managers when advice was required. New call handlers were mentored by more experienced call handlers. Mentors sat alongside the new member of staff and listened to the calls so that they could answer any queries and ensure they followed the correct protocol.

Emergency operations staff were trained in how to deal with people displaying challenging behaviour over the telephone. There was a specific protocol to follow if the caller became aggressive or threatening.

Mandatory training specific to their roles, for example customer service or urgent care desk training had been completed by most staff in the last six months. They received email reminders when their training was nearly due

Coordination with other emergency services

Control centre staff did not direct where ambulance staff should take patients to, however they could advise ambulance crews on current hospital pressures so they could assess which hospital emergency departments in the area they could access quickly.

There were hospital ambulance liaison officers at each location to manage turnaround time for ambulances at busy times. They liaised with A&E staff and the bed management teams to speed up admissions and decrease the amount of time ambulances and staff were held at hospitals.

Staff described how they were building relationships with other providers. For example at the time of our inspection they were liaising with out of hours services to improve access for patients. They were also producing a booklet for health care professionals to assist them in requesting appropriate ambulance services.

Police staff commented on the reliability, professionalism and calmness of the ambulance staff in reassuring a patient in a crisis.

Multidisciplinary working

The frequent callers' team, GPs and other social care providers discussed complex or significant frequent callers who had an impact on the delivery of the service. This ensured a person's health and social care needs would be addressed by the right provider.

GPs reported that the GP referral scheme in some areas was working well in ensuring that people got the right care in the right place.

Cheshire and Merseyside

Staff assessed people's needs and delivered care and treatment in line with current legislation, standards and nationally recognised evidence-based guidance.

Evidence-based care and treatment

- The trust had a system of audits to measure its service against clinical indicators and call centre staff operated to guidelines produced by the Joint Royal Colleges Ambulance Liaison Committee (JRCALC).

Assessment and planning of care

- The trust had specific phone numbers for HCPs to request transport for their patients. We listened to more than 10 of these calls, most of which were for urgent or routine transport and were triaged effectively by the call-taking staff. The callers agreed to the recommended dispatch time and vehicle.
- Call centre staff used evidence based care guidance in triaging patients to ensure callers were referred to the appropriate healthcare professional.
- We listened to and reviewed one case in which an HCP requested the transport of a paediatric patient from Mersey to Shropshire. The original call-taker had triaged the call as low acuity, so the patient had been referred to the trust's patient transport service. However, this service refused to accept the referral because the patient needed ventilation overnight. The call-taker referred the call to the urgent care desk, where the advanced paramedic triaged the patient as being suitable for the patient transport service. The call-taker was unable to make a decision regarding where to refer the patient, and requested support from a supervisor. The supervisor advised the call-taker to proceed on the advice of the advanced paramedic.

Access to the service

Patient outcomes

- Performance at the EOC was measured by several indicators including the following: call pick up time -target 95% in 5 seconds; location confirmed – target 80% in 30 seconds; first allocation for A & E vehicles – target 40% in 30 seconds and best allocation of rapid response/paramedic vehicles – target 60%.
- The Cheshire and Merseyside EOC performance against these targets rounded to nearest percentage point (with trust performance in brackets) was as follows for the period 1 April to 30 June 2014: Call pick up time 85.2% (85.3%); location confirmed 74.7% (76.2%); first allocation for A & E vehicles 18.9% (20.7%) and best allocation of rapid response/paramedic vehicles 42.8% (41.9%).

Competent staff

- Liverpool Emergency operations centre (EOC) staff had inductions that included training and shadowing.
- EOC staff had access to mentors to guide them. Call-taking staff was recruited in cohorts and received 6 weeks' training before starting work in the control centre under the supervision of a mentor.
- Staff at the Liverpool EOC raised concerns about the effectiveness of their work. They said they did not have team meetings or training in specialist subjects, such as the Mental Capacity Act 2005 or deprivation of liberty safeguards.

Coordination with other Emergency Services

- The trust worked with partners, such as St John's Ambulance, to respond to emergency and urgent calls, as well as to provide cover for special events.
- There was a range of specialist clinical networks in Cheshire and Merseyside, such as those for critical care, cardiac and stroke, and cancer. Each of these networks had links with The trust that resulted in projects such as piloting rapid discharge for end of life patients in the Southport area and an interhospital transfers meeting.
- A January 2014 peer review of the major trauma centre (MTC) in North Staffordshire highlighted that staff reported "poor engagement from the North West Ambulance Service" despite their "working hard to improve a collaborative structure."
- Trust managers said that their staff repatriated "a lot" of patients into and from East Midlands. They said that hospital staff in Staffordshire were not always aware of the services offered at the two local hospitals in East Cheshire. This sometimes resulted in requests for a second transfer to the right hospital, such as from Cheshire to Manchester.
- Some senior staff complained that the trust did not challenge inappropriate referrals from HCPs as often as necessary.
- One paramedic shared examples of two calls where the local police and fire services did not share relevant information in advance. This resulted in ambulance staff attending calls where they were not needed or were not safe.
- Staff said that police in different local authorities had different protocols for working with ambulance services, particularly about how to manage patients who were declared dead on arrival. This caused some confusion because staff worked across multiple areas on occasion. They believed these differences were due to the areas having different coroners.
- One staff member said they were challenged by other providers, but felt "backed up" by the trust.
- The trust's Making Experiences Count team reviewed and managed concerns raised by HCPs about The trust staff. We observed trust staff engaging with other providers in a positive way. For example, a paramedic shared information with the dispatcher who alerted a local hospital regarding the needs of an incoming patient. This transfer of information was managed carefully, to ensure it was accurate and the patient safe. Feedback about pre-alerts varied among ambulance and hospital staff and seemed to depend on local agreements.
- We also observed a paramedic serving as an intermediary, requesting information from dispatch on behalf of the police. This request did not relate to clinical care or treatment and meant that the paramedic was delayed in becoming available for the next call. The EOC staff confirmed that there was no system to ensure that requests from the police for information did not disrupt the trust's responsiveness.
- One paramedic shared examples of two calls where the local police and fire services did not share relevant information in advance. This resulted in ambulance staff attending calls where they were not needed or were not safe.

Access to the service

Multidisciplinary working

- Staff had a good working relationship with the other departments including ambulance staff and paramedics within the trust.

Is access to the service caring?

Cumbria and Lancashire

Call handlers demonstrated a caring response to calls that met the individual needs of each caller.

Callers who were distressed or anxious were assured and call handlers actively listened to callers and responded patiently and compassionately.

Staff involved patients as partners in their own care and support.

Compassionate care

- Callers were often distressed and anxious, and staff in the operations centre responded to them patiently, assuredly and compassionately.
- Operations centre staff built a rapport with callers and provided reassurance.
- Call handlers adapted their tone with consideration for the caller and the circumstances, and we observed staff involving patients as partners in their own care and support.

Providing emotional care and support

- We listened in on calls and heard operations centre staff giving appropriate emotional support to relatives who needed an ambulance for a family member.

Greater Manchester

The service was caring. We saw several examples of call handlers and paramedics based at the emergency operations centre talking with people compassionately. They listened carefully to the patients details and asked clear questions to gather more information to ensure the right action was taken, whether that was an ambulance or a telephone conversation with another healthcare professional.

Compassionate care

- We observed many compassionate conversations between staff and callers
- Staff took their time, were clear and informative to callers.
- Patients told us how they felt comforted and reassured by staff who stayed on the line with them while they waited for their ambulance to arrive.
- Patients and family members described the call centre staff positively, for example they said they were “very caring”, “helpful” and “reassuring”
- We heard a call with a patient who was in labour; the call handler continued talking with the patient calmly and compassionately until an ambulance arrived. An advanced paramedic listened to the caller and used their professional judgement to go and assist the staff that were being sent to the patient.

Providing emotional care and support

- We heard staff providing emotional support to callers.
- Staff told us how they had experienced some difficult calls and how they had learned from them to ensure they offered appropriate emotional support to callers in the future.
- We heard call handlers providing emotional support to carers and bystanders of people who needed medical attention.

Cheshire and Merseyside

Staff treated people with kindness, dignity, respect, compassion and empathy. However, call-taking staff did not have a system to refer patients with mental health problems to other services, such as a mental health crisis team.

Compassionate care

- Staff were sensitive to people’s emotional states. One staff apologised to a caller, to de-escalate the situation, and explained clearly why they needed to ask questions of the caller to triage the call.
- Call-taking staff regularly needed to repeat themselves or re-explain because callers were aggressive or not listening. Despite this challenge, most call-taking and dispatch staff were calm and professional while speaking to callers or ambulance staff.
- Call-taking and dispatch staff arranged call-backs to Green 3 and 4 calls (non-life threatening) that had passed the expected response time, in order to explain

delays and check for any deterioration in the patient. This was organised in an ad hoc way and sometimes overlapped with call-backs undertaken by staff at the urgent care desk.

Providing emotional care and support

- Although we observed staff genuinely caring about the wellbeing of patients with mental health problems, the call-taking staff did not have a system to refer patients with mental health problems to other services, such as a mental health crisis team.
- Call-taking staff reassured callers throughout the process of triaging, which was often quite distressing for the caller. Staff followed protocols that advised them when to stay on the line to provide support to callers, such as when a patient needed resuscitation. Staff told us that the trust supported them to make their own discretionary judgements about other calls that would benefit from their extended support, while the caller waited for an ambulance to arrive. We observed call-taking staff stayed on the line with callers, in some cases for over 30 minutes.

Is access to the service responsive?

Cumbria and Lancashire

The service had a dedicated team of paramedics who worked with frequent callers and others local providers to help manage the demand on the service and assist people to access the appropriate healthcare to meet their needs.

The trust had an urgent disconnect policy which enabled callers to drop less urgent call that met criteria and pick-up urgent calls in the queue. However, staff in the operations centre were not sure of how this policy worked and who could invoke it.

The call triage system dispatched vehicles when people's symptoms may have suggested an alternate response if clinical input had been available, but call handlers at Broughton did not access clinicians for advice.

Service planning and delivery to meet the needs of local people

The service was actively engaging with commissioners of services, local authorities, GPs, other emergency services and other relevant groups to provide coordinated and integrated pathways of care to meet people's needs.

Most individuals accessing the 999 system did so with legitimate healthcare requirements. The identification and management of those who accessed emergency healthcare on an abnormally high number of occasions had led the service to identify individuals who were at risk, vulnerable or accessing the incorrect care for their needs.

The trust introduced a team of specialist paramedics to support these frequent callers. This team worked with patients, when they gave consent, on an individual basis.

Access and flow

In non-life-threatening emergencies, patients would be treated by an ambulance crew or a single responder.

These calls were rated as Green 1 – blue light response within 20 minutes, Green 2 – blue light response within 30 minutes, Green 3 – telephone assessment within 20 minutes and response within 1 hour and Green 4 – telephone assessment within 1 hour.

Patients could also access a clinical telephone advisor by calling the NHS 111 line that operates from a call centre.

If calls were waiting in a queue and call handlers were dealing with non-life-threatening calls that met certain criteria, they could invoke an urgent disconnect policy and drop the call.

However, at Broughton, staff we spoke with were unclear as to how to invoke the policy, what call types could trigger it and whether they needed to ask permission to drop a call.

The use of the policy was inconsistent across the trust because we saw the policy working well at the trust's operations centre in Manchester Parkway.

If the urgent disconnect policy did not operate as intended, and staff held on to non-urgent calls when an ambulance was already on its way, then the centre was not responding appropriately to callers waiting in the queue.

We observed several calls when call handlers could have made a sound judgement that they did not need to stay on the call; instead, they kept the line open.

For the most recent data collated in January 2014, the trust was performing below the national average for the percentage of calls abandoned before being answered. The trust was ranked 9th out of 10 ambulance trusts.

Access to the service

People are cared for in consideration of their needs
When observing the use of the triage system called the 'advanced medical priority dispatch system' known as AMPDS, we saw that this triggered ambulances to be sent out to patients who potentially did not need them.

If a patient had chest pain or breathing difficulties, then AMPDS did not provide enough prompts for call handlers to assess the context of these symptoms for that patient.

We heard a call in which a patient said he had breathing difficulties and had been advised by his GP to call 999; however, they were talking in full sentences about what they'd had for breakfast that day.

As the caller was reporting breathing difficulties, this call was categorised by the system as a R2 call, meaning that the service had to provide an ambulance within 8 minutes of the call.

We also saw calls triaged in this same way and met with the same response when callers said they were experiencing anxiety or chest pain.

At Broughton there were no clinical call handlers who could take these calls and make a judgement as to the most appropriate response.

Consent & Mental Capacity Act
Generally, If a third party calls on behalf of a patient, ambulance service staff might ask to speak with the patent to obtain their consent to care and treatment or they might seek advice from clinical colleagues.

Similarly, if a caller refuses assistance, a member of the operations centre staff might have to decide whether the need for intervention overrides that person's wishes, or whether to seek clinical advice.

At Broughton, when using AMPDS and without clinical support, call handlers and dispatchers in the operations centre did not ask these questions and a vehicle would automatically be dispatched in these instances.

Greater Manchester
The service was responsive to peoples' needs. There were clear escalation protocols in place for increasing levels of demand. All staff were well equipped to provide care for people in consideration of their needs. Screens were visible to staff to make them aware of the demands on the service and the flow.

Service planning and delivery to meet the needs of local people
Staff told us that the rotas were planned taking into consideration busy times and events.

We were told that escalation procedures were followed in response to an increase in calls.

Access and flow
The frequent caller team identified and supported those at risk, the vulnerable, and those accessing inappropriate healthcare.

The trust's definition of a frequent caller is an individual who calls 999 more than twice in a seven day period or more than four times in a 28 day period.

The team made initial contact with the patient discussed their healthcare needs and offered advice and support when needed. They then engaged with other healthcare partners to work in collaboration to address the patient's specific health and social care needs. Then an ongoing monitoring and support procedure was followed until this was no longer considered necessary.

Other healthcare professionals such as GP's or hospitals received a direct number to call the emergency operations centre. This meant they were not required to go through the BT system identifying which emergency service they require before being connected to the emergency operations centre.

We observed call handlers being able to message the paramedic for advice whilst still on the call. They could message and not have to talk with the paramedic and continue to be able to advise the patient whilst still on the call. Handing the call over to the clinician also enabled the handler to be able to move to the next call.

Staff could see the number of calls that needed answering. We spoke with staff about call queuing and how it affected their decisions. The call handlers were clear that patients' needs come first and the supervisors managed the queue.

In non-life-threatening emergencies, patients would be treated by an ambulance crew or a single responder. These calls were rated as Green 1 – blue light response within 20 minutes, Green 2 – blue light response within 30 minutes, Green 3 – telephone assessment within 20 minutes and

response within 1 hour and Green 4 – telephone assessment within 1 hour. In Greater Manchester performance on response to 'green calls' was impacted by the high volume of life threatening calls.

People are cared for in consideration of their needs

Staff had immediate access to language line for people who made 999 calls and could not understand English.

Call handlers were trained in 'Typetalk' which is a national telephone relay service for deaf, deafened, hard of hearing, deafblind and speech-impaired people.

Call centre staff had a protocol to follow if they identified during the call that the caller may have a learning disability.

Out of hours mental health support was limited and accessing their records and history was difficult to ensure appropriate care was offered. A project was in operation to improve this.

Staff had worked with Village 'street angels' in Manchester Gay village. Staff had taught them some basic first aid and what to look for in unwell people, and when to call an ambulance.

Frequent callers team worked closely with other healthcare professionals such as GPs and mental health teams to engage with patients who used the ambulance services frequently.

Patients with mental health concerns were taken to a place of safety (Sanctuary) in Manchester

At the time of our inspection the Advanced Paramedics (AP) were developing links with out of hours mental health providers in order to access patient records to help assess the patient's needs and support them appropriately.

Consent and Mental Capacity Act 2005

Most staff had been trained in Consent and Mental Capacity Act 2005 as part of their mandatory training.

Learning from complaints and concerns

Complaints were handled and investigated by the 'making experiences count' team. All complaints were graded according to the seriousness. Senior staff responsible for the location/staff complained about were involved in any investigation. Outcomes and learning were shared with the individual concerned.

Cheshire and Merseyside

The provider took steps to ensure that their protocols and procedures met the needs of the general population. We observed changes to the call-taking protocols for HCPs, as well as for managing calls where the primary complaint related to mental health. These changes had only just been implemented, so there was not enough time to assess whether they had had a positive impact on these two areas.

Service planning and delivery to meet the needs of local people

- In July 2014, the trust reported an 'unprecedented rise in calls'. Data provided by the trust showed that they did not have enough call takers to meet the demands of the service.
- The trust designated specific staff to manage the flow of HCP referrals in Southport and Chester, located in the Liverpool emergency operation centre (EOC). Their aim was to triage patients, allocate the appropriate resource to meet their needs, and reduce peaks in demand. In practice, however, HCP referrals were managed by all call-taking staff, depending on who was available to take the call. The EOC manager explained that this pilot's success was limited because of the low number of calls; the trust was engaging with the clinical commissioning group to extend the trial to other areas.
- Calls are assessed and divided into Red 1 or 2 or Green 1, 2, 3 or 4. Red calls were 'immediately life threatening'. Green 1 and 2 were serious but not immediately life threatening. Green 3 and 4 were neither serious nor life threatening).
- If the patient's condition was triaged as an emergency, the trust aimed to dispatch an ambulance to reach the patient within 8 minutes. If not an emergency, but the patient's condition was serious, the trust aimed to dispatch an ambulance to reach the patient within 20 minutes. If the patient's condition was not serious, the trust aimed to reach the patient within 1–4 hours (if urgent) or, with enough notice, as agreed with the HCP (if routine).
- Referrals from HCPs were triaged and responded to within a specific time scale, depending on need. The trust asked HCPs to inform the trust if a patient's condition constituted a serious emergency, such as significant airway compromise, severe breathing problems, possible myocardial infarction or other acute coronary syndromes, aneurysm, meningitis, lack of consciousness, or obstetric emergency.

Access to the service

- If the patient's condition was triaged as an emergency, the trust aimed to dispatch an ambulance to reach the patient within 8 minutes. If not an emergency, but the patient's condition was serious, the trust aimed to dispatch an ambulance to reach the patient within 20 minutes. If the patient's condition was not serious, the trust aimed to reach the patient within 1–4 hours (if urgent) or, with enough notice, as agreed with the HCP (if routine).
- We observed changes to the call-taking protocols for HCPs, as well as for managing calls where the primary complaint related to mental health. These changes had only just been implemented, so there was not enough time to assess whether they had had a positive impact on these two areas.
- Staff explained that calls from GP surgeries prompted a rapid response vehicle and ambulance as a priority. Staff who were designated rapid responders said they were unhappy about being used to 'baby sit' patients in GP surgeries and walk-in centres, while the patient waited for transfer to hospital. They believed that the other clinicians on the premises should be responsible for the patient.
- Trust managers said that it could be hard to challenge a doctor's decision to admit patient to hospital, because often the referring doctor had already spoken with the hospital doctor and agreed admission. This meant that the staff were not able to triage the patient fully, but had to treat them as an emergency (red) call regardless of patient need. The staff said that sometimes a patient did not need to be admitted immediately. This meant that the EOC could not fully manage the peaks in the number of HCP referrals.
- The trust performed worse and much worse on patient outcomes when compared with the other 10 ambulance trusts in England on dealing with calls closed with telephone advice (worse) and calls managed without transport to A&E (much worse).

Access and flow

- The trust had supervisors and a manager to monitor calls during a shift. Their role was to qualitatively monitor for risks to the service and ensure call-taking and dispatch staff met trust targets regarding response.
- The trust also used clinical risk indicators to measure delays in emergency response.
- Some staff had concerns about patients who had deteriorated after the referral by the HCP, but no one had updated the ambulance. In many cases referred by a GP, the patient was left alone at home because the HCP needed to go and see other patients. We observed ambulance staff doing call-backs in quieter moments, to obtain updates about patients' conditions. When appropriate, they spoke directly with the patient.
- The trust requested support from volunteer or private ambulance services when they were unable to meet demand. These were used more in rural areas, such as Cheshire, where ambulances were more likely to be taken out of area on calls.
- The trust generated a monthly report identifying the number and outcome of calls where high-priority Cat A (Red 1 or 2) patients waited longer than 60 minutes. Clinical teams investigated adverse outcomes (approximately two incidents per month), such as transfer to hospital via a 'stand by' call or being declared dead on arrival, and presented their findings to the Board of Directors in their monthly report.
- The trust's response time performance for 2013/14, as reported in the Quality Account, showed a small improvement on 2012/13, especially for Red 1 patients. It had responded to 75.9% of Red 1 patients within 8 minutes and 77.4% of Red 2 patients within 8 minutes. It was ranked 8 and 2, respectively, out of 11 ambulance services.
- The 2013/14 Hear and Treat Survey contacted adult callers who had received telephone triage and advice when calling 999 in December 2013. The survey consisted of 26 questions relating to the call handler, clinical adviser, outcome and overall impression of the service provided. The trust performed, on average, the same as other ambulance trusts for 23 questions, worse than other trusts for 1 question and better than other trusts for 2 questions.

People are cared for in consideration of their needs

- More work was needed to ensure that the trust response took into account patient vulnerability. Call-taking staff acknowledged that often the most vulnerable people were the least likely to share information about the seriousness of their condition, resulting in inappropriate responses to their needs. Call-taking staff said they were restricted by the triaging system and could not always make adjustments to trigger a more rapid response for particularly vulnerable patients.
- One person commented on the NHS Choices website in June 2014 about a relative's transport to hospital, which

had been requested by their GP after a home visit at 3pm. The GP insisted the patient had to go into hospital immediately. The patient waited with another elderly relative. The ambulance did not arrive until 9:55pm, which was significantly past the trust's targeted response time. "This service for elderly people is completely unacceptable and I intend to make a formal complaint." The trust responded with contact details for the Making Experiences Count team.

- Staff said that, if a vulnerable patient called 999 and then hung up, they would try to re-call the patient three times and then leave a voicemail message. If they had a potential address for the patient, they would seek support from the police and dispatch an available vehicle to check out the situation.
- During one 999 call, a vulnerable patient refused to provide an address but did not hang up. Three call takers plus a manager were involved in this call, which lasted around 45 minutes, speaking with relevant people such as the police and the local hospital, to identify the person and their address.
- The trust had a comprehensive policy and procedures regarding the transport of patients who had 'do not attempt cardio-pulmonary resuscitation (DNA CPR) orders in place. Staff we spoke with told us how a person's resuscitation status was established before the transport of the patient, and how they worked with other agencies to ensure the appropriate documentation was in place before the transport.
- Call centre staff said they had not received training in how to communicate with vulnerable patients, such as those with dementia. However the trust told us that call centre staff received training on communication with vulnerable adults and children, although not specifically on patients with mental health issues.
- In triaging one patient with dementia, staff on the urgent care desk did not ask to speak to the patient but instead addressed questions to the patient's care manager. The care manager then asked the same questions of the patient and relayed their answers to the paramedic on the urgent care desk.

Consent & Mental Capacity Act

- We observed that call handlers did not have an adequate system in place to manage patients whose primary complaint was related to mental health. The protocols that the call handlers followed did not include referrals to crisis or other specialist mental health teams. This meant that patients with mental health concerns were triaged either as a Green 3 or 4 or referred to the urgent care desk.
- The trust stated that it did not expect 999 call handlers to refer mental health patients due to their lack of clinical training and the time constraints on handling and processing a 999 call. Following assessment by a clinician, a decision would be made on whether it is safe for the patient to be referred to a mental health service.

Learning from complaints and concerns

- The call-taking and dispatch staff sometimes received complaints during 999 calls. We observed them sometimes seeking advice from managers to respond to these complaints. Staff said that, if they were unable to respond appropriately, they would escalate the call to a manager.
- The control centre manager said they were responsible for providing information to the trust Complaints team, so that the complaints team could respond to complaints. The manager showed us the evidence they reviewed to investigate a complaint, which included reviewing the control centre databases, the call-taking and dispatch audit reports, and the occurrence log. When appropriate, they addressed the findings with the staff involved in the complaint. The delays meant that this feedback was not timely.
- The control centre manager had a backlog of complaints waiting for review and response. They had no protected time to do this work and therefore were not able to complete it when the EOC was busy. This meant there were sometimes long delays in complainants receiving responses from the ambulance service.

Is access to the service well-led?

Cumbria and Lancashire

The operations centre managers were not able to provide us with individual call handler data which meant that they could not benchmark call handler performance or provide evidence when discussing individual performance with staff. Local action plans measures were not specific and timed and so it was not clear whether measures would be implemented or not.

Access to the service

The trust had developed a process for responding to calls when a patient had already been seen by ambulance staff within the previous 24 hours. These calls were automatically flagged and alerted the clinical governance department alerted.

The support centre team in Carlisle were proud of their unique function and felt supported and well-led.

Many staff at Broughton felt supported and that they had opportunities for careers progression, but morale was low in the dispatch team.

Vision and strategy for this service

The trust's vision is, "we aim to deliver a high quality service to patients by ensuring we deliver the right care, at the right time and in the right place".

The Broughton emergency operations centre is part of the trust's long term strategy for the delivery of emergency and urgent care services in Cumbria and Lancashire.

New work streams were regularly being reviewed as suitable for the support centre in Carlisle to adopt, to help to meet the demand of calls and on administrative resources in this area.

Governance, risk management and quality measurement

We found that the trust had recently introduced the role of performance manager into the operations centre, and two new performance managers had been employed.

However, the service was unable to give us audit data for the performance of individual staff members, which suggests that management were unable to identify when staff were not performing or to benchmark staff against targets.

The service recognised in its own meeting minutes dated 14 May 2014, that operations centre staff were not routinely completing incident report forms, but this was not turned into a targeted action in the associated improvement plan.

These minutes also stated that the logistics of carrying out a 'deep clean' of the operations centre were being discussed with IT. However, the audit trail for this agenda item showed that it had been outstanding for over three years.

Good practice we had found in other emergency operations centres, such as at Manchester Parkway, had not been shared and implemented at Broughton. One example was that Manchester staff were able to contact the urgent care desk for clinical support, and could obtain clinical support through instant messaging, but these communication channels were not being used at Broughton.

The trust had developed a process for responding to calls when a patient had already been seen by ambulance staff within the previous 24 hours. These calls were automatically flagged and alerted the clinical governance department alerted.

After they had been triaged, the calls were passed to a local advanced paramedic to investigate and identify any potential care planning needs or learning that would be of benefit to the person using the service.

Leadership of service

Some staff told us that they did not have regular appraisals. Indeed, some staff who had been with the trust for several years said that they had only received one appraisal in that time.

Staff also told us that they could not have time off the phones to speak with a supervisor, and, as well as not being listened to, they rarely received feedback.

We saw evidence of feedback through bulletins; we also saw evidence that staff concerns and suggestions were being logged in minutes and translated into action plans. However, some tasks in action plans were not measurable and had not been completed in some considerable time.

Recorded actions on the back of staff suggestions were non-committal and hard to measure. They were worded for example, as 'Look at getting the EOC deep cleaned' and "Discuss with…' or 'Enquire about…'

The team in Carlisle were proud of their unique function and demonstrated how they worked to support service delivery across the trust and not just throughout Cumbria and Lancashire. This team felt supported and well-led.

Culture within the service

We spoke with several of the managers and various project leads based at Broughton who told us they felt supported by the trust and gave examples of how they had been provided with opportunities to learn and develop.

However, in our meetings and focus groups with many of the operations centre's staff, we were told that they were not given an opportunity to voice their concerns and they were not listened to.

We saw that the performance managers were taking decisions about deployment away from some dispatchers. They would call out the decisions the dispatcher should make rather than empowering the dispatcher to make the decision.

Several staff in dispatch demonstrated low morale and did not feel supported to improve their own performance.

None of the call handlers we spoke with wanted to work in the dispatch team in the future.

Local leaders discussed staff suggestions, but their recorded responses did not engender confidence in changes being made.

Greater Manchester

Staff performance was monitored and each specialist paramedic's results were published to the team. Each paramedic had a unique identifying number so only they would know which results related to their performance. This meant they could compare their performance against their colleagues without knowing which results related to whom.

Staff were proud of their roles and felt supported and well-led. Their health and well-being was considered and there was a 'no blame' culture within the team.

Vision and strategy for this service

- Staff freely quoted the trusts vision - Delivering the right care, at the right time in the right place

Governance, risk management and quality measurement

- The senior managers monitored each team's performance the results were displayed in the emergency operations centre.
- Staff performance was monitored and each paramedic's results were published to the team. Each paramedic had a unique identifying number so only they would know which results related to their performance. This meant they could compare their performance against their colleagues without knowing which results related to whom.

Leadership of service

- Senior managers at the emergency operations centre clearly described their role, responsibility and accountability.
- The management team knew the cost improvement programme, however they stated it had not affected the emergency operations centre and had recently been given permission to recruit.
- There was a clear management structure at the emergency operations centre.
- All staff knew who their immediate line manager was.
- Staff felt supported by the managers and felt confident they could speak to them about anything. Many staff gave us examples of approaching their manager or more senior managers about circumstances relating to their role.
- Managers sat with call handlers so that they were readily accessible and could easily monitor the workload and staff.
- The trust considered the health and well-being of their staff. For example all staff were offered an influenza vaccination and a health and well-being survey had recently been launched in response to feedback and the staff survey.

Culture within the service

- Paramedics in the control centre were confident and empowered to use their clinical judgement. They did not fear recriminations even if they made the wrong decision because they felt they worked in a supportive environment.
- We were told by many that there was a 'no blame culture'.
- Staff had regular breaks from the computer screens during their shifts. They worked no more than three night shifts in a row because it was recognised that doing more could compromise wellbeing, safety and decision making. Paramedics used the Manchester Triage System and could directly access the clinical team that had developed the system. They felt supported and involved in its development as a system that worked.

Staff engagement

- Staff gave us examples of being involved in the development of work systems, such as working hours and the development of the urgent care desk modules.

Access to the service

- Emergency operations centre staff reported being informed of anything they needed to know and were not overloaded with information that was not required.
- Staff were informed of anything pertaining to their role through one to one contact, team meetings, briefings or circulars.
- All staff had access to a staff suggestion scheme on the intranet.
- Staff could access the Chief Executive directly through the intranet or email. Some staff followed him on social media.

Innovation, improvement and sustainability

- To ensure patients were treated by the right healthcare professional and to reduce demand on call handlers an urgent care desk at the call centre based at Parkway was set up.
- Specialist paramedics helped direct non-urgent callers to the best care for them. For example a patient who was not in need of an emergency 999 response to their health concern could be called back by a specialist paramedic who has clinical knowledge to discuss the person's health needs. After further triage it may be identified that the person may be best placed to treat themselves at home, or visit their or a local GP, visit a local urgent care centre or continue to wait for an ambulance to be transferred to hospital.

Cheshire and Merseyside

The trust had a clear vision and strategy of which most EOC staff were aware.The Making Experiences Count team supported the trust to seek and act on feedback from people who used the service. The trust made frequent changes to the service; however, these changes were not always implemented safely, monitored adequately or evaluated fully.

Vision and strategy for this service

- The trust's vision was to the deliver high-quality care safely. In the Quality Account for 2013/14, the trust proposed to improve its safeguarding processes by developing its services for frequent callers, adolescents at risk including those making the transition to adult services, and people experiencing or vulnerable to domestic abuse. The trust also planned to identify and act on missed opportunities to intervene and refer.

Governance, risk management and quality measurement

- Call-taking and dispatch staff were aware of the systems in place to monitor their work and readily explained their purpose and value. This included the use of an electronic database to provide an audit trail of any actions they took.
- A specialist audit team worked well together to audit a sample of calls yearly, as part of the routine quality monitoring process. These audits fed into staff appraisals. However, the team fell short of their target number of calls to audit, which they said was due to a lack of staff. The audit team prioritised audits requested as part of complaints or incident investigations. The resulting feedback helped staff identify good practice and opportunities for improvement.
- When concerns had been raised, audit staff were usually given a brief in advance. This may have introduced unnecessary bias into the call review.

Leadership of service

- Call-taking and dispatch staff asked supervisors for advice. We observed staff escalating decisions to commanders according to their internal protocols, such as when receiving a request for an ambulance and team to transport a patient across England.
- Junior staff spoke positively about progressing within the ambulance service, such as by becoming an emergency medical technician or joining the dispatch team.
- Although some positions had a high turnover, some staff members had been working for the service for over 6 years.
- Some call-taking and dispatch staff said they did not have access to email and were dependent on their supervisor to share information. This meant that, at times, they received little or no warning about upcoming changes, such as new protocols, that they were expected to implement immediately.

Culture within the service

- Call-taking and dispatch staff said they were generally able to take a break if they needed to; however, they agreed that in most cases they just "got on with the next call".

Access to the service

- Staff said the trust was responsive when staff experienced abuse during a call. The emergency operation centre (EOC) managers said they encouraged staff to press charges, in line with their policies against abuse of staff. However, some staff chose not to.

Public engagement

- The trust had a public education campaign to change people's perception of the ambulance service from "getting an ambulance to take you to hospital" to accessing a range of treatment options, including treatment at home. It was too early to tell if this had had a positive impact on service demand or patient outcomes.
- The trust used a range of methodologies to engage with people regarding their services, such as one-to-one interviews, focus groups, use of patient stories and a patient experience board game.
- The trust also encouraged service users to complete the NHS Friends and Family Test by stocking ambulances with Friends and Family Test postcards and sending texts to service users on their mobile phones. The trust trialled the use of mobile data terminals in ambulances.
- The trust had a total ranking of 4 out of 5 stars by people who visited their webpage on NHS Choices.
- At the time of the inspection, The trust's page on a popular social media website had 7,029 'likes', approximately 2,000 visits, and a total ranking of 4.5 out of 5; 84.3% (445) of reviewers had given The trust 5 out of 5.

Staff Engagement

- Staff engagement took place via many electronic routes including the 'Talk to Us' online web-based method. The trust's overall performance was rated as better than expected or tending towards better than expected for 10 of the 28 key findings in the NHS Staff Survey 2013. However, most staff told us there weren't many face-to-face interactions and team meetings did not routinely take place.

Innovation, improvement and sustainability

- The trust had plans to build a new EOC in Liverpool.
- The trust evaluated how changes to the service would have an impact on quality by requiring staff to complete impact assessments for business cases or other budgetary changes. The quality of the impact assessments varied. Some of them had not been fully completed and therefore lacked details regarding potential risks or positive impact. For example, when the author identified a positive impact on patient safety, there was no description given to clarify what the positive impact was. It was not clear how these impact assessments could be used to inform business decisions.
- The trust took part in the NHS England Friends and Family Test Pathfinder Pilot, which demonstrated its commitment to innovation in obtaining patient feedback.

Outstanding practice and areas for improvement

Outstanding practice

Greater Manchester

- Caring
- Being able to stay on the line with the caller whilst messaging a paramedic
- Environment at parkway, Manchester
- Cleanliness of vehicles and ambulance stations
- GP referral scheme
- Detailed handovers - PRF

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff 23. (1) The registered person must have suitable arrangements in place in order to ensure that persons employed for the purposes of carrying on the regulated activity are appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard, including by — (a) receiving appropriate training, professional development, supervision and appraisal.