

North West Ambulance Service NHS Trust

North West Ambulance Service NHS Trust

Quality Report

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Date of inspection visit: 23-27 May 2016
Date of publication: 19/01/2017

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 known to CQC and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this ambulance location

Requires improvement



Emergency and urgent care services

Requires improvement



Patient transport services (PTS)

Good



Emergency operations centre

Good



Are acute services at this trust safe?

Requires improvement



Are acute services at this trust effective?

Good



Are acute services at this trust caring?

Good



Are acute services at this trust responsive?

Good



Summary of findings

Are acute services at this trust well-led?

Requires improvement



Letter from the Chief Inspector of Hospitals

The North West Ambulance Service (NWAS) NHS Trust is one of 10 ambulance trusts in England and provides emergency medical services across the North West region, which has a population of around 7 million people. The trust employs 5162 whole time equivalent (WTE) staff who are based at ambulance stations and support offices across the North West.

The trust has 109 ambulance stations distributed across the region, three emergency operations centres, one support centre, three patient transport service control centres, and two Hazardous Area Response Team (HART) buildings (one being shared with Merseyside Fire & Rescue).

The trust also provides, along with Urgent Care and out of hours partners, the NHS 111 Service for the North West Region. Operating from five sites across the North West, in Greater Manchester, Merseyside and Lancashire and Cumbria.

We last inspected this trust between 19 and 22 August 2014 for the announced element of the inspection, and the unannounced inspection visits took place on 26 and 27 September 2014. As the first ambulance trust inspected under the new model, the trust was not rated as part of this inspection. Additionally the 111 service was not inspected at the time of this previous inspection. We told the trust that they must make improvements to:

- Review the process for pre-alerting hospital accident and emergency 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 emergency operation centres (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.

Before carrying out this inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the Ambulance Service. These included clinical commissioning groups (CCGs); Monitor and the local Healthwatch.

We carried out our announced focused inspection of NWAS between 23 and 26 May 2016, with an unannounced inspection taking place on 6 June 2016. We carried out this inspection as part of the CQC's comprehensive inspection programme.

We inspected three core services:

- Emergency Operations Centres
- Urgent and Emergency Care
- Patient Transport Services

We also inspected the NHS 111 service provision during this inspection.

Our key findings were as follows:

Leadership and Culture

- There were regional variations in the culture both across the trust as a whole and within regions. Staff in some areas felt very positive about the culture, but in other areas they felt there was a high degree of pressure and that focus was on performance targets rather than care for patients.
- The Chief Executive Officer had recently commenced in a substantive post on 10 May 2016, following a period of covering the post as an interim, from March 2016.
- The urgent and emergency care service was moving towards a clinical leadership model, with more focus on clinical quality and a reduction in operational management. This leadership model included a

Summary of findings

consultant paramedic for the region and advanced paramedics in each sector. An increase in the number of senior paramedics and decrease in assistant operations managers was planned.

- Staff reported that the new clinical leadership structure with senior paramedics assuming a combined management and clinical leadership role was a positive development. This change had been well received as it provided clearer lines of reporting and less confusion, at the stations where it had already been implemented.
- Staff felt that leadership from heads of service was strong and visible. Heads of service and sector managers had been supported to develop their leadership skills with attendance at higher education courses.
- In Liverpool many of the staff said that staff morale was affected by the building which was cramped with teams located in different rooms.

Staffing

- There were staff vacancies across all areas of the urgent and emergency care service and the overall vacancy rate was 5.7%.
- Staff vacancy rates in North Cumbria were the highest in the trust with 35 vacancies, which represented 20%. The paramedic vacancy rate in this area was 16.7%. One of the initiatives to manage this deficit was the employment of paramedics from other countries. Two paramedics from Europe had worked in Cumbria for some time. The trust had employed 35 new European paramedics in Greater Manchester at the time of the inspection. There were plans to recruit a further 36 with 24 of these being appointed to North Cumbria.
- A high proportion of vacancies related to band five paramedics. A total of 16.2% whole time equivalent (WTE) posts for this role were vacant at the time of our inspection across all areas. This reflected a national shortage of paramedics.
- The staff turnover rate for the 2015/16 period for the service was 7.2%. The trust was looking at new ways to recruit paramedics to fill these vacancies. This included progression programmes for their EMT staff and also international recruitment. The trust's human resources department was working with managers on developments to improve the retention in Cumbria where rates were higher at 11%. This included the consideration of relocation packages.

Records

- Information relating to patients' care and treatment was recorded on patient record forms (PRFs) which were paper based forms in a duplicate book. This meant the ambulance service could maintain their own record and also supply one copy to the hospital or patient, depending on whether the patient was conveyed to hospital. They also had one copy without patient identifiable information to use for audit purposes.
- We reviewed 236 PRFs within urgent and emergency care. We saw that, in 218 of these cases, the records were completed in legible handwriting, were signed and dated and the history of the patient incident, treatment provided, medicines administered, assessments of pain and observations were completed.
- There was a limited amount of free text space available to record a full history and clinical assessment. If there was not enough space to complete all details, a second PRF would be completed. Some staff felt a continuation sheet would be beneficial but others told us there was enough space to document all necessary detail. Paramedics on the Manchester urgent care desk completed patient review forms for each patient seen. These records were posted into a locked cabinet in the office and were collected once a month to be stored securely elsewhere in the trust. The urgent care desk team did not have access to the cabinet and, as such, we were unable to review any of these records. This meant there was a risk these records could not be accessed urgently if required.

Governance and Risk Management

- The quality committee met every two months and discussed areas, such as risk and mitigation, safeguarding, response times, complaints, incidents, medicine management, infection prevention, quality improvement and National Ambulance Clinical Quality Indicators. This meant that the executive team only got oversight on these quality areas every two months.
- The board did not have an overview of the reporting and monitoring of serious incidents. This meant there was no monitoring of how quickly serious incidents were reported, timescales for investigations and how quickly actions were implemented following the

Summary of findings

outcome of the investigation. Serious incidents regularly took longer than the 60 day timeframe (set by NHS England in the serious incident framework) to investigate and conclude.

- There was a trust-wide risk register in place which recorded all operational risks with a score of 12 and above. There was evidence that the register was reviewed and updated regularly. However, there were some improvements required. In particular, some risk descriptions did not clearly describe the risk; some of the information recorded under controls and assurance were not actually controls or sources of assurance; there was no target rating for risks, meaning it was unclear what level of risk the trust was aiming for, and there were a number of risks without actions identified to mitigate the identified risk. Additionally a significant number of risks had been on the risk register for a number of years with little evidence of progress or impact being reported. In addition local risk registers were not totally aligned to the trust wide risk register.

We saw several areas of outstanding practice including:

- The Hazardous Area Response Team (HART) teams in both Manchester and Merseyside were delivering an excellent service to patients. They were proactive in their approach to gaining new skills and forging relationships with other emergency services, to ensure the smooth running of rescues in difficult areas. Their co location with the fire service training headquarters in Merseyside afforded them and all NWAS staff excellent and unique training opportunities. This ensured that they were equipped to deal with and manage a wide range of hazardous emergencies and undertaken formalised de briefs in a multidisciplinary manner.
- The service had community care pathway designed to share information across services and ensure ambulance clinicians were aware of pre-existing care plans for patients being managed by community services. This included when it was most appropriate for patients to be treated at home, involving other professionals or conveyed to an alternative care setting than an emergency department. This was also supported in some areas by the long term conditions teams based at local hospital trusts.
- The community engagement manager was in the process of implementing an electronic application

initiative called 'Good SAM'. This application could be downloaded onto mobile devices and alerts users who have been vetted and checked to a nearby cardiac arrest. Through this initiative the manager had also mapped all defibrillators in the North West area and from August 2016, this information would be available to call centre staff so that they could direct members of the public attending cardiac arrests to these devices.

- All staff we observed were exceptionally caring in their approach and went above and beyond their duty to provide compassionate, supportive care.

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

Importantly, the trust must:

In Urgent and Emergency Care:

- The service must ensure staff are given adequate opportunities to report incidents and safeguarding issues.
- The service must ensure that staff are reporting all adverse incidents in line with NWAS policy.
- The service must ensure all staff receive the required level of mandatory training.
- The service must ensure that all staff receive the required level of mandatory safeguarding training and ensure that there is a mechanism to check that staff have completed this training.
- The service must ensure all community first responders have the required level of training to undertake their role including how to recognise and act on safeguarding issues.
- The service must ensure that vehicle log books are completed fully and that checks undertaken by managers reflect the true content of the log books.
- The service must ensure that all equipment used in the delivery of patient care is subject to the appropriate and required checks, including that held by the community first responders.
- The service must ensure that vehicles receive deep cleaning when required.
- The service must ensure that controlled drugs are stored, managed and checked in line with trust policy and national legislation.

Summary of findings

- The service must ensure that all staff involved in the administration of medical gases, for example Entonox, have received the required level of training to ensure they are competent to undertake this duty.
- The service must ensure there are adequate numbers of suitably qualified staff deployed in all areas.
- The service must ensure that all guidelines and policies used in the delivery of patient care are reviewed and updated at the frequency required.
- The service must ensure that patients have timely access to care and treatment in line with national targets.
- The service must ensure all staff received their annual appraisal.
- The service must ensure all staff have received the required level of training to ensure they are able to exercise their duties in line with the Mental Capacity Act (2005).
- The service must ensure that the consent policy and guidance on mental capacity assessments issued to staff is in line with the Mental Capacity Act (2005) code of practice. The service must ensure there is specialist equipment and training for staff to safely manage the care of bariatric patients.
- The service must ensure that staff received back up when requested in a timely way.
- The service must ensure that risks are appropriately documented, reviewed and updated.
- The service must ensure that any allegations of bullying are taken seriously and managed appropriately with support provided to the staff involved.
- Ensure that departmental risk registers are kept up to date and reviewed appropriately.
- Ensure that processes are robust and effective in relation to safeguarding processes and procedures.
- Ensure compliance with the fit and proper person regulation.

In Emergency Operations Centres:

- The service must ensure that staff are reporting all adverse incidents in line with NWAS policy and ensure all staff have received appropriate training on the incident reporting system.
- The service must ensure there are robust processes for sharing lessons learned from incidents and complaints with staff across the three sites.

- The service must ensure that all safeguarding concerns are reported in line with the NWAS policy and must improve staff awareness of the safeguarding policy.
- The service must ensure all staff receive their annual appraisal.
- Ensure that risk registers clearly document short and long term risks local to each emergency operations centres (EOC) site as well as to the EOC service as a whole, including control measures that have been identified and implemented, and planned review dates.

In Patient Transport Services:

- The trust must ensure that investigation reports fully reflect the actions taken during an investigation and provide a summary of the root cause of the incident and the lessons learned, in line with trust policy.
- The trust must ensure patient information is kept confidential. The management of patient information provided to volunteer drivers did not promote confidentiality.
- The service must finalise its existing PTS structure and quality reporting framework to ensure that there is a clear oversight of escalation and monitoring of governance, risks and performance of the service.

In addition, the trust should:

In Urgent and Emergency Care:

- The service should consider implementing systems to ensure that feedback from incidents and investigations is consistent and accessible to all staff including community first responders.
- The service should ensure that communication aids for patients with visual or mental capacity impairments are available.
- The service should consider providing training to all frontline staff on the duty of candour and their responsibilities in relation to this.
- The service should consider ensuring that staff with level three safeguarding training are available for staff to access for advice and guidance.
- The service should consider providing training on key safeguarding subjects which crews may come across such as female genital mutilation, radicalisation recognition and human trafficking.

Summary of findings

- The service should consider implementing a system to ensure the key codes to access keys in the ambulance stations are changed regularly.
- The service should ensure that all records are completed fully and legibly.
- The service should consider implementing a system by which all staff members involved in the care of the patient can sign for the care they have delivered.
- The service should consider ways to improve staff compliance with the use of patient pathways and care bundles.
- The service should ensure that patients can be provided if necessary with information on how to feedback about the service.
- The service should ensure that complaints are dealt with consistently and in line with trust policy.
- The service should ensure that staff are aware of the trust vision and values.
- The service should consider implementing a more consistent way of monitoring of performance and quality across the regions.
- The service should improve staff engagement and address areas of low morale.

In Emergency Operations Centres:

- Improve EOC staff's skills in managing calls from children or from people who may have mental health problems, those who may be in crisis, and those living with dementia or learning disabilities.
- Improve communication across all EOC teams, including those working night shift patterns, of changes to procedures or announcements.
- Improve accessibility, and readability, of information transferred by the system to the EOC from NHS111, including the reduction of duplication of information.
- Raise awareness among all EOC staff on the trust's vision and strategy and how they can contribute to it.
- Consider how the environment at the Liverpool site can be improved, including what reasonable adaptations may be needed for staff who have reduced mobility.
- Review the policy for deploying the HART team and how it reflects the way in which the triage and dispatch system operates in practice.
- All patient records made by the paramedics on the Manchester urgent care desk should be made accessible to relevant staff, as required.

- Review the use of the MPDS system in terms of the tools not being available when a second follow-up call is made.
- Review the Mental Capacity Act (2005) training for all staff.

In Patient Transport Services:

- The trust should ensure all staff have timely access to a computer in order to submit electronic incidents or safeguarding referrals.
- The trust should consider facilitating ambulance crews to meet regularly to ensure new developments and lessons learned from local, trust wide and national incidents can be shared and discussed.
- The trust should explore that all recorded safeguarding incidents have been appropriately referred and that PTS staff are aware of what constitutes abuse or neglect and that they are all clear about the referral process.
- The trust should review the staff training requirements for the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) guidelines to provide a common understanding of how patients are cared for in accordance with their best interests.
- The trust should review its process for maintaining all vehicles in good visual repair and that rusty items are replaced as quickly as possible.
- The trust should review its process for reviewing and updating policies and procedures as appropriate.
- The trust should consider implementing regular refresher driving courses or skills checks for PTS drivers.
- The trust should review the process for ensuring that DNACPR documentation travelling with the patient is in the appropriate format.
- The trust should review the process for responding to and investigating complaints to improve the timeliness of this procedure.
- The trust should review its process for including operational issues within a strategic overview or central risk register related to internal risks.
- The trust should review its PTS operating model to produce a formal vision and strategy for PTS linked to the overarching organisation vision and strategy.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Emergency and urgent care services	Requires improvement 	Staff were not always given time to report incidents and told us that this discouraged them from doing so. Feedback from incidents was not consistent across the service. The uptake levels for mandatory training in some areas were lower than the trust's target. Data relating to safeguarding training uptake levels provided by the trust did not give a true reflection of the number of staff who had undertaken this and there was no mechanism for checking that staff had completed the training. Log books used to record vehicle checks including infection control and prevention checks were not completed consistently and some vehicles were overdue for their deep cleaning. Essential checks of controlled drugs were not completed consistently and key codes to access keys to these drugs had not been changed for a number of months in some bases and years in other bases. Some policies and protocols were past their date for review and appraisal rates were below the trust target in some areas. Response times to 5% of life threatening calls were worse than other ambulance trusts. Consent was not always appropriately sought from the patients themselves. There were insufficient processes to ensure mental capacity was assessed and considered, where appropriate. Response times to emergency calls did not always meet national targets. Communication aids for patients with visual or mental capacity impairments were not available on most vehicles and there was a lack of specialist equipment and training for staff to safely manage the care of bariatric patients. Information for patients about how to complain was not readily available on the vehicles and there was a lack of consistency between areas in how well staff learned from complaints.

Summary of findings

The majority of staff we spoke with did not know about the trust vision or values and had no awareness of the five year business plan. Risks were not always appropriately escalated to the locality risk register and monitoring of performance and quality was not consistent across the regions. The culture of the service was varied across the region, with some areas experiencing low morale or bullying and feeling separated from the rest of the trust. Staff did not feel they had the opportunity or time to read bulletins or emails and staff meetings were infrequent, if held at all.

Good



Procedures to ensure the safety of services were good, with systems in place for reporting incidents and equipment checks performed to a good standard. Ambulances were clean, and the service was well staffed. Ambulance crews were trained in using dynamic risk assessments and we saw evidence of this occurring. Effective systems were in place to facilitate the timely maintenance and replenishment of vehicles. Ambulance staff had good access to information about patients and journeys through the use of mobile data terminals which were regularly updated by the control centre teams.

Staff knew what steps to take when a patient became unwell while being transported and were clear on their roles should a major incident occur. Arrangements were in place to respond to emergencies and the service took account of seasonal fluctuations in demand, the impact of adverse weather or disruption to staffing. All areas had sufficient staff numbers to meet the needs of the service. PTS staff in all areas were seen as caring, compassionate and dedicated to improving the service. All staff took their duty to report safeguarding concerns seriously. Local culture was good in most areas and we found that the morale had improved in the control room in Chester immediately after the last inspection. The performance of call centre staff was

Patient
transport
services
(PTS)

Summary of findings

effectively audited to make sure they followed scripts and algorithms provided. Between 1 May 2015 and 30 April 2016 core service targets were met in Lancashire for nearly all months, for all KPIs related to journey and appointment times. However, we found no evidence that incidents were being managed at an overarching organisational level or that themes were being identified and addressed to prevent the same issues recurring. This meant that some issues were not dealt with effectively, for example ongoing problems with DNACPR forms not being in the correct format. Volunteers used by the service were not given enough supervision as they carried out their roles, and policies needed to be updated in light of the Savile enquiry. Safeguarding concerns were dealt with at a local level, but were not always reported to the safeguarding team in Carlisle. Enhanced priority service (EPS) patients spent longer on the transport than they needed to because journey times were longer than acceptable limits. Cumbria, Mersey and Cheshire failed to meet the 95% target for the KPI related to appointment times for all 12 months in the period May 2016 to April 2016. At our last inspection we found an apparent disconnect between managers and senior staff across PTS; senior managers acknowledged the challenges of working across such a large geographical area and the need to increase the visibility of the senior management team. At this inspection we found there was still no vision or formal strategy for PTS although we were provided with the service contract and operating model. We did not see any evidence of a project plan or timelines for the delivery and implementation of a PTS strategy. There was no clear governance framework for the service in terms of quality structures, lessons learned or risk registers.

Summary of findings

Emergency operations centre

Good



Overall we have rated the Emergency Operations Centre (the EOC) as good. Safety required improvement as we identified regulation breaches in relation to the reporting of incidents and safeguarding concerns. Staff were not always clear on what should be recorded as an incident. Incidents were not always recognised or reported by staff and staff told us they were not always given time to report incidents. Feedback and learning from incidents was inconsistent. However, incidents that were reported were robustly investigated, explanations were provided to those involved and, where appropriate, apologies were provided in line with the duty of candour. The trust's safeguarding policy was not well embedded and not all staff reported safeguarding concerns in line with the policy. There was no routine system in place to establish if ambulance crews had considered or acted on any safeguarding information passed to them from the EOC. However, mandatory training levels were above the trust's targets, and staffing levels were adequate with a good skills mix and few vacancies. Escalation and risk assessment tools ensured patients received the right level of response and clinical support was available. Clinical escalation plans and major incident plans were in place. Staff had limited or no knowledge of the Mental Capacity Act and making a judgement on whether or not a patient lacked mental capacity. There was no specific training on dealing with patients living with dementia or learning disabilities. However, the service worked with, and supported, frequent callers to manage their own health and reduce the number of calls they made to the service. Effective was good as staff were well trained in using the triage and dispatch system and had access to clinical support and advice when needed. The number of calls abandoned was better than the England average, with 95% of calls answered

Summary of findings

between three and four seconds. There was an effective system for communicating warnings or medical information to ambulance crews. There was good co-ordination and liaison with hospitals to manage handover times. The urgent care desk carried out telephone triage assessments to assess patients' need, which meant more patients were treated safely in their own home.

Caring was good. Communication with callers who contacted 999 was effective and reassuring. Staff were compassionate, reassuring and treated callers with dignity and respect. Staff showed kindness and empathy for those experiencing mental health crises and we saw numerous examples of letters from patients and carers thanking EOC staff for the care they provided.

Responsive was good because the EOC planned its services to meet the needs of the local population and different levels of demand. There were good escalation and risk assessment tools in place to ensure patients received the right level of response and clinical support was available, where required.

Call performance was continuously monitored with action taken to reduce pressures on the service. Complaints were thoroughly investigated, and learning was shared with staff involved. However, staff told us they would benefit from training in dealing with patients or carers living with mental health issues or dementia.

Well-led was good because there was a clear governance structure with good communication between the EOC site managers in the regions, and the local leaders were visible and staff told us they were supportive. Detailed plans were in place to develop the urgent care desk service further, and a telehealth scheme had been introduced to support suitable patients at home.

Summary of findings

The EOC sites in conjunction with the urgent and emergency care service engaged with the public, including frequent callers, to reduce the number of unnecessary calls. The EOC sites engaged with the public, including frequent callers, to reduce the number of unnecessary calls. The service developed public information campaigns, 'Make the right call' and '#Team999' to educate people about the services. However, we identified a regulation breach as the EOC was not adequately managing risk'.

Risks were recorded in different documents but did not give a complete picture of the risks to each individual site or to the EOC service as a whole. We could not be assured that all appropriate risks for the sites had been identified or mitigated.

There was no separate vision and strategy for the EOC, and staff were not clear on how they could contribute to the trust's vision and strategy. One of the sites was in a cramped, dated building, which was not suitable for staff with reduced mobility; staff told us the environment was affecting morale.

Overall rating:

Requires improvement



North West Ambulance Service NHS Trust

Detailed findings

Services we looked at

Emergency and urgent care; Patient transport services (PTS); Access to the service; Emergency operations centre (EOC); Resilience; NHS 111 service

Detailed findings

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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 8,000 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 1.3 million 999 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 1.2 million PTS patient journeys per year. It currently employs over 5400 staff.

North West Ambulance Service provides an emergency department service to respond to 999 calls; an NHS 111 service for when medical help is needed but it is not a 999 emergency; a patient transport service (PTS), for non emergency patients between community provider locations or their home address and emergency operation centres (EOC), where 999 and NHS 111 calls were received, clinical advice is provided and emergency vehicles dispatched if needed. There is also a Resilience and Hazardous Area Response Team (HART) and an air ambulance service.

Our inspection team

Our inspection team was led by:

Chair: Shelagh O'Leary

Inspection Managers: Nicola Kemp and Simon Regan

The team included two CQC Inspection Managers, 11 CQC inspectors, an analyst, inspection planner, two assistant inspectors and a variety of specialists including: the National Professional Advisor for ambulance services,

Detailed findings

Senior Quality and Risk Manager, a non-executive director, Head of Safeguarding, A&E Nurse, Paramedics, Interim Clinical Project Manager, Call Handler, a Pharmacist, Workforce Race Equality Specialist, a

Commercial Services Director, Director of 111 NHS services, National Operations Manager, Emergency Operations Centre Manager and Clinical Educator in Ambulance Service.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The inspection team inspected the following:

- Emergency Operations Centres
- Urgent and Emergency Care
- Patient Transport Services

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

We interviewed staff and talked with patients and staff from areas. We observed how people were being cared for, talked with carers and/or family members and reviewed patients' records of personal care and treatment.

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at North West Ambulance Services.

Facts and data about North West Ambulance Service NHS Trust

The trust receives over 1,170,000 emergency calls per year, with emergency crews attending more than 952,000 incidents each year, with around 800,000 of these requiring emergency transport. This represents approximately 16% of national activity. The trust undertakes over 1.2 million non-emergency patient transport journeys each year.

The trust employs 5162 whole time equivalent (WTE) staff.

The trust operates around 1,000 vehicles on both emergency and non-emergency operations. The trust has 109 Ambulance Stations, 35 being in the Cheshire and Merseyside area, 41 in the Cumbria and Lancashire area and 33 in the Greater Manchester area.

Our ratings for this service

Our ratings for this service are:

Detailed findings

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

Emergency and urgent care services

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

Information about the service

The main role of emergency and urgent care services is to respond to emergency 999 calls, 24 hours a day, 365 days a year. North West Ambulance Service NHS Trust (NWAS) provides an emergency and urgent care service across the North West of England, which covers the counties of Cheshire, Merseyside, Lancashire, Cumbria and Greater Manchester. The trust manages these by separating them into three locations of Cheshire and Merseyside, Greater Manchester and Lancashire with Cumbria.

There are 109 ambulance stations distributed across the region, three emergency operations centres, one support centre, two patient transport service control centres, two air ambulance bases and two hazardous area response team (HART) buildings (one being shared with Merseyside Fire & Rescue). NWAS works closely with other emergency services, including the police, fire service, mountain rescue and coastguard, both to provide emergency services and during major incidents.

The trust has around 1,000 vehicles on both emergency and non-emergency operations including rapid response vehicles (RRVs) and three air ambulances, over two bases. They receive over 1,170,000 emergency calls per year and emergency crews attend more than 952,000 incidents each year. Around 800,000 of these require emergency transport. This represents approximately 16% of national activity.

NWAS supports the work of voluntary community first responders (CFR) (members of the public who had been trained by NWAS to respond to 999 calls in their local area

to deliver early life saving treatment, such as basic life support and defibrillation) across the region who give basic lifesaving interventions prior to the arrival of the ambulance crew; this is co-ordinated by NWAS.

We conducted focus groups with staff in each division prior to and during our inspection to hear their views about the service. This included frontline ambulance staff, managers and support staff. During the inspection we visited a number of ambulance stations across all three locations, in both towns and rural areas, and we spoke to over 210 staff in various roles including Student Paramedics, Emergency Medical Technicians, Urgent Care Assistants, Senior Paramedics, Operations and Assistant Operations Managers. In addition, we spoke with support staff including cleaners and those who deep cleaned ambulances. We observed ambulance crews treating patients. We spoke with over 47 patients and relatives. These patients had used the service in their own homes or for conveyance to emergency departments.

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

Emergency and urgent care services

Summary of findings

We found that North West Ambulance Service (NWS) were providing emergency and urgent care services which required improvement because:

- Staff were not always given time to report incidents and told us that this discouraged them from doing so.
- Feedback from incidents was not consistent across the service.
- Staff and managers told us that mandatory training was provided over a two year cyclical basis for 33 specific competencies and subjects. However, since the cycle was two yearly, this meant that staff who had received the training at the beginning of the cycle may attend at the end of the next cycle and therefore not receive mandatory training for nearly four years. The trust told us that they had reverted back to the one yearly cycle to address this issue. Mandatory training included fire safety, life support, dementia awareness and the use of medical gases.
- The data relating to safeguarding training uptake levels provided by the trust did not give a true reflection of the number of staff who had undertaken this and there was no mechanism for checking that staff had completed the training.
- Log books used to record vehicle checks including infection control and prevention checks were not completed consistently and some vehicles were overdue for their deep cleaning.
- Essential checks of controlled drugs were not completed consistently and key codes to access keys to these drugs had not been changed for a number of months in some bases and years in other bases.
- We found that some patient record forms were not fully completed.
- We found that there were high numbers of vacancies in certain staffing groups across the service.
- Updates to clinical guidelines and processes were not consistently fed back to staff. Some policies and procedures were past their date for review and did not reflect changes that had been made in local health systems.

- Consent was not always taken appropriately. There were insufficient processes to ensure mental capacity was assessed and considered where appropriate. Staff had a poor understanding of the mental Capacity Act (2005).
- Response times to 5% of life threatening calls were worse than other ambulance trusts.
- Communication aids for patients with visual or mental capacity impairments were not available on most vehicles and there was a lack of specialist equipment and training for staff to safely manage the care of bariatric patients.
- Information for patients about how to complain was not readily available on the vehicles and there was a lack of consistency between areas in how well staff learned from complaints.
- The majority of staff we spoke with did not know about the trust vision or values and had no awareness of the five year business plan.
- Risks were not always appropriately escalated to the locality risk register and monitoring of performance and quality was not consistent across the regions.
- The culture of the service was varied across the region, with some areas experiencing low morale or bullying and feeling separated from the rest of the trust.
- Staff did not feel they had the opportunity or time to read bulletins or emails and staff meetings were infrequent, if held at all.

However:

- Staff were aware of how to report incidents and were able to give us examples of when they had raised an incident and robust investigations were carried out, when indicated.
- Staff were aware of when vulnerable patients required further referrals.
- Staff followed infection control and prevention guidelines and vehicles were visibly clean and tidy.
- Patients were appropriately risk assessed and staff responded to these risks appropriately.

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- Managers considered skill mix when planning rotas, were making efforts to recruit staff into vacancies and were working to improve and manage their anticipated resource and capacity risks.
- There were adequate and robust major incident plans in place and these were tested regularly to assess their suitability and efficacy.
- There were joint working initiatives with health and social care services in all of the geographical areas, which were designed to improve services for local people.
- There were systems in place to meet the needs of patients in rural locations, which included partnership working with the health, social and voluntary care sector.
- Access to the right ambulance and response times were monitored and formed part of the performance management system for each station.
- The service was working to reduce unnecessary admissions to emergency departments by increasing other services and through joint working with health partners.
- Heads of service were described as good leaders and most staff felt supported by local leaders.
- The HART team held regular staff meetings and engaged with staff in a positive way.
- The trust was improving engagement with the public via social media and the internet.
- The community engagement team were successfully recruiting community first responders and involving the wider community in education and training.
- There were a number of initiatives and schemes in place to improve the services the trust provided and ensure a sustainable future for the ambulance service.
- Patients were treated with compassion and kindness. Staff respected their privacy and dignity in all situations.
- Staff were dedicated and committed to caring for patients and often went above and beyond the expectations of their employment to provide care.
- Emotional support was offered to patients and their relatives in both life threatening and emergency situations and also during less urgent situations.

Are emergency and urgent care services safe?

Requires improvement



We rated emergency and urgent care services as 'Requires Improvement' for safe. This was because:

- Staff were not always given time to report incidents and told us that this discouraged them from doing so.
- There was an underreporting of certain types of incidents including adult safeguarding issues.
- Feedback from incidents was not consistent across the service.
- Staff and managers told us the mandatory training program was structured over a two year cycle. This meant that if staff had training at the beginning of this cycle and then had their next training at the end of the next cycle, the time between training could be nearly four years. The service told us that had recently reverted back to a one year training cycle to address this problem.
- The data relating to safeguarding training uptake levels provided by the trust did not give a true reflection of the number of staff who had undertaken this and there was no mechanism for checking that staff had completed the training.
- Log books used to record essential vehicle checks including infection control and prevention checks were not completed consistently and some vehicles were overdue for deep cleaning.
- The equipment used by Community First Responders was not consistently checked on a regular basis.
- Essential checks of controlled drugs were not completed consistently and key codes to access keys to these drugs had not been changed for a number of months in some bases and years in other bases.
- We found that some patient record forms were not fully completed.
- We found that there were high numbers of vacancies in certain staffing groups across the service.
- The trust was only piloting one 'make ready' station in Greater Manchester.

However:

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- Staff were aware of how to report incidents and were able to give us examples of incidents they had raised.
- Appropriate actions were taken as a result of incidents and robust investigations were carried out, when indicated.
- Staff were aware of when vulnerable patients required further referrals.
- Staff followed infection control and prevention guidelines and vehicles were visibly clean and tidy.
- Patients were appropriately risk assessed and staff responded to these risks appropriately.
- There was sufficient equipment to meet the needs of adults and children on board ambulances.
- All equipment we observed had undergone the relevant safety and electrical testing.
- Managers considered skill mix when planning rotas and were making efforts to recruit staff into vacancies.
- Managers within the service were working to improve and manage their anticipated resource and capacity risks.
- There were adequate and robust major incident plans in place and these were tested regularly to assess their suitability and efficacy.

Incidents

- Staff reported incidents via an electronic reporting system. Between August 2015 and January 2016, a total of 2997 incidents were reported across the service. There were 882 incidents reported for emergency and urgent care in the Cheshire and Merseyside area, 899 of these were reported for the Lancashire and Cumbria areas and 1,216 of these incidents were reported for the Greater Manchester area.
- The main category of reported incidents related to persistent callers and inappropriate calls. The service had regular meetings to deal with persistent and inappropriate callers and worked closely with other providers to reduce the number of persistent callers accessing the service.
- All staff were able to demonstrate how they would report an incident and gave recent examples, including safeguarding issues and abuse by members of the public.
- We were told about incidents that had happened but were not reported. The Greater Manchester HART team gave examples of where they were not requested to

respond to calls and subsequently had feedback which identified their skills would have been appropriate to use, or where they had been deployed to calls with delays.

- Some staff told us they felt they were not given sufficient time to undertake their incident reporting duties. Three staff told us this discouraged them from reporting incidents. We found that staff were not given protected time to undertake incident reporting and were expected to do this while on the road or on their meal breaks. The service lead told us they were aware of concerns from staff regarding this and, in response, were planning to implement computer screens at acute hospitals in the Cheshire and Merseyside area so that staff could have protected time to report incidents. However, although staff in the other localities raised similar concerns, there were no similar plans in place.
- There was also no facility, on the electronic system, for staff to save details of an incident they were in the process of inputting and were called on to another job. This discouraged crew from reporting incidents in between calls as they would have to restart the reporting process.
- Individual station managers had information about reported incidents in their area and the progress towards investigation. In one station there were 24 open incidents, the longest of which had been under investigation since October 2015. Incidents were discussed at senior management meetings, however we found there were no references to the number of incident reports left open.
- Community First Responders (CFRs) used email or paper forms to report incidents but said they received very little feedback from the service beyond an acknowledgment that the report had been received. CFRs are volunteers dispatched to attend local 999 calls until back-up ambulance services arrive.
- The severity of the majority of incidents reported were categorised as no or low harm. When an incident was categorised as moderate or severe these were reviewed and investigated robustly.
- Serious incidents were reported through the Strategic Executive Information System (StEIS). Six serious incidents were reported to StEIS between April 2015 and April 2016 across the service. Serious incidents were investigated using a root cause analysis approach. We

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reviewed a sample of two investigation reports which showed that a robust investigation had been undertaken and actions had been identified and implemented to prevent reoccurrence.

- We saw evidence in these reports that frontline staff were involved in the investigation process. Staff told us they felt positively about being involved in the root cause analysis investigation process and they felt supported by their managers and senior paramedics. There was an incident learning committee who reviewed themes and trends of incidents. Learning outcomes from the investigations were shared throughout the trust and this was discussed at the risk committee. One example of this was an incident involving faulty emergency medicine containers and, as a result, all vehicles were checked for this fault within two hours.
- Feedback from reported incidents to staff was variable across the areas. In the Cheshire and Merseyside area some staff told us they did not receive feedback about incidents they reported. However other staff in the Manchester, Cumbria and Lancashire areas reported they did receive meaningful feedback after reporting an incident. One example given to us in the Merseyside area was of a fault with a piece of equipment. The staff member had completed a report about this and received feedback from their manager the next day with an outline of what action had been taken to rectify the issue.
- The service produced regular briefings relating to individual safety alerts arising from incidents and general safety information. These contained key information about specific incidents where information needed to be shared. These briefings were shared through email and displayed prominently in all ambulance stations we visited. There was also a facility to issue an urgent alert to an electronic bulletin board on every vehicle. One example of this in the Cumbria area was regarding an investigation into a serious incident which resulted in a clinical information bulletin being circulated within 10 days to inform all staff of an equipment failure.
- Staff were encouraged to report incidents of physical violence via the incident reporting system and given time to return to base to complete these reports.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or

other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. Incidents where duty of candour applied were also discussed at the quality business group and there was a nominated member of the executive team with oversight of the duty of candour.

- Some managers we spoke with understood their responsibilities in relation to duty of candour; others told us that this duty was considered as part of the complaints process. Front line staff did not show a good understanding of this duty.

Mandatory training

- Staff and managers told us that mandatory training was provided over a two year cyclical basis for 33 specific competencies and subjects. However, since the cycle was two yearly, this meant that staff who had received training at the beginning of the cycle may attend at the end of the next cycle and therefore not receive mandatory training for nearly four years. The trust told us that they had recently reverted back to a one year training cycle to address this issue. Mandatory training included fire safety, life support, dementia awareness and the use of medical gases.
- The uptake levels for mandatory training varied between geographical areas in the urgent and emergency care service. Data showed 90% of staff in the Cheshire and Merseyside areas, 76% of staff in Cumbria and Lancashire and 78% of staff in the Greater Manchester area had completed the trust's mandatory training programme at the time of the inspection. These rates meant that a proportion of staff working operationally did not have up to date mandatory training required to undertake their role. Each area had plans in place to address the areas of low uptake and were planning to have all staff trained by September 2016. The service was on track with their internally set trajectory to meet this deadline.
- The trust had recognised the low training rates as an issue as it was recognised on the team's risk register, which detailed that mandatory training levels were low as training was stopped over the winter months in 2015 due to increased demand on services.
- All the staff spoken with in all areas told us that mandatory training had been reduced from three days to one day, which did not give enough time or opportunity to discuss subjects taught. The trust

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informed the CQC that training was previously delivered over five days, however the statutory content equated to 22 hours over a two year cycle. This equated to 11 hours per year and further decreased the face to face training to one day. This meant that subjects which require face to face training delivery were covered in one day as opposed to the three allowed previously and staff felt that the amount delivered in the session was intense.

- Overseas paramedics undertook a period of training followed by a probationary period working as an Emergency Medical Technician (EMT) alongside a qualified paramedic. This probationary period varied dependent on the practitioners progress and developmental needs.
- A four week mandatory driving course was undertaken by all staff. A driving occupational competency assessment and observation following this only occurred once every three to five years and consisted of a one hour observation assessment. This was in line with Road Safety Act 2006. Internationally recruited staff undertook a six week driving course to ensure they were familiar with driving on UK roads.
- Basic training was provided in-house for new CFRs following national CFR guidelines but subsequent mandatory training was limited to modules delivered online covering resuscitation, defibrillation and moving and handling. This was coordinated by volunteer team leaders or field trainers rather than NNAS staff, which meant there was no oversight of mandatory training for CFRs.
- Mandatory training had been completed by 82% of staff on the HART teams. HART staff completed mandatory training specific to their role as specified by the National Ambulance Resilience Unit (NARU). This included six monthly physical assessments that ensured they had the fitness and skills to deliver paramedic services in situations such as working at height and in confined spaces.
- The service lead for the HART team based in Merseyside had a training plan in place and was aware of areas of low compliance with mandatory training. In these areas they were working closely with station managers to improve compliance rates. This issue was also recognised on the team's risk register, which detailed that mandatory training levels were low.

Safeguarding

- Face to face safeguarding training was part of the two yearly mandatory training cycle and had been completed to level two by 81% of urgent and emergency care staff, which meant that 19% of staff had not undertaken this training. Training rates were variable with 90% of staff undertaking this training in Cheshire and Merseyside, 78% in Greater Manchester and 76% in Cumbria and Lancashire. This training was supplemented by a workbook, this acted as an additional training resource and reference guide. The workbook was to be completed outside of face to face sessions but 10 members of staff we spoke to told us they were not given any additional time to complete the workbook and were not expected to submit the workbook for review or assessment following the training. The trust informed us that there was paid time allocated for completion of the workbook (1.5 hours) but staff were unaware of this. The trust accepted that the systems for checking completion of this workbook were not robust. This meant that although the training rates were 81%, this did not reflect the true number of staff who understood the importance of safeguarding.
- Staff were aware of how to refer a safeguarding issue to protect adults and children from suspected abuse. Referrals were made via a call centre. Staff told us they were given time to make safeguarding referrals and were taken off the road to allow them to complete referrals. They told us the process was quick and simple. However, staff in the Cheshire and Merseyside area told us they were given time to complete children's safeguarding referrals but not referrals for adult safeguarding concerns. They told us this subsequently discouraged them from referring adult safeguarding issues. In one record we reviewed, we saw it was documented that the patient had refused a safeguarding vulnerable adults referral but there was no details about why a referral was required and no record of the patient's mental capacity to refuse such a referral.
- The current intercollegiate guidance for safeguarding children and young people (2014) states that qualified paramedics should receive level three training. However, the national ambulance safeguarding group and the College of Paramedics has agreed that front line ambulance staff, including paramedics, only require level two training and the trust delivered training in line with this agreement.
- The intercollegiate document also stated there should be access to a level three trained professional at all

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times. Staff had access to a senior paramedic trained to level two who could offer advice and guidance on issues of a safeguarding nature via the clinical hub; or to an advanced paramedic who was trained to level three, although at the time of the inspection we were told that this training was not up to date due to operation pressures. There were two professionals within the safeguarding team trained to level four who could also provide guidance and support during normal office hours, however the trust told us that these members of staff were not part of the clinical advice structure. This meant that ambulance crews may miss key opportunities to safeguard children or adults from abuse.

- We spoke with nursing staff from emergency departments who told us that ambulance crews highlighted any adult or children's safeguarding concerns to them when the patient was handed over. .
- CFRs were not required to complete mandatory safeguarding training and this aspect of training relied on attendance at non-compulsory training days organised by volunteer trainers which was not quantified. CFRs were unclear about policies and procedures governing safeguarding referrals and were not issued with the same information as mainstream staff about how to identify potential abuse and progress a safeguarding concern or the identity of key contacts.

Cleanliness, infection control and hygiene

- We inspected 26 vehicles across all areas of the service. We found that these vehicles were visibly clean and tidy.
- We observed staff cleaning vehicles thoroughly between patients using the appropriate cleaning equipment and products.
- Staff were aware of current infection prevention and control guidelines, and were able to give us examples of how they would apply these principles.
- Staff were observed using personal protective equipment, such as gloves and aprons and they changed this equipment between patient contacts. There was adequate access to hand gels. We saw staff washing their hands using the appropriate techniques at hospital locations and all staff followed the 'bare below the elbow' guidance.
- There were adequate arrangements in place for the handling, storage and disposal of clinical waste, including sharps. We saw that waste was being

segregated and disposed of appropriately. Clinical waste was disposed of at ambulance stations in designated yellow clinical waste bins. Sharps bins were stored securely on all ambulances we inspected.

- Crew were required to complete daily cleaning tasks on vehicles and record these in a vehicle infection and prevention control (IPC) log book. These log books allocated certain cleaning tasks to days of the week. This meant that if the vehicle was not in use on one day of the week then the cleaning tasks for that day were not necessarily completed.
- When we checked vehicle infection and prevention control (IPC) log books, we saw that nine out of 11 were incomplete. In seven of 11 we found the manager's assurance log was completed but had not identified that IPC logs had not been completed appropriately. This meant that no action was taken as a result of the findings in the manager's assurance log. Information provided by the trust showed there was monitoring of the numbers of infection prevention and control audits completed and the performance on those audits. There was a sharp decline in the numbers of audits undertaken in January 2016 due to operational demands on the 999 service. Performance on these audits was around 80% for equipment and cleanliness and over 90% for the management of sharps.
- Deep cleaning was scheduled every six weeks and was managed by a private company. Vehicles were labelled with a sticker on the windscreen so that staff could quickly and easily see if the vehicle was overdue a deep clean. Information provided by the trust showed, at 23 May 2016, 11% of all NWAS vehicles were overdue their deep clean with 13 vehicles being more than two weeks overdue. A weekly monitoring report of deep cleaning was produced and shared with managers. The company responsible for deep cleans told us that it was sometimes difficult to access vehicles that required deep cleaning as they were in use operationally.

Environment and equipment

- All ambulances, including one air ambulance, that we inspected had all the necessary equipment in working order and stored appropriately. There were sufficient quantities of equipment to treat both adults and children. This included essential emergency equipment such as oxygen, suction and defibrillators, paediatric pulse monitors and infant harnesses.

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- The vehicles we inspected contained radios including handheld radios and spare batteries for these radios.
- There was a daily vehicle check list which was completed at the start of each shift and this was up to date and signed in all vehicles we inspected. There was acknowledgement from the managers that this check included a large amount of information and had been reviewed by the trust's quality board. A reduced checklist was to be introduced in August 2016.
- The UK Resuscitation Council recommends that essential resuscitation equipment should be checked on a daily basis. We reviewed the daily checklist for seven vehicles and one air ambulance and found that all checks on essential resuscitation equipment had been undertaken for a three month period.
- Portable appliance testing (PAT) was up to date for all electrical equipment we reviewed.
- Disposable equipment and sterile supplies were available on vehicles and at ambulance stations and those we checked were within their expiry date.
- Patient safety equipment such as boards and collars to transfer and protect patients with suspected spinal injuries were available on each vehicle and vehicle harnesses were found to be in full working order.
- There were two manufacturers of ambulance vehicles in use which meant that not all ambulances were standardised in the way they were laid out. We did however see that the each type of vehicle had a standardised layout and one type was being phased out by vehicle replacement programmes. Staff told us they were familiar with where equipment was stored and the differences between the vehicles.
- Vehicles were replenished with stock at ambulance bases. We saw there were adequate stock management systems in place at these stations. Vehicles were replenished during shifts, when required, at the closest available station.
- Issues with vehicles were reported to the support centre in Carlisle. There was 24 hour access to the workshop in Bury, when required, although one model of vehicle could only be repaired at Preston. If the vehicle was within warranty it was returned to the manufacturer.
- We saw vehicles had been taken off the road when repairs were required. Where this had occurred the incident log was up to date. We observed one vehicle being taken off the road due to a fault with its lifting mechanism in the Cheshire area, and we saw that the maintenance team were in attendance within one hour to repair the fault. When vehicles were off the road alternative vehicles were available for use if the vehicle was expected to be off the road for a considerable length of time. The time vehicles were off the road was monitored by station managers and this was fed back to senior managers and the company carrying out the repairs.
- The HART service was 12 months behind the vehicle replacement programme that was in place, all vehicles are replaced on a set time basis to ensure they remain road worthy. This was a national issue experienced by other ambulance services. A change in the manufacturer of vehicles had improved reliability and there was a two year business case in progress to update all vehicles with reliability issues.
- There were trust wide forums specifically to discuss and resolve health and safety issues and equipment issues. Incidents and learning relating to equipment and safety were shared and discussed at these meetings.
- Staff had a number of ways to alert the control centre if they felt they were in danger. This was identified with them in their inductions to the trust. In addition to these the contact centre 'checked in' with crews frequently to ensure there were no safety or security issues. Staff at the contact centre told us that they would try and check in at least every 30 minutes but the frequency of these checks was not stipulated by a policy.
- Where the environment of the ambulance station did not meet the needs of the service or presented constraints, plans were underway to make improvements. This included Penrith in Cumbria where plans to move into the fire station were underway and a new build facility in Blackpool, Lancashire. In Merseyside area a number of new build hub ambulance stations had been designed.
- At the Central Manchester station, a 'make ready' pilot was underway. This was a system where vehicles were prepared for use by an external contractor (excluding medicines). This meant that ambulance crews did not use valuable time preparing vehicles and were able to respond to calls as soon as their shift started. This was a positive development and had been well received by staff.
- The 'make ready' scheme piloted in Greater Manchester was closely monitored by the ambulance service and managers of the 'make ready' service. There were regular meetings to review performance and compliance with the standards set down for preparing

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the vehicles correctly. There were good systems in place to monitor stock levels and use by dates. We saw that records of who the vehicle had been 'made ready' by, when the next deep clean was due and when stock on the vehicle would go out of date.

- There were no robust systems for auditing or maintaining equipment used by CFRs. Volunteers were asked to check their own kits on a monthly basis. Although random checks were undertaken at volunteer meetings this was normally carried out by volunteer team leaders not NWS clinical staff. One volunteer said their equipment had not been checked for five years. As CFRs are often the first to arrive at emergency call outs this may represent a safety concern for patients.
- There was access to dedicated neonatal transfer ambulances at designated stations throughout the service.
- Additional equipment to use at large public gatherings was stored at a central station in the Greater Manchester area over the summer period, when there were large numbers of sporting or musical events within the region. Storage for this equipment was limited at the station and was being kept in a meeting room.
- Staff were only provided with two uniforms. Three staff told us that ordering new uniforms was difficult due to issues with IT systems.

Medicines

- Emergency medicines were readily available in grab bags and there was a procedure in place to ensure they were fit for use.
- Controlled drugs which required additional checks and special storage arrangements, because of their potential for abuse or addiction, were stored appropriately in locked cupboards in the vehicles. This was in line with legislation on the management of controlled drugs. Records showed these medications were checked on a daily basis, in line with the trust's policy in the Cheshire, Merseyside and Lancashire areas.
- In the Cumbria area there was one vehicle which was off the road and the controlled drugs had not been checked in line with the trust's policy. There had been no check from 15 May 2016 to 20 May 2016. This was brought to the attention of the station manager at the time of the inspection who identified he would follow this up with the staff involved.
- In the Greater Manchester area we found that five out of five controlled drugs books were not completed in line

with guidance. We saw there was inconsistent use of the brought forward or carried over feature in the record books and vehicle details were not on every page. In one book we checked, two pages were blank and crossed through with no reason or signature recorded. In another book, there was one entry made in error and one entry crossed through without reason or a signature. There was limited evidence of auditing in the five books we checked in the Greater Manchester area.

- We saw evidence that incidents relating to controlled drugs, for example when ampoules of morphine had been accidentally broken, were reported via an incident form appropriately.
- Systems for auditing medicines management were unclear and not recorded consistently. The trust required a monthly audit be undertaken of the controlled drugs log in each vehicle; however these were not completed consistently in all of the vehicles we observed. We saw examples where checks had been recorded as stock checks rather than audits; while in other vehicles the audit checks were noted in red ink. Staff were unclear how often audit checks should be completed or the level of seniority of those conducting audits. Records demonstrated there were no clear patterns of weekly checks in some vehicles while others had no recorded audit.
- The system for checking the stocks of medicines was not robust at all ambulance stations in the Cumbria and Lancashire areas. The stock check for intravenous fluid at one station in Cumbria was incorrect and one bag was not present. This had not been identified prior to the inspection and was brought to the attention of the managers.
- Drugs were stored at sports stadiums, in locked cabinets, to use at public events. Stock levels were regularly checked by band six paramedics.
- Access codes to access the stations and for the keypad to the key cupboard, which held the keys to access vehicles containing controlled drugs, were not routinely changed. The codes were also the same for most stations. Staff told us these codes had not been changed for a number of years. This posed a risk that unauthorised access to controlled drugs could be gained by former or current employees. This was raised with the trust at the time of the inspection.

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- We observed crews administering medications to patients and they undertook appropriate checks including checking the patient's name, date of birth and allergy status.
- Guidelines on the use and preparation of medication were readily available, including specific guidelines for children including the NWS 'Clear Vision' Drug Administration Reference Guide (2013) and the 2016 Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines pocket book.
- Compliance with operational medicine management audits, for general medicines, had fallen from 76.3% compliant in December 2015 to 60.7% in January 2016. Controlled drugs compliance also decreased from 83.3% to 79.7%. We did not see any evidence of an action plan in place to address this.
- There had been a recent change in the management of medication on vehicles in the Cumbria, Lancashire and Greater Manchester areas. Medicines were pre-prepared in pouches. These pouches were stored securely in locked cupboards at ambulance stations in these areas until the crew required them at the start of the shift. These were tagged with green, yellow or red tags to indicate the level of stock within the pouches. When the stock fell below the required level, the pouch was tagged red and returned to the cupboard at the ambulance station. The pouch was then collected and replenished centrally. There were two specific pouches stored on all emergency vehicles to be used in the event of a cardiac arrest. This system was in the process of being rolled out to the Cheshire and Merseyside areas.
- There was a limited amount of free text space available to record a full history and clinical assessment. If there was not enough space to complete all details, a second PRF would be completed. Some staff felt a continuation sheet would be beneficial but others told us there was enough space to document all necessary details.
- We saw that, when a rapid response vehicle was the first to arrive on scene, the staff member in this vehicle began completing the form. This was then handed over to the double crew ambulance (DCA). There was no way for each staff member to sign and date the care they had provided. This meant the double crew ambulance signed the PRF and the crew from the rapid response vehicle did not sign for the care they provided. This record keeping did not meet best practice guidelines.
- In 18 out of 236 records there were key aspects of the form not completed. These included lack of dates, times and signatures. All 18 records were from the Merseyside area. In two of these forms there were recording errors in the dosage of a medication.
- Records were stored securely on vehicles and at stations.
- Hospital copies of PRFs were provided at ambulance handover and we observed this during visits to emergency departments.

Records

- Information relating to patients' care and treatment was recorded on patient record forms (PRFs) which were paper based forms in a duplicate book. This meant the ambulance service could maintain their own record and also supply one copy to the hospital or patient, depending on whether the patient was conveyed to hospital. They also had one copy without patient identifiable information to use for audit purposes.
- We reviewed 236 PRFs. We saw that, in 218 of these cases, the records were completed in legible handwriting, were signed and dated and the history of the patient incident, treatment provided, medicines administered, assessments of pain and observations were completed.

Assessing and responding to patient risk

- Staff assessed patients and risks to their safety appropriately using the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) 2016 guidelines.
- The service used a Pre Hospital Early Warning Score (PHEW) which we observed was routinely recorded in PRFs. Patient observations were taken and repeated, when required. We saw that staff calculated a PHEW score, to monitor for deterioration, in all cases.
- Assessments were appropriately completed for patients with suspected sepsis and actions were taken.
- There were facilities on ambulances to allow continuous cardiac monitoring of patients during transit.
- Ambulance crews pre-alerted hospitals when they were conveying patients with particular illnesses or injuries such as stroke or traumatic injuries, to ensure hospital staff were ready to receive those patients. Rapid handover was available for patients requiring care in the resuscitation areas of emergency departments. We observed staff handing over patients to emergency departments and noted that all relevant risk information was relayed in all cases.

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- Clinical advice was accessed from senior paramedics in the clinical hub, based within the Emergency Operations Centre (EOC). Staff could also request back up from senior or advanced paramedics, on scene, if this was required.
- Four members of staff were always deployed to cardiac arrest calls to ensure patients were cared for in the safest way possible, including a member of staff trained in advanced life support with the skills to use an interosseous device (a device used to deliver medication directly into a patient's bone marrow) to gain immediate vascular access.
- EMT1 (the entry grade of emergency medical technician staff) staff were required to contact the clinical hub for advice if a patient was refusing transport to hospital and the ambulance pathfinder (a document used to direct ambulance crews to the best place of care for a patient) indicated this was necessary. They then sought advice from the advanced paramedic and were provided with back up from a paramedic, if this was needed, to reduce any risk to the patient.
- Staff were aware of what to do if they had a concern about their own or another's safety. They told us they would alert the contact centre and wait for the police to attend. Staff were able to give us an example of where they had attended a call and, as they arrived, were informed a firearm may have been present. They immediately withdrew from the area, contacted the control centre and awaited police response units to arrive.
- There was a policy in place for the management of patients with disturbed behaviour. Staff were trained in basic breakaway techniques as part of their mandatory training schedule. Staff were able to access support from a counsellor following any verbal or physical assault.
- Clinical staff working within the HART services were all qualified paramedics who had further training to equip them with the skills to identify and manage deteriorating patients in potentially hazardous situations.
- Volunteers or CFRs could be dispatched to any level of call except those relating to children or obstetric/maternity calls. Although they were able to request back up from NWS crews, volunteers reported delays of up to three hours in the arrival of back up teams for urgent calls. One CFR had waited 50 minutes for support with a

call in the most urgent emergency call category. On these occasions the attending CFR could obtain telephone advice and support from the clinical hub based in Preston.

- Paramedics in the Greater Manchester area had recently started piloting use of the Manchester triage system to support them in their clinical decision making to leave patients at home safely. The Manchester triage system is used by emergency departments across the country to assess patients and determine the urgency of their injury or illness.

Staffing

- Staffing ratios and establishments were calculated using an electronic programme that used historical information about demand for services to plan what level of staffing was required. Rotas were compiled by administrative staff four weeks in advance.
- A variety of shift patterns were available to assist staff to have a flexible working pattern. These included eight, 10 or 12 hour shifts.
- Policies were in place to provide funding to train Emergency Medical Technicians (EMTs) to qualify as paramedics. However, in the Cumbria and Lancashire areas. The second year of this training was only available in Lancashire therefore staff from Cumbria were expected to travel over two hours daily which made it inaccessible to many of them. There were plans to develop links with Cumbria University in Carlisle to provide a more local base for staff.
- There were two levels of EMT's; EMT1 and EMT2. EMT1's assisted in the delivery of pre-hospital clinical care and patient transportation, respond to 999 emergencies under blue light and normal traffic conditions, undertook inter-hospital transfers, urgent hospital admissions and other allocated patient interventions commensurate with the role and responsibilities. They could also undertake emergency driving. EMT2's were able to respond to the full range of emergency, urgent and routine calls under blue light and normal traffic conditions and had enhanced skills and training. EMT2's were the lead clinician when working with EMT1's.
- Information provided by the trust showed, at 1 April 2016, 51.26% of full time staff were paramedics, senior paramedics or assistant operations managers. Data showed that 41.38% were technicians (EMT staff) and 6.36% were urgent care staff. Data also showed that, in a

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three month period between 1st February and 1st May 2016, attendance at calls by emergency ambulances had between 44.4% and 54.9% paramedic crews with the remainder being attended by technicians.

- Some staff raised concerns about the length of time they waited for back up at busy times. Between 1 December 2015 and 1 May 2016, there were 2587 incidents where a rapid response vehicle waited over 60 minutes for emergency ambulance back up. The vast majority of these were in Greater Manchester where 1836 such incidents occurred. In the same time period there were 25 occasions when a CFR waited between 60 and 90 minutes for assistance at a call.
- The HART was staffed by teams of six crew members. Four staff members had to be at base at all times to allow them to respond quickly to any call. Two paramedics worked in RRV's to support delivery of response to 999 calls. There was an agreement that crew members working in RRVs would be stood down or backed up immediately if they were required to respond to a designated HART call.
- Urgent and emergency care services were supported by CFRs. These were members of the public who had been trained by NWS to respond to 999 calls in their local area to deliver early life saving treatment, such as basic life support and defibrillation. The CFR's were then backed up by an ambulance crew to provide further care and treatment and transport to hospital, if required.
- The trust also used enhanced community first responders (eCFRs). These volunteers were trained to the same level as EMT1s, but did not undertake training to treat children and maternity patients nor did they complete the driver aspect of the EMT course.
- There were no systems in place to carry out welfare checks on lone working CFR's or RRVs who may have been waiting for back up for long periods of time.
- Staff were entitled to two breaks per 12 hour shift, and if meal breaks were missed due to operational demands then they received financial compensation. Staff were also able to inform control that they could be disturbed during meal breaks for urgent red one (immediately life threatening) calls and they were also financially compensated if they responded to a call.
- Meal breaks were not always allocated in effective ways. Staff told us they regularly worked for long periods without a meal break, or may be allocated the main meal break three hours into a 12 hour shift. They also told us it was frequent to work for eight or 10 hours without a break. Financial compensation was paid to staff when meal breaks were late or missed.
- There was evidence that managers planned staffing while taking into account the skill mix and competencies of the staff on duty. There were systems in place to ensure that skill mix on DCA's was appropriate and the EOC was aware of the skill mix on these ambulances so that vehicles could be deployed correctly. A matrix was available detailing each variation of skill mix on a DCA and which type of call combinations of staff could attend safely. For example, an ambulance staffed by two probationer EMT1's could only respond to urgent care calls, not 999 calls.
- Data showed that less than 0.1% of calls between 1 February and 1 May 2016 were responded to by crew without the correct skill mix.
- There were staff vacancies across all areas of the service. Information provided by the trust showed that as of 31 March 2016 vacancy rates varied across geographical areas. The highest rate was in Greater Manchester with 7.3% of posts vacant, 4.6% of posts were vacant in the Cumbria and Lancashire area and 5.3% of posts were vacant in the Cheshire and Merseyside area.
- Staff vacancy rates in North Cumbria were the highest in the trust with 35 vacancies, which represented 20%. The paramedic vacancy rate in this area was 16.7%. One of the initiatives to manage this deficit was the employment of paramedics from other countries.
- Two paramedics from Europe had worked in Cumbria for some time. The trust had employed 35 new European paramedics in Greater Manchester at the time of the inspection. There were plans to recruit a further 36 with 24 of these being appointed to North Cumbria.
- A high proportion of vacancies related to band five paramedics. A total of 15.7% whole time equivalent (WTE) posts for this role were vacant at the time of our inspection across all areas. This reflected a national shortage of paramedics. 87 paramedics had been recruited between 1 April 2016 and June 2016.
- The staff turnover rate for the 2015/16 period for the service was 7.2%. The trust was looking at new ways to recruit paramedics to fill these vacancies. This included progression programmes for their EMT staff and also international recruitment. The trust's human resources

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department was working with managers on developments to improve the retention in Cumbria where rates were higher at 11%. This included the consideration of relocation packages.

- Overtime shifts undertaken in all localities, with the higher proportion of these shifts being in the Cumbria area. An example of this was in one station in Cumbria where between 7 March 2016 and 6 June 2016 there had been 70 overtime shifts worked between 15 staff, with the majority being 11.5 hour shifts. Staff mainly worked these extra hours to provide cover for vacant posts.
- There was a high reliance on CFRs in the Cheshire, Lancashire and Cumbria areas. The highest use of these volunteers was in Cumbria where 850 of these volunteers were being used. CFR managers reported that recruitment of new volunteers had been problematic.
- Partnership working with a university in Cumbria was part of the long term strategy for improving the availability of qualified paramedics. A health studies course for 16 to 18 year olds had been developed which included student work placements with the trust.

Anticipated resource and capacity risks

- The trust used the national resource escalation action plan (REAP) levels to indicate internally and to external agencies the pressure being experienced by the ambulance service due to issues such as demand, major incidents or hospital closures. There were plans associated to each of these levels which set out actions to take in the event of a change to the REAP level. These levels also formed part of decision making in relation to the provision of mutual aid with neighbouring ambulance services. The REAP level was displayed in each ambulance station we visited.
- The NWAS winter capacity strategy was reviewed in November 2015 and due for review in June 2016. This detailed information about availability of additional resources, during periods of increased demand, or issues affecting the capacity of the service.
- A regional divert and deflection policy was in place, with actions for emergency diverts and formal or partial deflection of ambulances from emergency departments. Standby and life threatening calls continued to be received at emergency departments, even when formal deflection was in place to ensure patient safety.

- The service had close working relationships with local hospital emergency departments. They held daily telephone conferences and face to face meetings when there were increased pressures on resources.
- The hospital arrival screen (HAS) tracking system ensured there was real-time monitoring of ambulance locations and waiting times.
- Ambulance crews reported that on-going handover delays at hospital emergency departments caused significant disruption to the service. Staff cited examples of five hour delays and queues of up to 19 paramedic crews waiting to handover patients. This had a major impact on the capacity to respond to other local calls. In 2015, 8% of attendances by ambulances at emergency departments had a hand over time of over one hour.
- There were a number of Hospital Ambulance Liaison Officers (HALO) based at local emergency departments. The HALO would monitor the situation at the local hospital and inform seniors if pressure was increasing and alternatively free up crews to be redeployed on the road by 'co-horting' patients (where one crew cares for more than one patient). All emergency departments we spoke with told us this was a valuable role and helped facilitate the movement of patients and expedite ambulance handovers.
- A handover system was in use in emergency departments for patients, who were independently mobile and did not require ongoing monitoring by crews. These patients were taken to emergency department waiting areas and provided with an information sheet asking them to inform staff if they were feeling unwell.
- Records showed there was a proactive regime of vehicle maintenance, which reduced the risk of vehicle breakdowns and time spent off the road. However, at the time of the inspection, in one ambulance station in Cumbria three of the eleven vehicles were off the road. There was no resilience for this which meant they were reduced in number of available vehicles for that time.
- The trust had an Emergency Preparedness, Resilience and Response Policy (EPRR) in place. The policy referred to relevant legislation and guidance. This included the Civil Contingencies Act (2004) and NHS England EPRR documents and supporting materials.
- The HART team worked in partnership with pre-identified high risk sites in the NWAS region. This included development and monitoring of risk assessments for the sites and joint training with staff

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from the sites. This meant, in the event of an incident occurring, there would be an effective coordinated response with reduced risk of harm to staff and people living in the local area.

- Some frontline staff and the HART team received training in response to chemical, biological, radioactive, nuclear and explosives (CBRN-E) incidents. Frontline staff were chosen on the basis of individual request, team skills and their location in relation to high risk areas.

Response to major incidents

- The trust had major incident policies in place for each area and a number of different scenarios, including individual plans for high risk locations such as football stadia. These were available at ambulance stations and in the high risk locations. Staff showed a good understanding of the policies and what they should do in the event of a major incident.
- There were collaborative multi-agency working groups tasked with resilience planning for major incidents. This included the Emergency Preparedness for Resilience and Response (EPRR) group, which comprised senior portfolio leads and advisors for fire and police services, NHS England and NWAS across the region. A risk assessment working group met every quarter to assess and prioritise local risks. This group was responsible for legally mandated response planning, including quarterly resilience forums, table-top and live exercises to practice response and command arrangements. This was in relation to possible major incidents such as extreme weather events, major accidents and terrorist attack.
- There were leads for business continuity and special operations within the trust. There was an electronic business continuity system in place to allow immediate access to any plan for major incidents, gatherings of large numbers of people or system failures. There was a register of all mass gatherings across the region.
- The trust responded to changes in national threat levels by reviewing operations and identifying possible challenges to the operation of the service.
- The resilience team took an overview of plans for major incidents and mass gatherings and liaised with operations and sector managers. The trust used private providers to support some events and the resilience team had oversight of assurance to the trust board for this.
- Training was provided to staff in areas such as CBRN-E incidents and major terrorism and fire arms. There was a trust wide major incident and CBRN-E pocket guide, with a range of action cards to use in the event of a major incident which had recently been updated in line with Department of Health guidance.
- Ambulance staff, at all levels, undertook operational and tactical training as part of the Joint Emergency Services Interoperability programme (JESIP).
- Command training was delivered to senior members of staff throughout the trust. There were different levels of command from gold to bronze, depending on the level of responsibility the staff member was given, during major incidents. This ensured that staff were aware of who had responsibility for command in the event of any major incident.
- Training for commanders included strategic classroom days, major trauma and firearms live exercises and flood management. At the time of our inspection, there were 15 staff trained as gold 'strategic' commanders.
- The trust participated in large exercises with other emergency organisations, such as the fire service and police, in order to make and test out plans for major incidents. These were initially completed as 'table top' exercises, with or without a physical exercise depending on the need for this. We saw evidence of multi-agency debriefs following exercises with actions from debriefs allocated to relevant organisations and individuals.
- There had been a recent exercise at a local shopping centre in the Greater Manchester area to look at how the emergency services would respond to an act of terrorism. Debriefs and evaluations were completed following these exercises to ensure any necessary learning could be applied and changes made to major incident plans.
- Lessons learnt from exercises were taken to the trust wide learning forum. Action plans were developed with identified people responsible. Timescales and learning and changes to major incident plans were cascaded through command training. Lessons were also being shared outside of the North West region via joint organisation learning, which was part of JESIP.
- Staff could describe processes and triggers for escalation. They described the arrangements to deal with casualties contaminated with hazardous materials (HAZMAT) such as chemical, biological or radiological materials.

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- A number of mock major incident exercises had been undertaken in conjunction with the HART team including a building collapse, train crash and marauding terrorist threat.
- There had been a co-ordinated multi-agency response to the major floods in Cumbria in December 2015. Managers discussed how they had learned from previous serious flooding and had agreed plans in place which worked well.
- The floods affected one ambulance station in Cumbria and this was relocated to the mountain rescue centre. Staff from both services said this worked well and they took the opportunity to improve joint working procedures.
- In accordance with the requirements of Radiation (Emergency Preparedness and Public Information) Regulations (REPPPIR) 2001, an offsite emergency plan prepared for a nuclear power station was exercised on a three yearly basis to demonstrate the adequacy of the plan. Such exercises were scrutinized by the Office for Nuclear Regulation. NWS took part in the latest exercise which was in March 2015. There were no direct actions for them to take following this exercise.
- On our last inspection, we told the trust it must improve appraisal rates for staff. However, appraisals rates remained low in all areas with an average of 48% of staff with an up to date appraisal.
- Staff told us that there were limited support structures in place for newly qualified paramedics and there were no written records of supervision provided to them. However the trust confirmed that all new paramedics to the Trust undertook a core induction of 37.5 hours and then driving training if required. They then moved to sector areas and undertook a period of 75 hours (2 weeks) within the first six months supernumerary to a paramedic to assist in clinical practice, with a further 75 hours as part of a paramedic crew with a preceptor.
- Staff told us they found their training difficult to absorb due to the volume being delivered in a short space of time. They often completed training in their own time.
- There was poor understanding about the legal requirements and validity of Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms by frontline staff. There was a DNACPR NWS wide policy but the use of this policy varied across regions.

Are emergency and urgent care services effective?

(for example, treatment is effective)

Requires improvement



We rated emergency and urgent care services as 'Requires Improvement' for effective this was because:

- Updates to clinical guidelines and processes were not consistently fed back to staff.
- Some policies and procedures were past their date for review and did not reflect changes that had been made in local health systems.
- Audits of documentation showed low compliance of care pathways and bundles.
- Response times to 5% of life threatening calls were worse than other ambulance trusts.

- Staff had limited knowledge of the Mental Capacity Act (MCA) (2005) and their responsibilities in relation to this. MCA and Deprivation of Liberty Safeguards were not always included in the mandatory training. This had last been part of that training in the period 2013/14. Trust guidance on consent did not reflect the MCA code of practice. This meant that capacity assessments were undertaken when they were not required and equally, staff did not make assessments when there were reasons to doubt capacity as detailed in the code of practice two-stage test.
- Crews frequently experienced delays in receiving requested back up at patient locations.

However:

- Patients accessing the service received effective care and treatment that followed national clinical guidelines including those from the National Institute for Health and Care Excellence (NICE).
- The service participated in local and national audits. Action plans were formulated following audits and progress on these actions were monitored.

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- The trust met the national target for responding to immediately life threatening calls between February 2015 and January 2016.
- Data from national ambulance quality indicators showed that patients treated within the service had outcomes which were similar or better than patients treated in other areas of England.
- Patients' nutritional and hydration needs were identified and addressed appropriately. Patients received timely analgesia when they required it. Patients received care and treatment from staff who worked well as part of a multidisciplinary team.
- Evidence based care bundles and pathways were available in all the vehicles we inspected. These included specific pathways for patients presenting with symptoms of a stroke and children presenting with signs of serious infections.
- The trust submitted clinical performance indicator information to the National Ambulance Service Clinical Quality Group. This included cyclical information audited on measures against expected management of febrile convulsions, single limb fractures and asthma. This information was used to benchmark the service against other ambulance trusts and identify areas for improvement.

Evidence-based care and treatment

- NICE guidelines were available for staff and the 2013 Joint Royal Colleges Ambulance Liaison Committee (JRCALC) clinical practice guidelines had been issued to all staff.
- Policies and procedures were up to date however we found that the Emergency Control Procedure had a review date of November 2013 and this had not been reviewed at the time of the inspection.
- There were variations between localities for how staff were notified of clinical updates. This was done via email, displayed on notice boards at ambulance stations and via clinical bulletin in that area. There was no audit trail or monitoring tool to validate that staff were aware and understood new or updated information.
- Protocols were in place to ensure the management of new onset face arm speech Test (FAST) positive stroke patients was appropriate and to ensure paramedics had access to the correct acute facilities. For example, paramedics in East Cheshire took patients to a local NHS hospital if symptoms were over 48 hours or to the nearest hyper acute unit if symptoms were less than 48 hours.
- We saw evidence in the PRFs we reviewed from all regions that patients received evidence based care and treatment. For example, patients who had been conveyed to a local heart centre had intravenous access and had received appropriate medication and resuscitation.
- Across NWAS, monthly audits to measure clinical performance against care bundle improvement targets were completed. The audit completed in January 2016 showed a decreasing trend in the quality of care patients received. Of the patient report forms audited, 21.7% had been completed fully with regard to the management of patients with mental health needs and 78.2% for pain management. This was discussed at the quality committee meeting and an action plan was to be developed.
- Senior staff in Greater Manchester and Cumbria told us that audits of clinical performance indicators were audits of documentation rather than of the quality of care provided. We spoke to one consultant paramedic who told us there was a shift in focus in all-regions to reduce office based record audits and increase the time spent observing care and practice.
- Staff accessed advice on the care and treatment of patients from the clinical hub or the trauma cell based at the emergency operations centre (EOC). The hub was staffed by senior or advanced paramedics who provided advice over the telephone or arranged for support from senior staff, on the scene, if this was required.

Assessment and planning of care

- Paramedics used the "paramedic pathfinder" at the scene to conduct a face to face clinical assessment of individual patient needs. This provided flowcharts of symptoms to assist paramedics to determine the most appropriate care pathway.
- These pathways helped paramedics to direct patients to the right place of care at the right time. We found patients were transported to the most appropriate service based on their needs. Staff referred to current guidance from the JRCALC handbook to support their

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assessments; however, this was not always used when staff were assessing and planning care for patients presenting with mental health issues. Although newly qualified graduates had received training in mental health issues during their diploma, the trust recognised that there may be gaps in current training provision for mental health.

- Staff received training in managing patients with suspected stroke (FAST positive) or heart attack and had advanced life support training as part of their mandatory training. Stroke thrombolysis pathways were in place for each geographical area. These included information about the nearest stroke unit to convey a patient who had a positive FAST test. The protocols for Lancashire and Cumbria had no review dates documented. For one acute hospital trust in Cumbria, this was dated 2010 and for two others in the Lancashire area, it was dated 2011.
- There were pathways in place to guide where patients with major trauma should be conveyed to. On the unannounced inspection we observed a consultant challenge paramedics about the reasons why a patient had not been directed to the nearest trauma centre instead of their own hospital. Paramedics had followed pathfinder correctly and the Glasgow Coma Scale (GCS) was within parameters which did not warrant admission to a trauma unit. The GCS is a scoring system used to describe the level of consciousness in a person following a traumatic brain injury.
- Ambulance crews could refer to the EOC if they were unsure about which was the most appropriate hospital for patient treatment. Staff used PRF's to document the advice they were given and the reasons for decisions made.
- The community care pathway was designed to share information across services and ensure ambulance clinicians were aware of pre-existing care plans for patients being managed by community services. This included when it was most appropriate for patients to be treated at home, involving other professionals or conveyed to an alternative care setting than an emergency department.
- CFRs had been trained to be the first people on the scene of an incident. Once deployed they delivered first aid and liaised with the paramedics, informing them of the patient's condition. CFR's remained at the scene until the emergency response vehicles arrived.

- The CFRs were supported by the clinical hub which could be accessed by phone or radio. This enhanced clinical advice was available to all ambulance crews and volunteers. Senior paramedics discussed the symptoms and offered advice or when necessary dispatched another ambulance or advised about self-care for the patient. Volunteers were particularly complimentary about this service and said that they received good support while at the scene.
- The computer assisted dispatch system at the EOC had recently been updated and no longer prompted the dispatcher to consider the use of HART. Staff told us this led to incidents when HART would have been the most appropriate resource to dispatch but had not happened. Leaders told us work was ongoing with staff at the EOC to educate them on the role of HART.
- The transfer of patients between two acute hospital trusts in Cumbria was not always completed in line with their assessment of need. Examples were given of two patients with fractures being taken by family members in their car. One two year old child had waited in excess of 40 minutes for an ambulance and a young adult waited over two hours.

Response times

- Station level quality reports were available for each ambulance station. These documented various response times mapped against the best performing station. Included were the time from allocation of a job to the vehicle being mobile, emergency ambulance arrival at an incident to the rapid response vehicle being cleared to attend another job and time to clear at an emergency department. This gave each station manager the opportunity to compare their performance on a monthly basis.
- Response times for each geographical sector were discussed at the level three management meetings which took place on a monthly basis. Issues for poor performance were identified and actions to improve discussed.
- We reviewed a number of policies that set out the roles and responsibilities of each health professional involved in transferring patients from one organisation to another. Providers were asked to categorise their call and if the patient needed an urgent transfer, due to life threatening circumstances, an ambulance was dispatched with a response target of eight minutes. This

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was coded as an “emergency transfer red” (ETFR). If the hospital told the call taker that an ambulance was required immediately, with no immediate threat to life but still required ambulance services this was labelled as a green transfer.

- NWAS performed better than the England average between the period of February 2015 and January 2016. They achieved their 75% target in responding to calls within eight minutes (Red 1 calls). A Red 1 call is an incident where the presenting condition may be immediately life threatening and should receive an emergency response within eight minutes, irrespective of location, in 75% of cases.
- Response times to Red 2 calls were achieved in 72% of cases between February 2015 and January 2016. This did not meet the national target that 75% of calls are responded to within eight minutes but this was better than the England average during this time period. A red 2 call is an incident category for patients who presented with conditions, which may have been life threatening but less time-critical. In addition to Red 1 and Red 2 call targets; there was a national “A19” response time target. The target was that 95% of Red 1 and 2 calls resulted in an ambulance arriving on scene within 19 minutes. For these incidents, the trust had achieved the response times for 93% of calls between February 2015 and January 2016 which was the same as the England average during this time period. The trust had performed better than the England average and above than national target during the summer months of 2015 but performance had deteriorated over the winter period.
- Between April 2015 and January 2016, the Merseyside cluster exceeded the national performance indicator targets of 75% for both Red 1 and Red 2 categories. The Red 1 response rate was 81% and the Red 2 was 77%.
- Cumbria was the worst performing region with 64.08% of red one calls being responded to within eight minutes between 1 April 2016 and 17 May 2016. The service manager for Lancashire and Cumbria told us they failed to meet the response time target for 0.1% of red calls every day. In Cumbria they had a daily average of three red calls and met the target in two out of three but there was no account taken of the geography of Cumbria and the issues this caused in delays.
- In the period between 1 November 2015 and 30 April 2016, response times in Greater Manchester were worse than the national target at 73.6% for red 1 calls and 63.3% for red 2 calls. Lancashire and Cumbria were also the worst performing region for attendance within 19 minutes at 88.37% as opposed to Cheshire and Mersey who were the highest performing at 94.32% for the same period in the last financial year.
- There were instances where patients categorised as Red 1 or Red 2 calls waited for significantly longer periods than set out in national targets. For example, in the trusts' worst performing month in October 2015, 5% of patients waited over 27 minutes for a response and 1% of patients waited over 66 minutes.
- The trust had identified areas where response times were of concern in Greater Manchester and taken actions to improve them. For example, in the Bolton area NWAS received more calls in two postcode areas so additional resources (RRVs) had been deployed to these areas to ensure patients received a timely response.
- A patient with a serious clinical but not life threatening presentation was classed as a Green 1 call and paramedics were required to respond to this call within 20 minutes and respond to a Green 2 in 30 minutes. Green 3 calls required attendance within 180 minutes and Green 4 within 240 minutes. These targets were locally agreed. Calls classified as Green 3 and 4 required a telephone assessment and advice by a senior paramedic. This telephone based triage by a clinician allowed the paramedic to convey the patient to the appropriate care provider. In all cases green calls had the potential to be upgraded to red calls if the patient deteriorated. The integrated performance report February 2016 reported trust performance against the locally agreed targets for Green 1 – 4 calls. The Cheshire and Merseyside cluster achieved above the 95% trust target response rate for green 1 and 2 calls and responded to 96% of Green 3 calls within 180 minutes compared to Greater Manchester who responded to 56.5% of patients in 20 minutes (Green 1) and 56.7% in 30 minutes (green 2). Cumbria and Lancashire cluster did not achieve the trust target of 95% for green 1 and 2 calls. The cluster reported responding to 66% of calls within 20 minutes (green 1) and 68% of calls within 30 minutes (green 2) calls. They did achieve the trust target of 95% for green 3 and 4 calls.
- We saw that the numbers of handover delays, over 15 minutes, across the trust had increased by over 7500 when comparing February 2015 to February 2016. The

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leadership team was working closely with local partners to improve handover times and used ambulance liaison officers to manage queuing ambulances at emergency departments.

- Whilst we were on inspection at emergency departments across the region, the handover times were over one hour. This meant that ambulances were delayed because they were unable to handover the care of patients to the hospital which had a negative impact on the trust's ability to respond to other calls in a timely way.
- Staff in Lancashire and Cumbria reported there were frequent long delays when transferring patients to hospital care at most of the emergency departments across the region. One paramedic told us of one delay involving queues of up to 19 ambulance crews and staff commonly mentioned waits of several hours. We observed a queue of six paramedic crews in one emergency department mid-week which was not considered to be a busy period.

Pain relief

- There was a variety of pain relief available for adults on the ambulances. This included oral, intramuscular, intravenous and medical gases. For patients with injuries such as fractured neck of femur, morphine was correctly titrated to control pain.
- Staff assessed a patient's pain using a pain assessment on the PRF's. These had been completed on the all records we reviewed and patients had received pain relief when this was indicated. We observed staff checking with the patient that this had been effective and had updated the pain score.
- Patients we spoke with had been given pain relief by the paramedics in a timely way. The levels of pain had been reassessed, where appropriate.
- Hospital staff reported that patients were usually administered pain relief proportionate to their pain, and this was handed over by crews.
- Paramedics were trained and able to give a range of pain medicines that included Entonox (a gas used for pain relief) and morphine. Ambulance technicians were also able to administer pain relief medicines, with the exception of morphine.

- There had been concerns raised about the availability of appropriate pain relief for children on the ambulances. Staff felt that they did not carry adequate pain relief for children. This was under review and additional medicines were to be introduced.

Patient outcomes

- The trust routinely collected, monitored and reviewed information about the care and treatment people received from the trust and service. Data from Clinical Quality Indicators measured the overall quality of care and outcomes for patients. The trust submitted data as a whole and this was therefore not available to us by region.
- The trust collected data that included both out of hospital and in-hospital periods of care. This measured the effectiveness of the overall acute healthcare system in managing out of hospital cardiac arrest, which reflected the care delivered by both the ambulance services and acute trusts. NWS data showed that 9% of patients with coronary heart disease (CHD), were discharged from hospital alive (all patients) following cardiac arrest between November 2014 to October 2015. This was slightly above the England average of 8%. The Utstein comparator group showed that the percentage of patients discharged from hospital alive following a cardiac arrest was slightly lower (26%) than the England average of 27%.
- The main objective for all out-of-hospital cardiac arrests was to deliver immediate and effective treatment at the scene. To measure how effective the urgent and emergency care system was in managing care for all out-of-hospital cardiac arrests, NWS recorded the return of spontaneous circulation (ROSC) for patients. This included signs of breathing, coughing, or movement and a palpable pulse or a measurable blood pressure. The service collected two sets of data, the overall patient data on cardiac arrests and the rate of 'Utstein comparator group'. Utstein data provided the trust with a more comparable and specific measure of the management of cardiac arrests for the subset of patients where timely and effective emergency care was received. Data was excluded from the Utstein comparator group data set, if the cardiac arrest was not witnessed, and if the patient had gone into arrest several hours before paramedics arrived at the scene. The trust had a higher (better) percentage of all patients who had return of spontaneous circulation on arrival at

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hospital (32%) than the England average (28%) during the period of November 2014 to October 2015. This was the highest percentage of all trusts across England. The Utstein comparison group data showed that the trust performed slightly better at 55% than the England average of 50% between the same time period.

- The trust collected data on three key interventions undertaken by ambulance services: those patients who received the appropriate care bundle, those who were conveyed to the cardiac catheter lab for intervention, and those who received timely thrombolysis. Between November 2014 and October 2015 the proportion of patients receiving angioplasty (unblocking of a coronary artery) within 150 minutes was similar to the England average at 86%.
- A heart attack or ST segment elevation myocardial infarction (STEMI) is caused by a prolonged period of blocked blood supply within the coronary arteries. Early intervention such as thrombolytic treatment or primary percutaneous coronary intervention is vital to restore the blood flow. Additionally the right management and appropriate care bundle has been associated with reductions in STEMI mortality and morbidity. The number of patients with STEMI, who achieved an appropriate care bundle for angioplasty, was better than the England average of 78% during this period, at 88%. This meant, overall, patients who presented with ST segment elevation myocardial infarction (STEMI) received care and treatment in a timely and effective way.
- The trust also measured the health outcomes of patients who received care and treatment for stroke or transient ischaemic attack (TIA). The NICE national quality standard sets out the importance of recognising the symptoms of a stroke or TIA, the significance of quickly diagnosing, and early transport of a patient to a stroke centre capable of conducting further definitive care including brain scans and thrombolysis was essential to better outcomes. NIAS consistently had a larger monthly percentage of patients who received thrombolysis within 60 minutes than the England average between November 2014 and October 2015. Overall, 66% of patients received thrombolysis within 60 minutes during the time period; this was the highest percentage of all ambulance trusts across England. In addition 100% of patients received the appropriate care bundle across the North West of England.

- Performance against care bundles was reviewed by senior paramedics and data showed the trust did not meet any of their care bundle performance target levels of 95% for the last year. The following care bundle pathways; asthma care, cardiac chest pain care bundle, pain care bundle, patient referral form, completion care bundle, patient pathway care bundle, paediatric febrile convulsion care bundle and trauma- single limb bundle all showed a downward trend of performance against achieving the trust target between November 2015 to January 2016. The stroke care bundle year to-date (93.7%) performance was within 5% of the trust target of 95%.

Competent staff

- The previous inspection of NIAS, highlighted concerns relating to appraisal rates, with 44% of staff having received an appraisal. To improve compliance a new appraisal system was being introduced in Greater Manchester in September 2015 and was in the process of being rolled out to other areas. The appraiser and the staff member were given protected time to complete the appraisal, the pilot improved appraisal rate from 37% to 58%. Current data showed a small improvement, 48% of staff had received an up to date appraisal. Senior managers had recognised that further refinements to the appraisal process were required across all regions. Measures were in place across all regions and station managers had an appraisal date agreed with all staff members.
- During appraisals, a quality and performance monitoring report was used to highlight individual staff member's performance in relation to the care and treatment they provided and also performance targets, such as turnaround times.
- Additionally observational supervision carried out by a senior paramedic would take place at least twice per year. At the time of the inspection we observed one observational supervision session. Crew were given live feedback from the supervising paramedic.
- Paramedics received obstetrics training as part of their induction training when they first start in post. This was last refreshed in 2013/14 as part of the mandatory training cycle.
- When new equipment was introduced, training was provided for all staff by the advanced paramedic or representatives from the supplying company. However

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concerns were raised by 10 members of staff regarding the lack of training when new equipment was introduced onto vehicles. Staff signed a record form when the demonstration was completed. We reviewed seven staff training records forms, belonging to staff who received a demonstration of the new defibrillator. These records contained the date, time and name of the staff member. However, there was no competency based assessments carried out and no audit or control mechanism to identify who understood how to use the equipment

- The induction programme for international paramedics was kept under review. This programme included a period of classroom training and a mixture of Supernumerary training with a paramedic crew and shifts alongside advanced paramedics and or senior paramedics and shifts in EOC and the trauma cell, clinical support hub and 111. This took place over 12 weeks. International recruits worked alongside qualified paramedics for six months before being deployed with technicians or student paramedics.
- Paramedics were required to revalidate their registration every two years with the Health Professional Council and as part of the revalidation they received clinical supervision. However, supervisors across Cheshire and Merseyside received one day a week in their administrative roles and could be operational, if the service became busy. Staff in such roles found it difficult to complete all administration and supervisory tasks in the time they were given. This had been raised with senior managers and during the trust presentation the executive board had recognised that time for administration had been reduced.
- Mandatory training days had been shortened from five days to one day. All staff we spoke with across all areas told us one day did not give them enough time or opportunity to discuss subjects taught. Staff told us that the information taught was too concentrated in the time frame it was delivered in. The trust informed the CQC that training was previously delivered over five days, however the statutory content equated to 22 hours over a two year cycle. This equated to 11 hours per year and further decreased the face to face training to one day. This meant that subjects such as paediatric life support and mental health issues was taught in brief and risking some potentially vital information being missed.
- Ambulance stations we visited had a computer which was available to staff to complete their e-learning;

however, because of operational pressures, staff found it difficult to access computers during work time. Access to an online learning zone that contained self-directed and e-learning study modules were available to staff, so that they could complete them in their own time.

- There were no robust systems in place to ensure staff received regular and up to date training, We were given many examples of where staff felt training was insufficient, for example staff working in urgent care ambulances had Entonox they could administer for pain relief. Staff received one session on the safe use of medical gases during their induction.
- At the time of joining the service, ambulance crews were required to attend driving course induction programme that lasted over four weeks. This consisted of theoretical learning and practical driving and in line with Road Traffic Regulations section 19 High Speed Driving codes of practice. However we reviewed feedback from staff who attended the paramedic driving course in February and May 2016, which stated that delegates found it difficult to absorb the amount of information taught during the training days and felt more practical training was needed. The trust confirmed that around 85% of this course was practical and involves driving in a range of weather conditions and two night drives.
- Staff told us that there were limited support structures in place for newly qualified paramedics and no record of supervision provided to them from senior paramedics. Staff told us that newly qualified paramedics were given 12 hours (one shift) as 'third man' (an extra member of staff on a DCA) once qualified and then expected to work independently. However, the trust confirmed that all new paramedics to the trust undertook a core induction of 37.5 hours and then driving training if required. They then moved to sector areas and undertook a period of 75 hours (2 weeks) within the first six months supernumerary to a paramedic to assist in clinical practice, with a further 75 hours as part of a paramedic crew with a preceptor. A further review then took place with the sector team at six months and again at twelve month periods. The newly qualified staff member then moved into independent practice. The trust also told us that as a minimum the six and 12 month reviews were always documented. However, the trust advised that there was variation in the documentation being used and that both the policy and the documentation which were in use were under review at the time of the inspection.

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- Training and development programs for volunteer staff and their managers lacked consistency. CFRs had limited supervision or appraisal. After basic induction training, on-going learning opportunities depended on ad-hoc training days organised by volunteer field trainers which were not mandatory.
 - CFRs were required to complete an annual competency assessment conducted by NWS clinical staff. The lead CFR manager for Cumbria and Lancashire reported there was 93% compliance with competency assessments. CFR field trainers completed an advanced training course over a period of six months. Although field trainers were supposed to attend refresher courses none had been organised over the previous two years due to staffing shortages.
 - The trust offered staff opportunities to progress and develop new skills for example EMTs we spoke to had enrolled on to the paramedic training. They were expected to have two years' experience before applying for paramedic training but once enrolled the course was funded by NWS. We spoke with many staff who had joined the trust in less senior roles and had been supported to progress to roles such as senior and advanced paramedics.
 - Advanced paramedics felt they were competent in attending major trauma, training in this role included additional clinical skills, such as the management of a surgical airway.
 - In Lancashire and Cumbria there were 42 senior paramedics and the plan was to increase this to 64 by September 2016. Each senior paramedic would be responsible for 15 staff members. They would complete direct supervision of their practice by being the second crew during a working day on four days per year. This would include a protected two hours to discuss their personal development, offer support and address concerns.
 - The HART team kept up to date records of training for staff in specialist areas. Forty percent of HART staff had received an appraisal in 2015/16
- Coordination with other providers**
- The trust was part of JESIP. JESIP is a partnership between emergency services that ensures services work together at major multi-agency incidents to improve outcomes. Training and policies in place reflected the five joint working principles and models agreed in the JESIP standard approach.
 - The trust worked jointly with the police, fire and local authority services. For example the Cheshire and Merseyside police were invited to meetings with the local authority to organise the logistics of high profile events such as the Chester horse races and Merseyside football matches.
 - The special operations function of the trust was a trusted partner of the local counter terrorism unit and the head of special operations spent one day a week in this unit.
 - In Cheshire and Merseyside the HART team base was co-located at the regional training centre for the fire service. This allowed both services to work together on training. We visited six ambulance stations that were co-located with the fire service.
 - In Merseyside there was coordination with the local police force which included the placement of a paramedic at the joint control centre.
 - The service had regular representation on local systems resilience groups which included members from local hospitals, third party organisations and primary care.
 - In Cumbria and Lancashire the trust worked with local Clinical Commissioning Groups (CCG) on an initiative to provide a community response team to attend calls for patients who had suffered falls. A team consisting of a paramedic plus nursing, physiotherapist or occupational therapy staff attended these calls using a rapid response car. Liaison with GPs and care homes identified frequent falls patients and allowed direct contact with the falls team, where this was available. This joint working had reduced admissions and associated savings had been quantified in Lancashire (52% of these calls did not result in transfer to an emergency department, with an estimated £77, 000 saved on emergency admissions).
 - In Cumbria, occupational therapists attended calls to people who had fallen and frail older adults three days per week. In eight shifts of joint working five patients had been provided with additional community help from this resource. The cost savings for this had not been calculated at the time of the inspection.
 - There were 12 mountain rescue teams in Cumbria with around 30 active members who attended an average of

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160 call outs per year. These were volunteers who were co-ordinated by the NWS central desk at Broughton and they worked with the ambulance crews, when this was appropriate.

- The mountain rescue team members we spoke with said there was a good working relationship with NWS and they worked collaboratively for the best outcome for patients.
- Managers in all regions were working closely with local acute trusts to manage and improve the process of handover of patients in emergency departments. They met with local trusts monthly and formed part of the system resilience group.
- Funding had been agreed for late 2016 to establish a paramedic and nurse within an emergency department in Greater Manchester as part of a joint initiative to improve patient flow and reduce unnecessary admissions to hospital. This would support clinical decision making, improve flow through the department and challenge ambulance crews when patients did not need conveying to hospital.

Multidisciplinary working

- We observed detailed clinical information being provided to staff in the emergency departments (ED) when a patient's care was transferred to them from the ambulance service.
- Feedback from staff working in ED about the care and service provided by NWS was positive. We observed a good working relationship between ambulance and hospital emergency staff.
- Hospital ambulance liaisons officers (HALO) were located in certain ED's across the region, not all hospitals we visited had this service. The HALO helped to manage the transfer and management of patients during periods of high demand.
- At the time of the inspection, one emergency department had reached its full bed capacity, which meant ambulances were waiting for up to three hours. The liaison officer reviewed the bed capacity every three hours with the lead nurse and the escalation policy was triggered to support the flow of patients. This practice was seen in other areas too.
- We visited nine EDs that used HALOs to work with ambulance crews and hospital staff in order to reduce the time that an ambulance spends at emergency departments. HALOs were visible in the hospitals and attended hospital operational meetings to discuss how

to improve the hand over and flow of patients in the emergency department. In the operational meeting, forthcoming ambulatory activity was discussed, including predictive afternoon arrivals and the capacity within the hospital. The HALO worked alongside the bed coordinators and the matron to provide information such as how many ambulances were inbound, how many ambulances were waiting and hospital activity screen data (compliance currently achieved). The HALO also discussed the ambulance activity for neighbouring hospitals and discussed the impact on the hospital.

- There was an electronic pre-alert system in all EDs which indicated, the arrival of each patient, the level of call and type of patient being brought in (e.g. red call, trauma), and the estimated time of arrival. The system also indicated when the vehicle arrived at the hospital, when the ambulance crew notified arrival of the patient and when the patient was officially handed over to hospital care. The pre-alert system was managed by the EOC and hospital ambulance liaison officers (HALOs) at the emergency department so that hospital staff knew the volume and type of patients arriving.
- We observed handovers between ambulance and hospital staff, and found they were clear and succinct. Relevant information about the patient was conveyed to ED staff.
- There was evidence of good initiatives and partnership working in the community to reduce the pressure on the ambulance service and admissions to emergency departments. In the different regions we saw partnership working with external organisations. For example ambulance personnel worked jointly with external organisations to improve knowledge and awareness of saving lives. For example paramedics visited hospices to improve their knowledge of end of life care and the management of "just in case" medicines. In other areas there was representation by the trust at local network meetings for example, the stroke network and cardiology networks.
- Ambulance crews told us they had good working relationships with CFRs.
- There were strong working relationships between the HART service and other emergency services, at ground level and operationally. Training was delivered jointly and they participated in joint exercises to plan for major incidents.

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- There were monthly meetings with the Cumbria partnership regarding the care of patients with known mental health issues. The model used in another region was reviewed and adapted to improve the referral process to the mental health crisis team.
- Links had been formed with the rapid response team to refer patients with conditions, such as infections, which could be treated at home and prevent a hospital admission.
- There had been close collaboration between the trust and local acute hospitals to develop joint protocols and pathways for patients with an STEMI and the organisations worked together to complete the national Myocardial Ischaemia National Audit Project (MINAP) audit.
- There had been a reduction in the number of HALOs at some hospitals across the region; this meant during busy periods there was no additional support to assist in the transfer of patients from the ambulances in a timely way.

Access to information

- The Joint Royal Colleges Ambulance Liaison Committee (JRCALC) Ambulance guidelines (2013) were available to crews at ambulance stations. Staff carried a pocket size version of the JRCALC with them and used it for guidance. For example, crews told us they referred to the JRCALC for medicine dosages when caring for a child, if they needed to.
- Pathfinder pocket books were also available to staff and were used to determine where the patient would be conveyed. Some staff had downloaded the app version on their phones; this meant they could instantly access information.
- When patients became violent or aggressive, crews would inform the operation centre and a flag would be placed against that address or person on the electronic system. If a potentially violent patient was known to the trust, the emergency call handler would inform the crew so that they were aware. There was no monitoring tool to review or remove the flags when they were no longer relevant
- Crews were alerted to performance information on each vehicle, this was communicated to crews when they logged onto the vehicles each day. Notice boards on ambulance stations displayed a wealth of information relating to clinical performance indicators, how to

report abuse and hand hygiene. However, staff had inadequate time to read this material because they were usually on ambulances for the vast majority of their shift.

- Staff had access to a variety of information, such as policies and procedures on the trust's intranet. However, these were not immediately available to staff as they did not always have access to a computer during their working day, unless they were in the ambulance station. There were sufficient computers at the ambulance stations where staff could access trust policies and procedures via the intranet.
- Any clinical changes or policy updates were emailed to staff but there was no monitoring system in place to certify if staff read and understood the new changes. In some instances staff accessed information at home and again there was no process in place to assure the trust that staff had read and understood the changes.
- NWAS had a trust wide policy to alert ambulance staff from all areas to a do not attempt cardio-pulmonary resuscitation (DNACPR) order. Ambulance crews were informed by EOC if there were special notes on the dispatch system. These notes included things like a DNACPR order or if there was an advanced decision to refuse treatment (a legal document detailing what medical treatment a person refuses in the event that they do not have mental capacity) in place. However crews in some areas told us they were unaware how this system was kept up to date and they did not rely on it but would request original documentation on site.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The North West regional joint protocol for MCA was due for review in April 2013 but had not been renewed. The protocol stated that "ambulance staff are trained to assess and record mental capacity in line with the requirements of the MCA." However, we spoke with EMT1 staff who told us they were not able to assess capacity and if they doubted capacity they would seek advice from the clinical hub and request back up from a paramedic.
- Training in the Mental Capacity Act and Deprivation of Liberty Safeguards was not always included in the mandatory training. This had last been part of mandatory training in 2013/14.
- We noted that training figures for MCA varied across regions for urgent and emergency care staff. The

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trust told us that the target was that 100% of staff would complete this training by the end of the mandatory training cycle. Data provided by the trust in March 2016 showed that in the HART service, 82% of staff had completed this training and 64% of staff in Greater Manchester. The number of Cheshire and Merseyside staff who had received training in the mental capacity act by March 2016 was 83% and 62% in Cumbria and Lancashire. The figures in these two areas were below the trust target for that point in the training cycle.

- Staff acknowledged their understanding and knowledge of the MCA and Deprivation of Liberty Safeguards was limited and they would benefit from further training. We spoke with staff who, confused mental capacity with mental health issues.
- Staff were unclear of when the mental capacity assessment on the PRF should be completed. We reviewed three records in the Cumbria and Lancashire region where the mental capacity of the patient was incorrectly documented with either documentation of potential lack of capacity with no resulting assessment or an assessment completed where the dialogue recorded full capacity. In two cases in the Merseyside area we found that consent to refuse treatment had been obtained from a third party and not the patient themselves despite the patient having documented mental health problems. In both cases there was no evidence of an assessment of the patient's mental capacity. It is important that mental health patients are fully assessed to establish their mental capacity before any decisions are taken. This is to ensure they receive the appropriate level of care and to minimise risk to themselves and others.
- Guidance was available for staff to advise crew about a patients' capacity to consent in the event of a major trauma or life threatening situation. This guidance was written if paramedics were acting in the person's best interest, which was usually the outcome of the pathfinder. However, the guidance policy for conveying patients with a mental illness was out of date and did not mention how consent would be obtained when conveying a patient with mental health concerns.
- Trust guidance for the completion of the PRF detailed that assessment of capacity was only mandatory for patients who refused care and treatment or were discharged using a self-care pathway.
- This guidance was not in line with the two-stage test detailed in the 2005 Code of Practice. This meant that, in

circumstances where there was no reason to doubt capacity; staff were expected to complete capacity assessments. This also meant that if there was reason to doubt a person's mental capacity, there was no procedure in place to ensure that a capacity assessment was completed in line with the Code of Practice. This posed a risk that patients who lacked capacity to consent were treated without regard to their ability to consent, personal preferences or wishes or whether the decision to be made could be delayed to a later time.

- There was also no documentation to provide evidence that a decision had been made in a patient's best interest or the reasons for this, although crews told us they acted in the person's best interests.
- Across all regions we found that, mental capacity assessments on the PRF's were not always completed. Greater Manchester ambulance crews we spoke with confirmed that assessment of capacity was only completed if patients refused treatment or were being discharged via a self-care pathway. Other staff we spoke with told us they routinely completed the capacity section of the PRF as they believed this was good practice; however, this was not in line with the trust's procedure.
- The consent section of the PRF in Cumbria and Lancashire had been completed for some patients when it was documented they lacked capacity. There was no record of how this consent had been obtained in the best interest of the patient.
- Staff received training in managing patients with mental health problems, although several said they would like to receive more robust training in mental health and mental capacity. Dementia awareness and mental health awareness bulletins were displayed on notice boards in ambulance stations.
- During our observation of crews attending emergency calls, we observed that verbal consent was generally obtained from patients before giving any form of care and treatment. Crew always ascertained consent from parents of children who were being treated and from patients who were able to understand.
- On occasions where consent could not be given, for example where a patient was unconscious, staff acted in the patient's best interest and preceded with care and treatment to save their life. If family or carers were at the scene, consent was obtained from them.

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- All staff told us they only completed an assessment of mental capacity if a patient refused treatment or conveyance to hospital.
- Ambulance staff could access telephone support and advice from the clinical hub with regard to concerns about consent for patients with mental health issues.
- Where patients suffered from severe mental health issues and were known to the ambulance service, the call taker would request police assistance. This was to ensure crews were safe if the patient became aggressive or required placing under a legal section of the Mental Health Act (1983).

Are emergency and urgent care services caring?

Good



We rated emergency and urgent care services as 'Good' for caring. This was because:

- Patients were treated with compassion and kindness. Staff respected their privacy and dignity in all situations.
 - We received many positive comments from patients and relatives about the care and dedication of ambulance crews and this was confirmed by patients using the service at the time of our inspection.
 - Staff were dedicated and committed to caring for patients and often went above and beyond the expectations of their employment to provide care.
 - Care and treatment was explained to patients and their loved ones. Patients were involved and given choices when this was possible.
 - Emotional support was offered to patients and their relatives in both life threatening and emergency situations and also during less urgent situations. Staff continued to provide emotional support with friendly, personal interactions with patients whilst waiting to handover their care at emergency departments.
 - Patients were supported to manage their own health, where possible, including using frequent caller plans and signposting to primary health care or other local services.
- Across all regions, patients told us the care and treatment they received was good. They felt they had been treated with dignity and respect and were extremely positive about the care and kindness shown by ambulance staff.
 - We received many positive comments via our 'share your experience' web form about the care and dedication ambulance crews had provided.
 - We observed a high standard of gentle, kind and compassionate care throughout the inspection, both on board vehicles during transfer and at hospital emergency departments. Staff showed patience and sensitivity.
 - Staff were reassuring and calm and showed empathy and kindness at all times. We saw ambulance staff ensured that patients were warm and comfortable.
 - In Cheshire and Merseyside we saw that crews asked how patients wanted to be addressed; they introduced themselves using their names and were understanding about the person's anxieties.
 - Patients told us that paramedics maintained their dignity in public places through the use of blankets and by asking onlookers to move away. Once the patient was taken into the ambulance for further tests and/or treatment, doors to the ambulance were closed for privacy.
 - In Greater Manchester, we observed care for a patient in a public place and saw that the ambulance crew considered privacy and dignity and moved the patient into the ambulance as soon as possible. They also respected the patients' dignity by ensuring the male crew member was outside of the vehicle at times when clothing needed to be adjusted or removed.
 - In emergency departments, we overheard staff interacting with patients on a personal level while waiting to handover their care. They checked they were comfortable, if they needed anything and spoke with them in a comforting and informal manner.
 - Ambulance staff closed the curtains in the cubicle when moving patients from the stretcher to the bed.
 - Staff were dedicated and committed to caring well for patients. Staff often went above and beyond to provide care and treatment to patients, in Greater Manchester for example, attending uncovered red calls despite having finished their shifts. Some staff also worked as

Compassionate care

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'staff responders' in their own time. This was a system where staff informed the EOC if they were available to respond to red 1 or 2 calls even though they were not on duty.

- Other health professionals including staff working in the accident and emergency departments and hospital wards reported ambulance staff to be kind, caring and supportive to patients regardless of the pressure they were under.

Understanding and involvement of patients and those close to them

- Staff were professional and ensured they informed patients about what was happening, along with information on any treatment or other interventions being provided. They checked with patients to ensure they understood and agreed to the treatment offered.
- Patients told us staff explained their care and treatment and why they needed to be taken to hospital. Family members told us staff also provided them with information and reassurance and they appreciated being involved with their loved ones care in this way.
- We observed staff adjusting the way they communicated with different patients in order to explain treatment and gain their consent. One example of this in Cheshire and Merseyside was the use of a writing pad to convey messages to a patient who was profoundly deaf. In Cumbria and Lancashire we saw that staff understood the needs of patients with dementia and included their relatives in discussions about their care and treatment.
- In Cheshire and Merseyside, we observed patients being given options available for care and treatment at a different emergency department than the closest as they had previously had a negative experience at the local department. Staff listened to the patient's preferences and helped them to decide what care and treatment best suited their needs.
- In Greater Manchester, children told us that ambulance crews explained what they were doing and why. Parents confirmed that crew cared for their children in an understanding and sensitive way.
- Staff respected patient's decisions to refuse treatment or to be conveyed to hospital and this was documented, as required.

Emotional support

- Ambulance crews reassured patients at all times while they were in their care. They remained with patients on arrival at hospital emergency departments to provide continued support and comfort until responsibility for their care was handed to hospital staff, despite long delays in some instances.
- Patients told us they were given reassurance about their health condition. This happened even in emergency and life threatening situations. Relatives or friends were able to travel on vehicles to provide additional support and comfort.
- Ambulance staff were observed providing emotional support to patients and their relatives. Once a patient's condition was stabilised, staff talked to relatives, understanding their need for emotional support in emergency situations.
- We observed ambulance crews acting in a calm and supportive manner to reassure distressed patients and their relatives.

Supporting people to manage their own health

- When appropriate, ambulance crew used individualised plans to support patients who frequently used emergency and urgent care services. These plans were developed by the frequent caller team. In some circumstances, staff held joint meetings with the patient's GP and other professionals to support patients to manage their own health. In Cheshire and Merseyside we observed that, although a patient had been identified as a frequent caller, the crew used their clinical assessment and decision making alongside the frequent caller plan to ensure the right decision was made about care and treatment.
- In all areas, crews had access to local GP's and worked closely with them and commissioners to ensure that patients who would be best suited to accessing primary care services could access them in a timely manner.
- In Greater Manchester, crews told us that out of hours GP access to support people to manage their own health was good but it was more difficult to do this during normal working hours. In rural Cumbria there were examples of joint working with community nurses and social care providers to support people when emergency department admission was not necessary.
- There were examples of community paramedics in Cumbria working with other health professionals to reduce hospital admissions for patients with long term complex health needs.

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- When crews found that patients would be best suited to access a different service, this was communicated to them in a sensitive and educative way.

Are emergency and urgent care services responsive to people's needs?

(for example, to feedback?)

Requires improvement



We rated emergency and urgent care services as 'Requires Improvement' for responsive. This was because:

- Communication aids for patients with communication difficulties or mental capacity impairments were not available on most vehicles.
- There was a lack of support systems for staff to manage the care of people who had mental capacity impairments. This included training, completion of documentation and guidance on their role in assessments.
- There was a lack of specialist equipment and training for staff to safely manage the care of bariatric patients.
- There were delays in the attendance of emergency ambulance response, when requested, by a community first responder or rapid response vehicle.
- Information for patients about how to complain was not readily available on the vehicles.
- There was a lack of consistency between localities in how well learning from complaints was shared.

However:

- There were joint working initiatives with health and social care services in all the geographical areas which were designed to improve services for local people.
- The trust were an active partner in the 47 health service redesigns which had implications for the delivery of services in the future.
- There were systems in place to meet the needs of patients in rural locations which included partnership working with the health, social and voluntary care sector.
- Translation services were available to aid communication.
- There were systems in place to safely convey patients with mental health problems.

- Access to the right ambulance and response times were monitored and formed part of the performance management system for each station.
- The service was working to reduce unnecessary admissions to emergency departments by increasing other services and joint working with health partners.

Service planning and delivery to meet the needs of local people

- The emergency and urgent ambulance service was commissioned collaboratively through a formal consortium agreement by the 33 Clinical Commissioning Groups (CCG's) across the North West region. There was a single contract, derived from the National Standard Contract for Ambulance Services.
- The lead Commissioner for NWAS was NHS Blackpool CCG, which works on behalf of the CCGs across the North West, with an overarching Strategic Partnership Board (SPB) that was responsible for setting the strategic direction of ambulance service provision. This was further supported by local area based commissioning groups in Manchester, Cumbria, Lancashire, Cheshire and Merseyside.
- Services were planned, through these groups, to meet the needs of local people and to ensure that patients received the right care in the right place. There had been a number of initiatives using the skills of paramedics differently to enable this to happen. Examples included multidisciplinary working in admission avoidance schemes and education to other care services, such as care homes.
- The trust had established itself as an active partner and stakeholder in all the reconfigurations of health services taking place throughout the North West. This included membership of the Strategic Boards and Implementation Groups overseeing the development and implementation of service redesign. These reconfigurations included Greater Manchester Devolution and "Care Closer to Home" in Cumbria. There were 47 service redesigns which had implications for the delivery of NWAS services in the future.
- The trust worked strategically with key stakeholders in the public, private and voluntary sector to deliver the best care for local people. This included joint initiatives and plans for future changes with police services, fire and rescue, local authorities, air ambulance and out of hour's providers.

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- Changes to the hospital service at a hospital in Whitehaven had resulted in patients who required orthopaedic, ear nose and throat or some specific cardiac procedures to be transferred to a hospital in Carlisle. This had resulted in increased pressure on the emergency ambulance service in this area. Six hundred and sixty transfers had been completed between 1 November 2015 and 30 April 2016. This had an overall job cycle time of 180 minutes including the travelling time and to allow for the crew to safely transfer the patient into the care of the hospital.
 - The North Cumbria University Hospitals trust clinical guideline on inter hospital transfer of adult patients had been adopted by NWAS. This provided guidance on selection of the type of ambulance and escorts required for each patient group. Ambulance and hospital staff told us this was not followed and most times an emergency ambulance was requested unnecessarily. This reduced the number of ambulances available to respond to urgent calls.
 - A community partnership project in Blackpool town centre, the Safe Haven Team, had the objective of providing a safer community in urban areas and reassurance for the night time economy. The project involved joint working between a community support organisation, CCGs, the police and NWAS.
 - A static bus was provided in the Blackpool town centre on 30 weekends during the year, offering help and advice on issues such as substance misuse, domestic violence and sexual health. This was supported by a static ambulance with paramedic and nursing staff, which was able to act as a minor injuries unit with the ability to transfer to hospital if necessary. There was also a mobile police interview vehicle. The project had resulted in reduced hospital admissions and quantified savings.
- Meeting people's individual needs**
- There were multi-lingual phrase books to assist with communication for patients who required assistance with the English language. Translation services were available via a language line, when needed.
 - Pictorial books to assist with communication were available; however, there was no consistency in their use across the trust. Whilst they were used in Cumbria, Lancashire and Greater Manchester, staff across Cheshire and Merseyside did not carry them. In these areas, staff gave an example of how pain assessments were recorded by observing expressions and sounds made by the patient.
 - The service only had eight specialist vehicles to convey bariatric patients. This meant the first response crew would provide immediate support to the bariatric patient and the call centre would be contacted for further support and approval of a bariatric vehicle. This caused delays in conveying patients to hospital, but senior managers felt that risks were mitigated with this backup vehicle system. We also noted that most crew members had not been trained in assessing this patient group and how to use specialist clinical equipment because their vehicle did not house such equipment. The HART team frequently assisted with these patients.
 - A North West Regional Mental Capacity Act (MCA) joint protocol had been developed following consultation with the North West region police forces and NWAS. This formed a memorandum of understanding that all stakeholders had agreed to support and follow; however, this protocol was three years past its review date.
 - The Mental Health Act (MHA) Code of Practice (Parts 17.3 to 17.6) states that consideration should be given to the most appropriate method of transport for patients with mental health problems. However, the policy to guide this practice was out of date and had not been updated since 2013.
 - Patients under a section 136 of the MHA were conveyed in general ambulances and not in cars. The police were responsible for these patients.
 - Staff we spoke with did not feel confident when dealing with mental health issues and identified they needed further training and support. Similarly they reported they needed additional training in relation to dementia. Mental health training was available on the online learning zone; however, staff had to access this training in their own time. They reported they were able to access advice from an advanced paramedic, if needed.
 - PRFs contained an assessment guide for helping ambulance staff to identify people with mental health needs; this questionnaire was used to ascertain the patient's mental capacity and obtaining consent. However, staff we spoke with said they did not have the right level of knowledge to make judgements of a patient's mental capacity.

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- There was no lead for mental health within the trust. This meant there was no overall trust wide leadership for training, support and guidance on caring for this group of patients. The trust recognised mental health care as an area for improvement in the information they provided to us.
- Staff knew where the nearest place of safety was for patients requiring, or subject to, a section under the MHA and were aware of how to contact the police, if required, to assist these patients.
- There were no pathways in place to allow direct referral to mental health services which meant that patients had to be conveyed to emergency departments for referrals to mental health liaison teams.
- We saw staff had understood the additional needs a patient with dementia may have. For one patient they had recorded specific information provided by their formal carer which would reduce the risk of them becoming anxious. They used a patient's existing care planning documentation so that health care staff could understand the needs of people living with dementia.
- There were examples of ambulance staff working inventively to meet peoples' needs. This included, in Cumbria, community paramedics who had worked with a community learning disability nurse specialist to complete diagnostic tests in a day centre to reduce the anxiety of the patient. Staff at a station in Cumbria had been part of a local initiative for the care of people with dementia.

Access and flow

- Ambulances were dispatched according to the information relating to the patients' symptoms when a call was made to the emergency operations centre (EOC). The operator triaged calls and categorised them as either a Red 1, 2, A19 or a Green call. Once classified this determined the response time and the type of vehicle dispatched.
- Senior managers monitored the response times of emergency vehicles and used performance indicators to review each teams' productivity. This was fed back to the teams on a monthly basis and provided to the individual stations. We saw these displayed and the reasons for any targets that had not been met were discussed at team meetings.
- Frontline staff said that sometimes a limited number of vehicles were available to attend a 'red' call in a specific area, especially rural areas in Cheshire and Cumbria.

This was a particular problem if ambulances had transferred patients to specialist centres out of their usual geographic area. They would then often be used to attend calls in that area delaying the time until they returned to their designated area.

- Data supplied by the trust showed that between 1 December 2015 and 30 May 2016 the Cheshire and Mersey team spent 276,480 hours servicing its home area, and the time spent servicing other areas was 5,430 hours. When compared to the Greater Manchester and Cumbria and Lancashire team, Cheshire and Merseyside spent more time providing care in neighbouring areas than the other teams.
- The responsiveness of the service was adversely affected by frequent, long handover delays at hospital emergency departments which resulted in a shortage of staff and response vehicles to attend to emergency and urgent calls. Turnaround times for attendance at the emergency departments were monitored and had remained over 25 minutes, on average, since 2013.
- Whilst on the unannounced inspection in a large acute emergency department in Liverpool we tracked four ambulance arrival times. One trauma patient was taken straight into resuscitation for care and treatment. The PRF for this patient was completed and the patient was handed over to the emergency department staff within 15 minutes. However, the other four patients with their NWS crews waited between 10 and 20 minutes. Staff in the department told us the average waiting time for handover for ambulance crews was between 30 and 40 minutes which exceeded the national target set for acute trusts of 15 minutes. When ED's were extremely busy in other areas, crew told us they waited up to three hours.
- All areas were working to reduce admissions to emergency departments and we saw a number of care pathways used to redirect patients to the appropriate community health services. This included GP surgeries and in rural areas, links for timely follow up by community nurses, when appropriate.
- In April 2016, 7% of patient calls had been managed through the "Hear and Treat" system. The Hear and Treat system was an advanced triage system which used senior paramedics to assess patients over the telephone. Crew members agreed this helped to improve the flow of care to patients in more rural areas and patients were placed on the correct pathways as a result. They may receive advice on how to care for

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themselves or where they might go to receive assistance. The implementation of this service was highest in Greater Manchester at 8% of calls and lowest in Cumbria and Lancashire at 5.8%.

- There was a reliance on volunteer services to provide first response to emergency calls when mainstream staff were not available. In the six months between 1 November 2015 to 30 April 2016 there were 9253 incidents where a community first responder or rapid response vehicle first attended and waited over 30 minutes for the emergency ambulance assistance they requested. Community first responders we spoke with did not always report these delays as incidents as they had seen no change in practice when they had done so in the past.
- North West Ambulance Service (NWAS) had liaised with acute trusts and the CCGs to develop the North West divert and deflection policy. This document provided a clearly defined approach to aid consistency throughout trusts and ensure the timely handover of patients arriving at hospital by preventing or reducing delays.
- The neonatal transfer policy provided guidance for emergency staff on how to facilitate a transfer of an infant, what equipment was required and deployment of the appropriate crew with the relevant skill mix. Transfer response times differed depending upon their priority and the clinical need of the patient and were not routinely measured.
- The transfer of neonatal patients from a hospital in Carlisle to Newcastle was carried out by a neighbouring ambulance service with specialist neonatal staff. However, if the Mother required transfer by ambulance, for example following caesarean section, this was carried out by NWAS staff. As they were not a high priority they could lose vital hours with their severely ill baby and not be available to give consent for treatments at Newcastle.
- In Greater Manchester there were delays with inter-hospital transfers at times. Nursing staff in a paediatric emergency department told us that the week prior to our inspection a transfer requested within an hour had taken five hours to arrive.

Learning from complaints and concerns

- There were over 2500 complaints for urgent and emergency care services at the trust in the past 12 months.

- The trust's comprehensive complaints policy stated that all complaints should be dealt with locally and this was termed stage one. If a complaint could not be resolved locally then the complainant was referred to the Parliamentary Health Service Ombudsman. The Ombudsman is independent of the NHS and the Government and derives their powers from the Health Service Commissioners Act (1993).
- There were posters and leaflets with information for patients that informed them how to complain. We found these were not available in the majority of vehicles we inspected. This varied between the geographical areas for example there were none on the vehicles we inspected in Cheshire, Merseyside or Greater Manchester; however, they were available in Cumbria. Frontline staff said patients could also be referred to the patient advice and liaison service (PALS) if they wished to complain.
- Complaints were graded using a decision tree and allocated to an appropriate level of staff for investigation, according to the seriousness of the concern. Level one or two complaints were handled locally at ambulance stations. Level three and four complaints were escalated to the consultant paramedic for the area and level five complaints were handled by the head of service for the area.
- The system for learning from complaints was via a weekly clinical safety bulletin or operational bulletin depending, on the nature of the resulting change required. There was a lack of consistency amongst frontline staff in the amount and value of sharing lessons from complaints. Staff in Merseyside were able to give us examples of when they had learned from a complaint and told us they routinely received feedback on complaints from managers. However, frontline staff in the other areas told us they did not receive any information about complaints, which meant no learning took place.
- Managers described complaints as 'the window to quality' and valued feedback from complaints to improve services. The move towards the clinical leadership model would move the focus of complaints away from disciplinary action for staff and enable staff to learn via verbal feedback or written reflective accounts.
- Patients and relatives we spoke with gave positive feedback about the care they received from ambulance

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staff. Ambulance crews said that, where possible, they would try and solve or answer the concerns of patients or relatives immediately to prevent them needing to make a formal complaint.

- The central patient experience team managed complaints and any patient feedback which they received via email, NHS Friends and Family test and letters.

Are emergency and urgent care services well-led?

Requires improvement



We rated emergency and urgent care services as 'Requires Improvement' for well-led. This was because:

- Staff did not know about the trust vision or values and had no awareness of the five year business plan.
- Risks were not always appropriately escalated to the area risk register. Risk registers did not provide sufficient detail of actions required to reduce risks further or when the next review was due.
- Monitoring of performance and quality was not consistent across the regions. In some areas, evaluation of new schemes was not robust and in others, systems to monitor handover times in emergency departments were not used correctly.
- The culture of the service was varied across the region, with some areas experiencing low morale or bullying and feeling separate from the rest of the trust. Some staff felt there were high levels of pressure or felt demotivated and demoralised.
- Staff engagement posed a challenge. Staff did not feel that they had the opportunity or time to read bulletins or emails and staff meetings were infrequent, if held at all.

However;

- Heads of service were described as good leaders. Most staff felt supported by local leaders. The HART team held regular staff meetings and engaged with staff in a positive way.

- The trust was improving engagement with the public via social media and the internet. The community engagement team were successfully recruiting community first responders and involving the wider community in education and training.
- There were a number of initiatives and schemes in place to improve the services the trust provided and ensure a sustainable future for the ambulance service.

Vision and strategy for this service

- The trust's vision was to deliver the right care, at the right time, in the right place and there were a set of values based on the NHS constitution (2015). The trust had a five year business plan in place labelled "good to great". There were three strategic values attached to this plan: to deliver safe care closer to home, being a great place to work and causing no harm. The trust was aiming for foundation status and there was a shadow board of governors in place.
- In addition to the trust wide business plan, there was also a resilience business plan which outlined the work the resilience team was undertaking in relation to the NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR) and NHS England Emergency Planning Framework (2015).
- The trust's values and vision were available on the intranet page for all staff to access and were displayed around stations we inspected. However, we found there was little awareness of the trust's vision, values or five year strategy and staff were not clear about the ambitions of the trust, at this level. In Cheshire and Merseyside for example, only two of the 44 staff we spoke with could articulate the current strategy and vision for the service. In Greater Manchester, only one staff member out of six we asked had an awareness of the five year plan.
- Although staff told us they received emails about the vision and values and said that bulletin boards displayed information in ambulance stations, they considered it largely irrelevant to their everyday jobs and were not able to explain how to translate trust aspirations into their working practice.
- Ambulance crews and managers in North Lancashire and Cumbria were aware of the Better Care Together strategy which was guiding the future vision for the service. 'Better Care Together' is a review of local health services to develop integrated care communities.

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- There was close working with other providers and commissioners in the Greater Manchester area to ensure the ambulance service was represented in strategic Greater Manchester plans such as the 'Healthier Together' and Devolution Manchester programmes of work. The Head of Service sat on the Greater Manchester urgent and emergency care board to ensure the trust strategic vision was represented and aligned with locality plans.

Governance, risk management and quality measurement

- Each region held a regional risk register, with a separate register for HART. Registers identified risks and reflected area wide risks, for example delays at emergency departments. These risks were documented with appropriate action plans to mitigate and manage risks. Sector managers and operations managers were aware of the main risks on the regional risk register. These risks were reviewed at the level three (sector managers and head of service) meetings and sector managers were able to escalate any new risks to the register at this meeting.
- We reviewed risk registers for all areas and HART and saw that dates of the last review were detailed on the register but there were no details of when the next review was due. There were insufficient details of actions required to mitigate gaps in controls and there were no target dates for completion of required actions.
- Regional risk registers did not always reflect risks identified at individual ambulance stations, specifically in Cheshire and Merseyside and Cumbria and Lancashire. Although risks at area level had been identified and documented, this process was not duplicated at lower levels and the risk register did not reflect risks identified at individual ambulance stations. Similarly, staff identified there was a risk that HART may not be appropriately deployed due to a change in the computer assisted dispatch system at the EOC, meaning staff with a lower level of training in these incidents may be required to respond, putting staff and patients at risk. The trust had however recognised a risk that there may be a delay in response from HART or that the team may be pre-committed to an incident and had provided additional training to frontline staff to form a special operations response team (SORT). Subsequently areas of risk were identified, but they were not recorded and there was no record of actions taken or reviews being completed.
- In addition to regional risk registers, there were risk registers in place relating to specific projects, for example the make ready pilot at the central Manchester station. There was also a separate register for estates issues that was held centrally by the trust. For example, this included issues with the estate at the Wigan ambulance station.
- There was a trust wide process in place to review area risk registers. This was a quarterly meeting of the risk moderation group chaired by the Head of Governance.
- Incidents were not consistently reported by staff. This meant that themes and key risks to the service may not be identified. For example, incidents when HART had not been deployed or deployed late were not reported therefore there was no monitoring or overview of how frequently this occurred and no actions taken to reduce this risk.
- Daily teleconferences were held between the sector managers in Lancashire and Cumbria. At these meetings any risks to the service were discussed including staffing issues, potential delays due to road works or vehicle issues and management arrangements.
- In each region a 'performance cell' operated from the area operational co-ordination centre which was co-located at the EOC. This was a centralised place where operational issues were managed and led by a silver commander. Issues discussed within this arena included significant issues, turnaround delays at hospitals, resource and staffing and events. There was a scrutiny meeting four times per day attended by a representative from urgent and emergency care, a dispatcher from EOC and the silver commander. This meeting then cascaded or escalated information, as required, to ensure the operational running of the service was optimum.
- Senior managers monitored information relating to performance against key quality, safety and performance objectives and audit outcomes. However, we saw that audit management at local level was variable across ambulance stations with missing and incomplete data for audits of medicines management, controlled drugs and infection control.

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- An integrated performance report was prepared on a monthly basis and presented to the trust board. This included key information relating to urgent and emergency care on operational delivery, quality, finance and the workforce. We saw that this report highlighted issues, such as increase or decrease in demand, incidents, complaints, clinical performance indicators, appraisals and sickness and reviewed the key risks and mitigations that were in place.
- Meetings were held on a regular basis involving area managers, sector leads and Head of Service. There was a system in place that allowed managers to escalate risks to these meetings and senior staff told us they frequently escalated issues through this route. Key performance indicators and patient outcome data was also discussed at these meetings and minutes showed that realistic actions were planned and taken to address any areas of low performance. However, frontline staff were not routinely informed of the outcomes of these meetings and the trust's performance against KPIs unless there were problems identified, for example, long handover times at hospitals.
- The consultant paramedics met monthly at a quality business group meeting, alongside the Medical Director, to discuss clinical issues, changes to practice and development of the service. The information from this meeting was shared at a bi-monthly meeting with the trust wide quality committee.
- There were service level agreements in place with private providers to supplement the urgent and emergency service provided by NWS. Heads of service told us that they carried out regular 'spot checks' of these providers to ensure they were working safely and within the scope of the agreement.
- In Cumbria and Lancashire there were some concerns that initiatives such as some work of the community paramedics were not adequately measured to reflect success and justify further development. There had been no key performance indicators in the first year of the strategy to reduce admissions to hospital following falls. This had resulted in challenges to the effectiveness of the service.
- In Greater Manchester, staff told us at some emergency departments it was common practice to 'dual PIN' (personal identification number) on the hospital arrival screen (HAS). This was when ambulance crew entered their PIN and the hospital PIN rather than carrying out this process with a member of staff from the ED. We saw

that the hospital PIN number was displayed on the HAS in two emergency departments. This meant that information gained from the HAS may not be accurate and that associated financial penalties may be incorrect.

- In Cumbria and Lancashire, governance of CFRs and quality assurance systems was weak, although there was acknowledgement from volunteer workers and management staff that improvements were being made and tighter regulation planned. In Greater Manchester, Cheshire and Merseyside, monitoring systems for these volunteers were better, with regular skills reassessment and auditing of care provided to ensure CFRs were working within the agreed scope of practice.

Leadership of service

- Each region was led by a head of service who was supported by sector managers, responsible for managing staff by area. In turn, sector managers were supported by operational managers (OMs) and assistant operational managers (AOMs).
- The urgent and emergency care service had had a clinical leadership model in place since 2012, with more focus on clinical quality than was previously the case. The leadership model included a Consultant Paramedic in each area and advanced paramedics in each sector. The structure had been reviewed recently and the operational and clinical team leader roles were in the process of being merged.
- Staff reported that the new clinical leadership structure with senior paramedics assuming a combined management and clinical leadership role was a positive development. This change had been well received as it provided clearer lines of reporting and less confusion, at the stations where it had already been implemented.
- There was a service lead for resilience and heads of business continuity and special operations. Leadership within HART was supported by band six team leads.
- During our visit the OM and AOMs were visible in the stations and we observed staff approaching and speaking with them. Staff told us they never saw members of the executive team but were aware of who the Chief Executive was.
- The majority of staff told us that they felt well supported by their seniors. Front line staff reported good relationships with their immediate managers. They felt there was open and honest local management.

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- Staff felt that leadership from heads of service was strong and visible. Heads of service and sector managers had been supported to develop their leadership skills with attendance at higher education courses.
 - There was a 'raising concerns' and a 'dignity at work' policy in place at the trust. However, four staff in the Merseyside area told us they did not feel adequately supported by their seniors and felt their concerns were not taken seriously when they raised them. Three staff told us that despite raising their concerns in relation to bullying with their operational managers these concerns had not been addressed adequately and they had not received feedback on their concerns.
 - Senior staff described that the size of the organisation could sometimes mean that making changes or improvements to services was a challenge. Leaders also felt that, in some circumstances, NWAS was being held back by acute trusts from making changes to services that would better meet the needs of local people.
 - We observed good clinical leadership from the senior paramedics and HART team during our visit. Senior staff were visible and, during periods of high demand, often worked alongside frontline crew.
 - Staff respected the HART team leaders and members told us that they felt they were approachable and helpful.
 - CFRs complained that, although they received very good clinical support during call outs, the service was very slow to respond to general queries and requests. An example of this was requests for information and guidance about DNACPR forms.
- Culture within the service**
- There were regional variations in the culture both across the trust as a whole and within regions. Most frontline staff we spoke with in Cumbria felt less valued by the trust with four managers stating they were the "poor relations". Due to their geographic distance from trust headquarters and main centres they felt less included in the service development. They were also aware their performance against targets was worse than other areas but did not feel the reasons for this were understood or well managed by the wider trust management. One example was that no account was taken within the performance indicators of the effect the major floods in December 2015 had on the work of the service in Cumbria. Within Greater Manchester we had mixed feedback about the culture of the service. Staff in some areas felt very positive about the culture, but in other areas they felt that there was a high degree of pressure and that focus was on performance targets rather than care for patients.
 - Staff in HART and the air ambulance service spoke very positively about the culture, cohesiveness and commitment of all team members. However, there were some feelings that HART RRV staff were treated differently to RRVs deployed in the general operation of the service. For example, at night time, HART single crew RRVs were expected to be 'on the road' whereas those in general operation were able to work out of a station, for safety reasons.
 - All staff told us they felt secure raising a concern or issue with their immediate line managers. However, four staff in Cheshire and Merseyside told us that they felt they would be viewed negatively for raising a concern but that this would not deter them from doing so.
 - Staff were proud of the care and treatment they provided to patients and relatives and we observed that staff showed dedication to their job. There was a reward and excellence scheme in place which recognised compliments that staff received from members of the public and linked these to the trust values.
 - Staff reported good access to occupational health and welfare checks, where required.
 - In the central Manchester sector, leaders described the culture as "positively diverse". They had recently received an award as public sector partner of the year from a local lesbian, gay, bisexual and transgender (LGBT) organisation.
 - Most staff told us they felt they could access support and debriefing following upsetting incidents. There was an established system of debriefing from incidents to support staff following difficult situations. This included a 'hot debrief' that happened immediately with a follow up 24 hours later to offer ongoing support and identify any additional needs, such as counselling. Staff in Greater Manchester gave us examples of when this support structure had been used and spoke positively about their experience of this. Although staff told us this system was followed in Greater Manchester and Cumbria, staff in Cheshire and Merseyside told us their debriefing was informal and unstructured. Air

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ambulance and HART staff said there was a strong culture of peer support for their colleagues. CFRs told us there was an inconsistent approach to debriefing across the regions.

- Some frontline staff told us they did not always feel adequately supported when they had dealt with a traumatic incident in the Cheshire and Merseyside locality. In Cheshire and Merseyside, two staff told us they felt there was a culture of 'get on with it'. They cited an incident where they had attended a very distressing incident involving paediatric patients and despite being visibly upset they were not given any down time to recover.
- Staff were aware of the trust whistleblowing policy and said there was a confidential contact number available, if needed.
- We found limited evidence of bullying, harassment or discrimination although three staff in told us they had felt bullied by another staff member.
- Overall staff turnover in 2015/16 was 7.2%, which was a total of 239 staff. This was slightly higher at 8.4% for band five paramedic staff which was a total of 111 staff leaving. Turnover rates were increasing year on year and the rate was higher than the assumed turnover rate in the trusts recruitment plans of 7.5%. Within HART, turnover was much lower at 2.9%. The trust was working to improve retention of staff.

Public and staff engagement

- With the exception of HART and the air ambulance service, there were no formal staff meetings within areas or at individual stations that staff were expected to attend and there was no evidence of information cascade from managerial meetings to frontline staff. This was due to the difficulties gathering staff to a meeting who were also required operationally to respond to emergency calls. HART held team meetings on a two monthly basis. We reviewed minutes of meetings and saw they were well attended and followed a set agenda including business continuity, training, appraisals and risks.
- Senior leaders told us it was difficult to know whether key messages got through to front line ambulance staff. The majority of communication was via email. One staff member reported "we're bombarded with emails; we just do the job and keep our heads down."
- Staff forums were arranged, publicised and chaired by Heads of Service on a rotational venue basis. Forums

took the form of an open question and answer session and information sharing opportunity. The forums were generally meetings of a two hour duration, held over shift change periods to capture staff starting or finishing their shift. Attendance tended to be variable, for example at a meeting held on 23 May 2016 in Cumbria and Lancashire, 22 staff attended which we were told was an unusually high number. This meeting had been for staff to discuss how to better manage the shortage of clinical staff.

- All staff we spoke with told us they would have liked more forums and meetings to express their views and learn about what was going on in the wider trust.
- We saw that clinical and operational newsletters were displayed in the staff rooms of stations we visited; however, staff told us they rarely had time to read these.
- There was an on-line forum, which staff could use and various social media accounts for the trust although staff expressed mixed views on how useful these were and some staff were not aware that these existed.
- The HART team had conducted a number of staff focus groups in November 2015 to gather staff opinions prior to making changes to the major incident and chemical, biological, radioactive, nuclear and explosives (CBRNE) pocket book to ensure the book was updated in line with the information staff needed and how this should be presented.
- The trust was using a number of different methods to increase the uptake of the NHS Friends and Family test (FFT) to gain feedback from the public. This included freepost postcards, text messaging services, online surveys and telephone surveys.
- There was a community engagement manager in post who had worked closely with local businesses, communities and schools. This work included recruiting and training community first responders, offering basic life support training in schools and increasing the numbers of automated external defibrillators (AEDs) within the community. For example, within the city centre of Manchester there was access to a community placed AED within four minutes.
- Patient representatives were sought when there was a planned change to a service. These representatives would sit in on meetings and give the patient perspective on any planned service changes.

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- Leaders used social media to engage with the public to publicise the work they were undertaking and to improve public awareness of alternatives to 999 outside of life threatening situations.

Innovation, improvement and sustainability

- We saw business plans and strategic objectives including a winter pressures plan and a five year plan. There was evidence that leaders had assessed the sustainability of these plans and subsequent improvements.
- Community paramedic initiatives were improving the care patients received closer to home. This was part of the NHS five year forward view to deliver more healthcare out of acute hospitals and in the community. In Greater Manchester, there was close working with the system resilience group and Clinical Commissioning Groups to improve community referral pathways, for example there was a pilot scheme in progress with district nurses to test out a pathway for patients with skin tears.
- In the Merseyside area there was a HART team base which was co-located with the fire service. This base had been chosen due to the excellent training facilities and opportunities available there. There were different types of disaster scenarios set up including fire houses, tunnels and train carriages. This was the regional training centre for the fire service so offered the best training opportunities in the North West. This innovative collaboration meant all staff involved in the HART team received an exceptionally high and varied standard of training, which prepared them for a range of possible real life scenarios.
- The community engagement manager was in the process of implementing an electronic application initiative called 'Good SAM'. This application could be downloaded onto mobile devices and alerts users, who have been vetted and checked, to a nearby cardiac arrest. Through this initiative the manager had also mapped all defibrillators in the North West area and, from August 2016, this information would be available to call centre staff so that they could direct members of the public attending cardiac arrests to these devices.
- There were a number of admission avoidance initiatives across the trust that aimed to keep patients at home rather than admit them to hospital. The Healthier Radcliffe scheme was a pilot system in one part of Greater Manchester that aimed to avoid admission to hospital. There was partnership working between NWS, local GPs, the local social services department, housing and the community response team. Paramedics working in this scheme were able to arrange short term care (up to 72 hours) or six weeks of reablement services to allow patients to remain at home. Around 60% of patients were able to stay at home and avoided conveyance to emergency departments, compared with the overall emergency department avoidance for the trust of 27%.
- The scheme had also demonstrated success with a reduction in calls from frequent callers within the area of 72.5%. There was a similar scheme being run by a community paramedic in South Cumbria.
- In Cumbria the community paramedics had met with the children's commissioner from the Clinical Commissioning Group to discuss the pathways for children's care. This included providing education to children about accessing the various services available, rather than dialling 999. Some paramedics had been into schools to provide this education.
- In the Merseyside area paramedics were based at a police station to try and reduce call outs to the police custody area and also treat and direct patients leaving custody to the correct care option, if they required it.
- There were monthly meetings with human resources to discuss staffing and recruitment. There was a recruitment plan in place in Cumbria with identified short term and long term actions to be taken to address the high vacancy rate of band five paramedics in this region. There were plans to replicate this plan in Greater Manchester. In Greater Manchester, leaders attended colleges, universities and job fairs to increase interest in positions within the trust and the trust was engaging with higher education providers to develop the provision of paramedic training places in Cumbria. The success regime in West, North and East Cumbria is a multiagency collaboration established to help develop the right quality of health and social care in the region. The NWS Chief Executive was on the board of the organisation and the senior paramedics were involved in the clinical developments.

Patient transport services (PTS)

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

Information about the service

North West Ambulance Service (NWS) NHS Trust is the largest provider of patient transport services (PTS) in the North West, covering the counties of Cheshire, Merseyside, Lancashire and Cumbria. The trust is currently in a period of change in preparation for providing new services in Greater Manchester and the transfer of Cheshire PTS to another provider.

In 2014/15, NWS PTS provided over 1.2 million patient journeys. PTS plays a large role in facilitating patient access to healthcare appointments. The service also enables patient flow by taking people who have been discharged from hospital either home, or to another care setting.

We visited NWS PTS Lancashire, Cheshire, Merseyside and Cumbria as part of our announced inspection on 23, 24, 25 and 26 May 2016. We met with the delivery managers, the head of service, contact centre managers, control and planning managers and the quality and performance manager for each county. We visited 25 ambulance bases, seven hospitals and three control centres. We also visited outpatient departments, hospital discharge lounges and accompanied ambulance staff to observe practice.

We spoke with 72 staff including senior managers, ambulance care assistants, ambulance liaison assistants and volunteer drivers. We spoke with 14 patients and four carers. We observed care on PTS vehicles, reviewed records for 12 people, reviewed 11 monthly records on the vehicles and completed 16 vehicle checklists. We inspected 27 vehicles.

Summary of findings

We rated Patient Transport Services (PTS) as “Good” overall. This is because;

- Procedures to ensure the safety of services were good, with systems in place for reporting incidents and equipment checks performed to a good standard. Ambulances were clean, and the service was well staffed. Ambulance crews were trained in using dynamic risk assessments and we saw evidence of this occurring.
- Effective systems were in place to facilitate the timely maintenance and replenishment of vehicles. Ambulance staff had good access to information about patients and journeys through the use of mobile data terminals which were regularly updated by the control centre teams.
- Staff knew what steps to take when a patient became unwell while being transported and were clear on their roles should a major incident occur.
- Arrangements were in place to respond to emergencies and the service took account of seasonal fluctuations in demand, the impact of adverse weather or disruption to staffing.
- All areas had sufficient staff numbers to meet the needs of the service.
- PTS staff in all areas were seen as caring, compassionate and dedicated to improving the service. All staff took their duty to report safeguarding concerns seriously.

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- Local culture was good in most areas and we found that the morale had improved in the control room in Chester immediately after the last inspection.
- The performance of call centre staff was effectively audited to make sure they followed scripts and algorithms provided. Between 1 May 2015 and 30 April 2016 core service targets were met in Lancashire for nearly all months, for all KPIs related to journey and appointment times

However;

- We found no evidence that incidents were being managed at an overarching organisational level or that themes were being identified and addressed to prevent the same issues recurring. This meant that some issues were not dealt with effectively, for example ongoing problems with DNACPR forms not being in the correct format.
- Volunteers used by the service were not given enough supervision as they carried out their roles and policies needed to be updated in light of the Savile enquiry.
- Safeguarding concerns were dealt with at a local level, but were not always reported to the safeguarding team in Carlisle.
- Enhanced priority service (EPS) patients spent longer on the transport than they needed to because journey times were longer than acceptable limits.
- Cumbria, Mersey and Cheshire failed to meet the 95% target for the KPI related to appointment times for all 12 months in the period May 2016 to April 2016.
- At our last inspection we found an apparent disconnect between managers and senior staff across PTS; senior managers acknowledged the continued challenges of working across such a large geographical area and the need to increase the visibility of the senior management team.
- At this inspection we found there was still no vision or formal strategy for PTS although we were provided with the service contract and operating model. We did not see any evidence of a project plan or timelines for the delivery and implementation of a PTS strategy.
- There was no clear governance framework for the service in terms of quality structures, lessons learned or risk registers.

Are patient transport services safe?

Good



We rated patient transport services as 'Good' for Safe because;

- There was an incident reporting system in place and staff knew how to use it. Issues raised were dealt with at a local level and staff recognised when patient safety concerns arose that needed reporting.
- Duty of candour was understood by staff we spoke with.
- At the time of the inspection there were sufficient numbers of ambulance crew and the skill mix was appropriate to provide safe delivery of care.
- Ambulances were visibly clean and stocked with the necessary equipment to promote the safety and wellbeing of patients.
- Repairs and maintenance of the fleet were mostly well managed so that sufficient roadworthy vehicles were available to provide a service.
- We observed ambulance crews with good infection prevention control practice and systems were in place to ensure ambulances were regularly deep cleaned.
- Medication (oxygen) was stored and administered safely.
- Ambulance crews were trained in using dynamic risk assessments and we saw evidence of this occurring.
- The service provided staff with a manual which included flowcharts to follow for dealing with safeguarding, patients at the end of life and other protocols such as actions to be taken following a road traffic collision.

However,

- We found no evidence that incidents were being managed at a an overarching organisational level or that themes were being identified and addressed to prevent the same issues recurring.
- Where actions had been put in place, these were not referred to on the incident report provided to us by the trust; therefore there was no record to refer back to should a similar incident recur.
- High risk incidents were not always graded correctly and did not always reflect the level of potential or actual harm inflicted and so incidents were not always given the level of attention and scrutiny required.

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- Safeguarding concerns were dealt with at a local level but not always reported for review through the safeguarding system; this meant additional steps could not be taken, if required.
- There were rusted areas in some of the Cumbria ambulances which meant these could not be adequately cleaned to prevent the spread of infection.
- The management of patient information provided to volunteer drivers, via personal emails, did not promote confidentiality.

Incidents

- The trust used an electronic system to record incidents and all staff we spoke with in each locality knew how to use it. When working remote of a base staff were not always able to return to the base immediately to report an incident. However, all staff attended a base at least twice daily at the start and end of a shift. Less serious incidents were reported as and when time allowed but if a serious incident occurred, the control room would stand the crew down so they could report it.
- The trust as a whole performed worse than other ambulance services in the 2015 NHS staff survey for the percentage of staff reporting errors, near misses or incidents witnessed in the last month (NWS 73% Average 79%).
- Reported incidents were graded using a risk management matrix with scores for likelihood of recurrence and for consequences of the outcome, ranging from one (insignificant) to five (catastrophic).
- We reviewed the March 2016 minutes from the PTS health, safety and security business group meeting which recorded that all grade three (moderate) incidents should be investigated.
- There was evidence that individual incidents were being managed appropriately at a local level, but limited evidence of systematic investigation or actions being put in place to ensure lessons were learned. This meant that similar types of incidents were recurring.
- For example, there were 649 incidents for patient transport services (PTS) reported between 1 April 2015 and 20 May 2016. Of these, 237 had nothing documented in the 'actions taken (investigation)' column of the report submitted to us by the trust, despite 18 of them being categorised as either moderate or major.
- There was one serious incident, involving a patient fall, reported on the strategic executive information system (StEIS) during this period between 1 April 2015 and 31 March 2016. This incident, which occurred in May 2015, was not reported by the third party provider and only came to light following a letter of complaint from the patient. However, the report showed that NWS conducted a full investigation using a root cause analysis (RCA) approach and identified learning, which resulted in changes to the policies for commissioning third party provider contracts. One of the actions was to advise third-party providers of their obligations within the context of duty of candour and openness. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.
- There was a clear 'Being Open - Duty of Candour' written procedure in place although this had been due for review in January 2016. This document set out the purpose of duty of candour and provided direction for staff regarding their individual roles in the process. Staff we spoke with were clear about their responsibility to be open and transparent when things went wrong.
- We requested the investigation documents for five incidents reported through the electronic incident reporting system. Three had been categorised as moderate, and two as minor. Only one had clear actions in place. Three had identified recommendations but no action plans were in place.
- One moderate incident regarded a patient who the crew declined to take home from hospital as they felt it was not safe to leave him at home alone. They later saw a private ambulance take the patient from the hospital. There were several similar incidents, including one of the minor incidents we requested further information for, where crews had conducted a dynamic operational risk assessment (DORA) but their decisions were overridden. Comments from a separate incident said "as with previous incidents of this nature, it is increasingly apparent that crews who carry out a DORA are continuously over ridden by the ambulance liaison officer (ALO) and ward staff due to pressures of availability of beds and PTS vehicles.
- The moderate incident report identified possible actions; however, there was no action plan in place to support these.

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- The second moderate incident we reviewed related to do not attempt cardiopulmonary resuscitation (DNACPR) orders and is referred to later in this report. The third moderate incident did not require an investigation.
- For the final minor incident we looked at we were told a full investigation had been completed, with multi-disciplinary team involvement, including safeguarding. Staff had been issued with guidelines regarding the safe conveyance of the patient. Conversations during our inspection confirmed the staff knew about this incident and the actions they needed to take. However, none of these details were recorded on the incident report submitted to us by the trust.
- PTS staff who had raised incidents electronically told us they received an automated email when submitting an incident, but not individual feedback about investigations, changes or lessons learnt.
- Regular and single issue bulletins were produced by the trust in order to keep ambulance staff informed of safety issues, changes and developments in the service. We reviewed 10 different types of bulletins covering January 2015 to May 2016 and these did not provide information about lessons learnt from incidents that had been reported by staff.
- Team leaders told us they discussed lessons learnt from the investigations they completed between themselves but these meetings were not recorded or shared with staff responsible for reviewing the quality of the service.

Mandatory training

- The trust had a mandatory training programme. Some modules required annual renewal, such as equality, diversity and human rights, infection control and moving and handling for people handlers. Others were two-yearly, such as conflict resolution, dementia awareness and safeguarding adults level two. The training was delivered in one day, face to face. Some courses were also provided through e-learning on the trust's intranet; however, staff had limited access to computers on which to complete the training.
- Mandatory training was monitored on an annual (calendar year) basis from January to December, as opposed to a rolling programme. This meant that someone could complete their annual mandatory training in January one year, but not be deemed to be overdue until the January, two years later. For example,

if a member of staff completed their mandatory training in January 2015 and again in December 2016, they would be considered to be compliant and would not be overdue until January 2017.

- Electronic records indicated that PTS staff in all areas had completed their mandatory training in 2015. Figures provided at a later date showed an average PTS compliance of 30% across the different areas, which met the target of 29% in April 2016. For control centre staff and PTS management, compliance was 82% which did not meet the 100% target.
- Team leaders we spoke to stated they could not rely on the electronic reporting system to identify whether mandatory training was up to date and so some held a paper record of the training staff had completed.

Safeguarding

- There were processes in place to safeguard people from abuse. This included a clear trust-wide policy to follow and an action chart with guidance for staff to refer to readily available for staff to refer to in all ambulances.
- Senior staff told us there was a safeguarding pack on every PTS vehicle and we saw this on all of the vehicles we inspected. Information included a definition of safeguarding and instructions to staff regarding their responsibility to report safeguarding concerns. In addition, contact details for the trust's safeguarding team, were clearly laid out, with a crib sheet detailing what staff should do and how they should support the patient. There were prompts for the patient's consent, presenting concerns, risks and vulnerability.
- We saw evidence that safeguarding issues were being addressed and dealt with at a local level to keep patients safe; staff provided recent examples of contacting managers, the control centre and other agencies. However, there was little evidence that formal safeguarding referrals were being completed and there was limited evidence regarding reporting to the central support centre.
- We were concerned that the number of safeguarding referrals made by PTS was significantly lower than would be expected, considering the number of patients making use of the PTS service, who were more than likely to meet the criteria of being an adult at risk.
- Figures provided by the trust showed that between November 2015 and April 2016 (26 weeks), safeguarding calls from Cumbria and Lancashire combined totalled 25 (24 adult and one child), i.e. at an average rate of just

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less than one call per week. In the same period, for Cheshire and Mersey combined, there were 18 adult safeguarding referrals, and none for children. Figures per individual area were not provided.

- Staff told us they did not always get feedback about how issues were concluded and a senior manager said the service received no reports back regarding actions or learning from the safeguarding centre in Carlisle.
- The safeguarding central call centre audited 20% of calls received per month. The audit collected information about what was recorded in the referral and whether the call centre staff and referrers fulfilled expected criteria such as introducing themselves and providing clear information. Data was also collated about the nature of the referral, and which team was referring. We reviewed the audit data from January 2016 but no calls from PTS services were included.
- The 2014 mandatory training cycle included safeguarding content on both adults and child safeguarding at level two. The 2015 content included only adult safeguarding which was the majority of the safeguarding issues faced by PTS. The 2016 programme included both adult and child content, level two.
- Safeguarding information for PTS volunteer drivers was provided in the handbook and memorandum of understanding; however, the three volunteers we spoke with said they had not received safeguarding training.
- The independent report produced by Kate Lampard in February 2015 entitled 'Themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile' recommended that all NHS trusts should ensure their staff and volunteers undergo formal refresher training in safeguarding at the appropriate level at least every three years to ensure they are equipped to identify safeguarding issues and respond to them appropriately. PTS volunteers did not receive additional safeguarding training or updates.
- Volunteers we spoke to had provided services for the organisation as a volunteer for between five and fifteen years but they told us they had not completed additional training.
- We saw evidence that mental health concerns and information about patients living with a learning disability was recorded on the computer aided despatch system (CADS) when we reviewed 12 patient records.
- Several different staff told us they had to have the patient's consent to make a safeguarding referral and if they did not have this they would complete a mental

capacity assessment. Some of the staff we spoke with were unclear about making a safeguarding referral for a patient with capacity if consent was not given. The current policy (2015) was clear that when staff identify a safeguarding concern, for a child or adult at risk, (i.e. they suspect abuse or there are indicators of abuse) then they must make a referral.

Cleanliness, infection control and hygiene

- There was a trust-wide policy in place for infection prevention and control procedures. The policy stated that all equipment must be cleaned with detergent wipes and disinfectant wipes after every patient use. We observed this taking place during our inspection.
- The policy also required routine cleaning to be undertaken every shift, a weekly vehicle clean and a deep clean every six/ twelve weeks. This involved cleaning all the vehicle interiors and equipment including stretchers, mattresses, carry chairs, wheelchairs, spinal boards and scoops thoroughly over and above the general routine cleaning by crews. There was a form in use entitled 'six weekly deep clean audit form'; however, for PTS vehicles this took place every 12 weeks. The policy was not clear about the criteria for a six week or 12 week deep clean.
- The deep clean programme was managed through an electronic system which flagged vehicles as red if they were overdue. All vehicles we inspected displayed badges or certificates which indicated their deep clean schedule was in date.
- The policy set out further details around cleaning of equipment, decontamination procedures and cleaning of the vehicle exteriors. Vehicle and equipment cleaning was recorded in a monthly record which was kept on the ambulance. This monthly record was a comprehensive record of vehicle incidents, such as defects, damage, service and deep clean history, daily and weekly checks, with checklists to be completed and signed by the drivers, and a manager's audit log.
- There was a monthly managers' performance audit sheet at the back of each monthly record, which was torn out and audited on a monthly basis. The team leaders, with the exception of Cheshire, completed these logs, and entered them on to a healthcare governance page on the trust intranet.
- The policy also included instructions about working with patients who have an infection. This included use of specialist protective clothing, transporting the patient

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alone and decontaminating the vehicle immediately after use. Personal protective equipment (PPE) was readily available on all vehicles. Staff used antiseptic hand cleansing gel as appropriate.

- The March 2016 clinical safety indicator assurance report provided by the trust showed that all PTS sectors met the vehicle deep clean targets (less than 5% being overdue by two weeks) in each of the six months between September 2015 and February 2016.
- Assurance was provided through the use of internal quality systems facilitated by the clinical safety practitioners (CSPs), PTS senior team leaders, and the service delivery managers. Two types of monthly audit were routinely carried out to assess compliance against cleanliness. Assurance audits were facilitated by the clinical safety practitioners (CSPs) and performance audits were undertaken by those delivering the service. Practices audited included bare below the elbow and hand hygiene, cleanliness, crew competence, management of equipment and management of waste and linen.
- The quality committee identified that variation in results between the two types of audit for the same standard was sometimes due to the audit sample sizes involved.
- Audit results for the infection prevention and control clinical safety indicators were presented at the bi-monthly quality committee for discussion and assurance regarding actions. We saw six sets of minutes from these monthly meetings which mostly included appropriate action plans where problems were identified.
- We looked at some outcomes from both the assurance and performance (service delivery) audits between June 2015 and April 2016. In the cleanliness and bare below the elbow assurance audits in Cumbria and Lancashire PTS, there was an average compliance score of 96%. In the performance audits compliance was 93% and 92% respectively.
- For the same period of time in Cheshire and Mersey the assurance audits showed 97% for cleanliness and 99% for bare below the elbow and the performance audits showed compliance was an average of 94% and 86% respectively.
- There were 21 PTS vehicles audited during January 2016 and 18 in February as part of the routine monthly audits. Area information was not provided. In the assurance audits the vehicles achieved 100% for compliance with cleanliness in January 2016 but only 94.4% in February.

This was mainly due to one question, 'is the vehicle deep clean sticker in date' which did not make provision for a two week window allowance period. Wording was to be changed.

- The vehicles achieved 100% for compliance with management of waste and linen in January 2016 but only 94.4% in February. The clinical safety indicator assurance report for March 2016 identified that 'waste is not stored appropriately' was the main reason for non-compliance. PTS vehicles had no provision for carrying clinical waste and some vehicles were placing clinical waste bags in the holders designed for domestic waste only. No actions to address this were identified in the report.
- PTS ambulance staff were made aware of patient related infection control issues through the electronic patient information record used to plan journeys. Staff told us suitable arrangements were in place as they had access to a specialist team if the hazard was out of the ordinary.
- Also included in the information on the vehicles was a vehicle and equipment decontamination certificate. Staff we spoke with were familiar with how to deal with deep cleaning, for example if there was a blood spillage that got into any cracks or crevices the vehicle would go into the workshop to be stripped down.
- We inspected 25 vehicles used by PTS; all were uncluttered and visibly clean. However, we saw there were rusted areas in some of the Cumbria ambulances which meant these could not be adequately cleaned to prevent the spread of infection. This included the legs of stretchers and seats, safety locking mechanisms and door casings. This was raised with the station manager in Barrow at the unannounced inspection.
- We observed approximately 25 members of uniformed staff and all their uniforms were visibly clean. Crews were responsible for washing their own uniforms.
- Some ambulance stations had washing machines and tumble driers for staff to wash uniforms. Old uniforms were sealed in special bags and sent to a company for shredding.

Environment and equipment

- The provision of equipment and the standard at which the ambulance bodywork was maintained was mostly good. In Cheshire, Lancashire and Merseyside all

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vehicles we observed appeared to be in good condition and equipment was provided in keeping with policy and met the needs of the patients. However, in Cumbria we saw some rust on the vehicles.

- There was a trust-wide electronic management system in place to ensure that all PTS vehicles were serviced every 12 weeks. Vehicles were serviced at in-house depots situated throughout the different areas.
- We reviewed the electronic system and scrolled through the service history of approximately 50 PTS vehicles. We noted that a red flagging system was used to identify when services were overdue. There was a clear protocol in place which included email reminders to the PTS team leader and a final warning letter. We reviewed the response to emails and the warning letter and noted that overdue ambulances were presented for service within 24 hours of receiving the warning letter.
- A manager checked the service status of vehicles once a week and the maximum lapse we saw in time between service due date and actual service was three weeks. Vehicles were always legally roadworthy because there were no instances of lapsed MOTs.
- There were three vehicle workshops in Lancashire which meant maintenance was easily accessible. In Lancashire, the vehicles were due to be replaced within a few months so there was a reluctance to invest in expensive parts for such a short period of time. Staff told us that vehicle breakdowns were their biggest issue.
- In Cumbria, however, we found some concerns regarding the maintenance of vehicles. This included poor access to routine maintenance and emergency provision. The depot where maintenance was undertaken required a travelling time of over an hour from some locations and was only open Monday to Friday 8am to 4pm. Cumbria PTS did not have local access to mobile or emergency workshop provision. This had implications for availability of suitable vehicles.
- Staff in Cumbria had difficulty in accessing specialist moving and handling equipment. This was due to equipment such as stair climbers being stored in a small number of ambulance stations which could result in long journeys because of the geography of the area.
- There was a monthly record log on each vehicle where maintenance details were recorded. We checked nine monthly records in Lancashire and one each in Cumbria and Cheshire and found all were up to date. Records indicated that checks were appropriately completed.

- All staff completed a vehicle checklist at the beginning of each shift. The checklist book was specific to each vehicle. Checks included the vehicle lights, moving and handling equipment, first aid box, oxygen and a visual check of the vehicle tyres for obvious defects, such as nails. We reviewed 16 checklists and all were appropriately completed to indicate that the checks had been completed.
- There were systems for reporting vehicle defects and there were sufficient PTS vehicles available to provide replacements, when required, to enable service continuity.
- We checked 16 vehicles and each carried appropriate moving and handling equipment including banana boards, handling belts and slide boards. Staff confirmed moving and handling training included the opportunity to practice using this equipment so they knew how to handle patients.
- There were 21 PTS vehicles audited during January 2016 and 18 in February as part of the routine monthly audits. No issues were reported with equipment following these audits according to the clinical safety indicator assurance report minutes from March 2016.
- There had been limited station assurance audits conducted by service delivery in the twelve months to March 2016; however, this had increased in January and February 2016 with 33 of the 34 audits completed for Cumbria and Lancashire. None were completed in January and February 2016 for Cheshire and Mersey. Stations, which were shared by emergency and PTS crews, did not meet the compliance targets for any of the six audit topics which were audit controls, bare below the elbow/ hand hygiene, cleanliness and management of equipment, sharps and waste and linen.
- Vehicles were fitted with a wheelchair lift and straps for securing wheelchairs when travelling. This equipment was standardised across the PTS ambulances that we looked at.

Medicines

- Every vehicle had piped or portable oxygen and the levels were checked daily to ensure the gauge was showing at least 50% full. Where it was less than 50%, the oxygen was replaced. We saw evidence in the vehicle monthly record books that these checks were being completed.

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- There were paper patient report forms (PRFs) detailing the patient's medicine requirements, including oxygen.
- Patients sometimes had their own nasal tubes which were used with the ambulance oxygen. Staff said they preferred to use the oxygen on the ambulance rather than the patient's own, as they were sure of the system supplying it.
- When patients needed to carry their own medication, for example if they were transferring from one ward to another, this was contained securely on the vehicle.

Records

- The service used an electronic computer aided despatch system (CADS) to manage and record the transport operation including planning, journey booking, control and patient information including risk assessments.
- All risk assessments and additional contact with other providers were recorded on the electronic system used by the central control centre.
- Computerised records were kept securely. Each team carried a mobile data terminal and PTS staff members had their own unique login and password which needed to be re-entered if the terminal was inactive for five minutes.
- When patients had a DNACPR order in place there was an alert flagged on the electronic system. Details of the order were saved on the CADS and were checked by the ambulance care assistants (ACAs) for patients leaving hospital.
- A step by step DNACPR flow chart was provided on each ambulance. The policy stated that the patient must have a valid document on their person.
- If patient records were transported, they were secured in an envelope and handed directly to the nurse or carer on arrival at the destination.
- In Lancashire and Merseyside, we reviewed 16 patient records on the CADS, eight archived records and eight in real time. All included basic details, for example name, address, and pickup time (planned and actual), drop off time, mobility needs, destination and escort needs. The majority of records were complete and appropriate. However, we found that one patient, booked by the bed bureau, had no emergency contact details and no GP recorded.

- Risk assessments were in place where appropriate. For example, we saw a risk assessment for a bariatric patient and dynamic risk assessments were completed and changes, such as a larger crew or vehicle change made accordingly.
- Patient records at ambulance stations, such as risk assessments, were kept in locked cupboards and the keys held by the team leader.
- There were shredders at ambulance stations so that any confidential information could be disposed of.
- The management of patient information provided to volunteer drivers did not promote confidentiality. This was because volunteers received this information through an email to their personal computers. We were told that the emails were not encrypted. Volunteers then printed the patient list to use during their volunteering sessions. Volunteers said they discarded or destroyed this information at home. Volunteers told us there was no check to ensure that the method of disposal was effective.

Assessing and responding to patient risk

- Information about patients' needs was collected at the time of booking and communicated to PTS drivers through the electronic record system.
- We observed staff responding to patient risk appropriately with respect to mobility needs.
- All ambulance staff were trained in the use of dynamic operational risk assessment (DORA) and described this as an ongoing process. They were continually reviewing what they were doing and considering their environment and what was going on around them. For example, they were aware if it was particularly wet, or there was a narrow stairwell, and made adjustments or decisions as necessary. This included assessing the person and contacting the team leader and the referring agency if unmitigated risks were identified when they met the patient. We observed this in practice.
- Formal risk assessments were carried out by team leaders for patients with complex needs and where there were particular considerations with a patient's property, including access. Sometimes extra help was needed to move bariatric patients and staff from the paramedic emergency service (PES) were called upon to assist.
- There were templates for risk assessments, such as a manual handling for conveying patients with complex physical needs, such as bariatric patients for example,

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which included prompts for information about vehicle positioning, environment, patient height, weight and mobility and what type of equipment would be required.

- Risk assessments were stored electronically on the CADS system and, where needed, paper copies were kept in locked cabinets at the ambulance base.
- In May 2014, NWAS appointed a gazetteer team to take over the responsibility for managing markers and addresses in the CADS. The gazetteer contained a dataset of business names, domestic and commercial property names, addresses and grid co-ordinates used within the trust to accurately identify the location of incidents. The gazetteer team shared information, when necessary, for example a marker could be put on a record in the CADS system to alert staff about particular risks related to that patient.
- Staff told us if a patient became unwell whilst being transported, the policy was to alert the control centre and call the emergency services or transfer to the nearest general hospital depending on the severity of the illness.
- PTS staff told us patients with behaviour that may challenge, were usually escorted by care staff or carers; however, if they had to deal with challenging behaviours in the course of their work, this was reported as an incident.
- Staff told us, and incident records indicated that staff called the control centre and additional back-up was provided from other crews when required. PTS staff also accessed the police when necessary. Team leaders documented in incident reports that action taken to complete investigations and update risk assessments included conducting joint visits to the patient's home.
- The handbook for volunteers instructed drivers to call an ambulance if a patient became unwell. The handbook also included a direct line number to the emergency control centres for use if they were escorting patients outside of office hours. Volunteers we spoke with were aware of this.
- The policy and guidelines instructed control to prioritise patients receiving renal dialysis or chemotherapy when adverse weather affected the service and this was policy was deployed during the Cumbria floods in 2015.
- Ambulances were staffed by ambulance care assistants (ACAs). Substantive staff were mainly employed at band 3 level.
- Historically there had been band 2 ACAs in post and although no new band 2 substantive staff were being recruited, bank staff could still be employed to work at band 2 level. Band 3 staff were trained at a higher level for moving and handling than band 2, and could also provide oxygen therapy which band 2 staff were not trained for.
- Each area had sectors consisting of between two and four ambulance bases. Each ambulance base had a band 4 team leader and each sector had a band 6 senior team leader. There was a band 7 delivery manager in each area who was responsible for local operational matters.
- The team leaders were responsible for the routine daily tasks around managing staff, producing the rotas, wages, monitoring sickness and appraisal rates and management of vehicles. For example, on the morning that we were at a Lancashire station two of their nine vehicles had gone into the workshop for minor repairs so the team leader was managing the consequences of that and shuffling vehicles around to accommodate the immediate waiting jobs.
- Core activity for ambulance staff was between 7am and 7pm, Monday to Friday. Enhanced priority service (EPS) was outside of core activity at weekends and the late shift. Traditionally, staff were allocated to either core or EPS shifts but new recruits rotated, which had given former EPS staff the opportunity to do more core hours work.
- There were different shift patterns, dependent on the available vehicles and whether staff were working a four or five day week. Staff said there was flexibility in shift planning and where they had private appointments or specific requests team leaders would try to accommodate these.
- Staff told us they usually had adequate breaks and time off between shifts and, if breaks were missed, it was reported as an incident. We saw two incident reports for delayed breaks for the Cheshire PTS.
- Between April 2015 and January 2016 the average sickness rate for all PTS staff was approximately 6%.
- There was a 12% whole time equivalent (WTE) vacancy rate for front line staff, which meant that of the baseline number of 465 ACAs established in April 2016 there were

Staffing

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409 in post and 56 vacancies. The staff we spoke with reported no issues regarding staff shortages. ACA staffing was supplemented by an operational bank and recruitment to permanent posts was ongoing.

- The vacancy rate within PTS for control staff was around 29% in March 2016.
- Control staffing was supplemented by agency staffing which did not show in the figures provided by the service. New services were due to be provided in Greater Manchester and Cheshire PTS was to be transferred to another provider. A recruitment freeze was being maintained until the impact of the new contracts could be assessed.
- Control staff told us that of about 40 staff in the Lancashire contact centre team, five were permanent, one supervisor and approximately 35 agency staff. Despite not being permanent they were mostly regular, long term staff who wore the same uniform and worked with the same procedures as the permanent staff regarding human resource policies such as annual leave and sickness reporting.
- Call handlers were band 2 staff, but there was access to more senior staff if there was a problem with a call.
- There were 21 staff working in the Lancashire planning and control team, making up 15 whole time equivalent (WTE) posts. There were six ambulance liaison assistants (ALAs) based in local hospitals and three band 5 duty managers who coordinated cross-boundary working. One further ALA was employed directly by a local hospital trust. In other areas we found a mixed approach to the deployment of ambulance liaison assistants with 7 staff based in hospitals across Mersey and Cheshire.
- The vacancy rate for both ambulance care assistants and control staff was around 5% in March 2016.
- The turnover rate for PTS frontline staff was around 5% between April 2015 and February 2016, and a similar rate between 1 April 2014 and 31 March 2015.
- Female staff who were pregnant did not work on the ambulances due to the lifting and carrying implications that the role entailed so they would work at the bases doing administrative duties such as audit.

Anticipated resource and capacity risks

- The NWS winter capacity strategy was reviewed in November 2015 and due for review in June 2016. This detailed information about availability of additional resources, during periods of increased demand, or issues affecting the capacity of the service.
- Vehicles were de-commissioned and replaced every seven years.
- Some of the ambulance bases had their own workshops so maintenance could be carried out on site, unless the vehicle was under warranty and had to go to a specific garage.
- There were additional resources available in all areas to provide transport if NWS vehicles were unavailable. These included contracts with private ambulance services, taxi companies in each major town and volunteer drivers.

Response to major incidents

- The trust had produced a detailed major incident plan which included guidance and corresponding action cards for different scenarios. The cards were available in the major incident response plan on the intranet, on local ambulance stations, and in the pocket book. The pocket book also contained prompts for situation reports, briefings and triage as well as information on site layout and use of some equipment.
- Staff told us roles would be allocated from a single control centre with an overview of the entire fleet. Possible responsibilities included taking less injured patients to hospitals further away from the epicentre of a major event.
- Major incident awareness training was available for staff at band 6 and above. As the ambulance care assistants were bands 2 and 3 this was not applicable for them; however, staff we spoke with had a good working knowledge of their role should a major incident occur.
- All operational staff had a major incident and chemical, biological, radiological, nuclear, and explosives (CBRNE) pocket book; however, these were due for renewal. Focus groups had been held in November 2015 and the staff feedback gathered was used to improve the content and format of the pocket books.
- Staff we spoke with gave examples of different situations that may arise and disrupt the service, for example heavy snow. Staff were advised to attend the

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base nearest to them. Patients with dialysis needs and cancer would be prioritised and anything non-urgent cases would be re-booked. Solo crews would double up, to help with manoeuvring wheelchairs in the snow.

- During the Cumbria floods of 2015 and the resulting road closures, NWAS staff had worked with volunteer car drivers and private providers to ensure necessary patient journeys, such as those for dialysis, continued.

Are patient transport services effective?

Good



We rated patient transport services as 'Good' for Effective because;

- A standardised system was in place for assessing the transport needs of patients. The eligibility criteria for receiving patient transport services reflected Department of Health guidance and differentiated between transport, medical and social needs for transfer.
- There was an audit programme in place with most actions documented where improvements were required.
- The majority of target-related key performance indicators (KPIs) were met in all areas.
- The performance of call centre staff was effectively audited to make sure they followed scripts and algorithms provided.
- There was a thorough, three week induction course in place which new recruits described as helpful.
- We observed good communication between Ambulance Care Assistants (ACAs) and the control centre, between different ambulance crews, patients and treatment centres.
- There was good coordination with other providers.
- Use of the mobile data terminals meant there was good, current access to patient information which was regularly updated as and when required.

However;

- Many enhanced priority service (EPS) patients, primarily those receiving dialysis or chemotherapy, spent longer on ambulances than expected and many patients also arrived for their appointments earlier than expected.
- Central records were not always reflective of the status of performance appraisal and development reviews (PADRs) and the way these were recorded (year to date) did not show which staff had completed a PADR within the last 12 months.
- PTS staff in Cheshire did not feel supported with opportunities for personal development. However, it was recognised that these staff were due to transfer out of the trust under a TUPE transfer arrangement and this may have affected the availability of longer term development.
- Volunteers were not provided with updated training to ensure they remained competent.
- There were recurrent similar incidents related to do not attempt cardiopulmonary resuscitation (DNACPR) documents travelling with the patient, and no actions were in place to address this.
- Staff did not receive formal 'stand alone' training on the Mental Capacity Act (MCA) or Deprivation of Liberty Safeguards (DoLS).

Evidence-based care and treatment

- NWAS provided policies based on best practice and legal guidance, for example the communicable disease policy and associated procedures had been developed in consultation with the infection prevention and control forums and groups including Public Health England.
- Eligibility for transport by PTS did not take into account age, or distance, but was based on the patient's mobility and whether they had a medical diagnosis for which they were receiving treatment. For routine patients, their eligibility lasted for 24 hours.
- Where patients did not meet the eligibility criteria, control staff directed them to alternative providers and there was an information line for that purpose. If there was a medical need the patient could be referred to their GP or the clinical commissioning group (CCG). Eligibility criteria could be over-ridden by a GP or their representative, or by a hospital doctor. If there was a financial issue the patient could be referred to local charities or the Healthwatch website for further information and help.

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- Enhanced priority service (EPS) patients were those receiving dialysis or chemotherapy treatment. EPS transport activities continued at weekends and on the late shift to ensure continuity of care for these patients, outside of core service hours which were primarily for routine outpatients appointments and discharges from hospital.
- Patients undergoing dialysis were preauthorised for six months, meaning they did not have to go through all the eligibility criteria each time they booked transport. Oncology patients were ring-fenced for three months. For routine patients, their eligibility lasted for 24 hours, after which they would need to go through the process again. Only healthcare professionals could book patient transport services online.
- A range of monthly audits (referred to as clinical safety indicators) were conducted to monitor standards in the PTS vehicles and ambulance stations. Practices audited included bare below the elbow and hand hygiene, cleanliness, crew competence, management of equipment and management of waste and linen.
- Primary reasons for failing to meet the targets had been identified and actions were in place to address the main themes, including the introduction of labelling for food stored in the refrigerators, and plans clearly stating who was responsible for undertaking the station audits each month as there had been some confusion around this.

Assessment and planning of care

- During the booking process call handlers took information regarding mobility aids, whether or not a stretcher was required, details of any oxygen or medication for the patient and whether there was an assistance dog. Risk assessments may be indicated if there were complex needs or for bariatric patients.
- The initial assessment tool included questions about the patient's historical and current mental health needs; however, this did not always provide information about anxieties related to travelling or receiving treatment.
- The results of the assessments and transport needs indicated the crew to which the patient would be allocated and the information was shared accordingly on the patient record. This was uploaded on the mobile data terminal used by PTS drivers or via email to volunteers, private ambulances and taxi firms, as appropriate.
- We observed PTS crew reviewing this information and planning their journeys accordingly. Staff told us they

were able to make dynamic assessments of the needs of patients at the point of pick up and make adjustments. Changes were communicated to the control centre verbally.

- We observed 10 pickups and noted the information in the electronic patient records provided accurate information about the needs of the patient.

Nutrition and hydration

- PTS staff did not routinely provide food and drink to patients. We noted that PTS staff asked patients if they had money to buy refreshments. Staff told us that if a patient had diabetes this was highlighted in the notes section of the patient record and they would specifically check that the patient had brought medication and food as required.
- There was a small supply of drinking water on the vehicles for patients, if required.
- Patients told us they brought their own snacks or money to buy food and drink if required.

Patient outcomes

- There were key performance indicators (KPIs) set by commissioners of the service as part of the contract agreement. KPIs are a set of measurable standards used to check and compare performance in terms of meeting agreed standards or comparing to similar organisations. Staff at the control centre monitored performance and produced a daily performance report using data generated by the mobile data terminals. Where targets were missed, the control centre informed the local duty manager who sent a team leader to investigate.
- Monthly quality reports were collated for each area, showing where targets had met, and been missed. KPIs included targets for booking systems, eligibility, travel time, arrival (at treatment centre), collection (from treatment centre), provider cancellations, missed collection, breakdowns, complaints, patient experience and misidentification.
- For EPS patients they included travel time, early arrival, on time arrival, late arrival and collection times.
- Between 1 May 2015 and 30 April 2016 core service targets were met in Lancashire for nearly all months, for all KPIs related to journey and appointment times. For two months the KPI compliance was 89% for patients

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arriving less than 45 minutes earlier or 15 minutes later than a scheduled appointment time. The threshold was 90% and financial incentives were in place when the target of 95% was met.

- The majority of targets were also met in Cumbria, Mersey and Cheshire, however they failed to meet the 90% target for the KPI related to appointment times for all 12 months in this time period. The average compliance with meeting the target related to appointment times was 89% in Cumbria, 86% in Mersey and 85% in Cheshire.
- Enhanced priority service (EPS) work was primarily renal and oncology patients attending regular treatment clinics so these patients were always prioritised. For EPS patients the KPIs included patients spending less than 40 minutes on the vehicle and patients arriving less than 30 minutes earlier or 15 minutes later than a scheduled appointment time.
- The target threshold for compliance was for 90% of EPS patients to spend less than 40 minutes on the vehicle and this had not been achieved in any area for the 12 months between 1 May 2015 and 30 April 2016.
- Similarly, during this same period, the EPS target was for 95% of patients to arrive within 30 minutes of the scheduled appointment (on time arrival). This had not been met in any month in any area. However, the EPS target to collect 90% of patients within 60 minutes of scheduled collection time was met every month in all areas.
- One delivery manager acknowledged the service had struggled to meet the EPS targets and told us these had been reviewed and revised for new service contracts in order to make them more achievable.

Competent staff

- Ambulance care assistants (ACAs) completed a three week training course, on induction, which included a week's training for a level two award in ambulance driving. External driving instructors were sometimes used to supplement NWS driver trainers in order to meet peaks in demand for trainees but all were fully qualified, checked and met the requirements of the awarding body.

We spoke with six new PTS recruits from different areas and each confirmed that induction into the service was thorough and helpful.

- New staff worked under the supervision of an experienced colleague for the first few weeks and did not take on single crew jobs for up to three months, dependent on their progress.
- The trust did not conduct any refresher driving courses or skills checks for PTS drivers unless the driver was involved in an accident, concerns regarding competence were raised or there had been an extended period of absence. On-going skills assessments for PTS staff were not a legislative requirement under the Road Safety Act 2006.
- Performance appraisal and development reviews (PADRs) were recorded at a local level as well as centrally but the two records differed. Central records showed that at the end of February 2016 the percentage of PTS Lancashire staff who had completed a PADR since 1 April 2015 was 69%. However, local records provided by the service showed staff names, the date of last PADR and the date the next one was due. These showed that 83% of Lancashire PTS staff had completed a PADR within the last 12 months. The trust target was 100%.
- Central records showed that at the end of February 2016, 35% of staff in Cheshire, 87% of staff in Mersey and 73% of staff in Cumbria had completed PADRs since 1 April 2015. However, in two areas team leaders had plans for PADRs which showed all staff were up to date and appointments were booked in for the next 12 months to achieve ongoing compliance. Therefore it appeared that the central records were not always reflective of the status of PADRs and that the way these were recorded (year to date) did not show which staff had completed a PADR within the last 12 months.
- On the trust intranet there was an NWS learning zone with access to specific subjects such as online training for safeguarding and resilience. Continuing professional development (CPD) information was also on the learning zone. Staff could access this from home, for example if they wanted to develop their CPD portfolio in order to progress to patient emergency services (PES) but there was no protected time for this.
- Staff, with the exception of those in Cheshire, said they felt supported to develop and had completed various different courses. One member of the control team had completed a bomb threat awareness course and had shared this learning with colleagues. Two of the ACAs

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had completed an NVQ level two mental health awareness course funded by NWAS and staff regularly progressed from PTS to PES. One ACA was studying for an infection prevention and control qualification paid for by their union and supported by NWAS.

- Established Cheshire PTS crew told us there were limited opportunities for further development unless it was self-funded; however, the majority were satisfied with this situation.
- Staff told us they received training on new pieces of equipment and we saw training on the use of a bariatric stretcher during our inspection. Trainers were visiting the different hospitals to bring the training to the crews.
- Although the PTS volunteer policy had not been updated directly in response to Savile recommendations we found that volunteer drivers underwent a comprehensive vetting process before working with the PTS. This included checking references, use of the disclosure and barring service (DBS), and completing MOT and insurance certificates checks. Processes were in place to ensure that MOTs and insurance certificates were checked yearly and a DBS check completed every three years.
- When accepted, volunteers completed five days induction. This included one day driving assessment, competency and skills training; moving and handling training and safeguarding level one training. The driving assessment was not reviewed or repeated. This meant the service did not check whether these drivers continued to work in accordance with trust safety policies.
- Volunteers were provided with a handbook which included information about the expected conduct and standards to be maintained with regards to confidentiality, incident reporting, infection control and dress code.

Coordination with other providers

- Advance PTS bookings were coordinated through the two PTS regional control centres. Staff followed an algorithm of questions which helped to assess eligibility for the service and the most appropriate type of transport and size of crew.
- There were established relationships with local health care providers. We observed two-way communications between drivers and control centre staff in relation to collecting and transporting patients while waiting for patients to finish appointments.

- We observed good working relationships between staff employed by the trust and those commissioned to supplement this service, such as private ambulance or taxi drivers and volunteer drivers.
- We observed the processes for patients travelling to and from a number of health care services in the different regions. We observed that PTS staff worked well with staff at each service.
- Nursing staff at a renal dialysis unit told us the Cheshire PTS was efficient and flexible, the centre was alerted if there were problems and on weekdays patients were escorted home almost instantly following dialysis.
- Renal patients told us the Cheshire PTS service was mostly good. NWAS used taxis to transfer these patients which they said was preferable to the ambulance because they were taken straight home. The exception was delays in transport at the weekend.
- Hospital discharge lounge staff and ALAs in different areas told us PTS staff responded to their requests in a timely way.
- Senior control staff said they had a good relationship with the commissioners and were working closely with them to develop the next version of eligibility criteria.
- Duty managers from control and planning coordinated cross boundary working, for example assessing which service had most capacity to collect a Lancashire patient from a Cheshire hospital. Usually it would be Lancashire's responsibility but the teams liaised to work out the best experience for the patient. They also engaged with services from other trusts, for example neighbouring ambulance services.
- Information provided by the service showed that approximately 40% of the patient transport business in all areas was undertaken by 'green uniform' operational staff. The other 60% was undertaken by a third party, including volunteer car service, taxis and private ambulances. The delivery managers were responsible for the operational aspects of all these staff.
- The PTS quality and performance manager was responsible for managing the administration team which recruited the third party staff, arranged payment and inducted them to the service. The control centre allocated their work and managed them on a day to day basis as for any other resource. The manager told us use of private or third party resources was for financial reasons as it made sense to use a lower cost resource where possible.

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- In one Lancashire location the EPS stretcher vehicle was part funded by a local hospital trust. Part of the time the vehicle was used by the hospital, then after 6pm, the vehicle was managed by the PTS control room for NWS patients. Most of the work it completed were discharges and transfers, whereas the other vehicles were predominantly covering outpatients. This allowed flexibility in the service and good partnership working with the trust to cover holiday periods.

Multidisciplinary working

- We observed multidisciplinary working so that patients were prepared for their journey and travelled with the correct level of escort. This meant that patients were escorted by trained nurses or care assistants, when appropriate.
- Control centre staff had direct access to information about patients and were observed liaising with nurses, care home staff and others in order to make sure the correct transport and crew was dispatched.
- Ambulance liaison assistants (ALAs) were operating in some of the hospitals we visited across the North West. The ALA role was seen as pivotal for the PTS ambulance crew and clinic staff and they were able to deal with transport issues in a flexible way. We saw that hospital staff rang the ALAs to coordinate same day discharges for patients and ambulance staff referred to them for additional pickups if their job list changed. ALAs also allocated work to volunteers, provided reassurance to patients and monitored delays in pickups.
- Usually the ALAs were employed by NWS, but in one Lancashire location, there were two ALAs employed by the local hospital trust. The ALAs we spoke with described a good relationship with the ambulance crews.
- PTS staff said they had a good relationship with PES staff. They shared ambulance bases so there was a good deal of relaying experiences and shared learning. There was some cross over between staff, with some PTS staff progressing to PES and some PES staff stepping down to PTS services.
- PES and PTS also shared resources. At the time of our inspection, some specialist stair climbing equipment was on loan to PTS from PES. Staff had been trained to use this equipment and it was kept with the PTS staff who delivered it back to PES when they needed it.
- PTS had a vehicle that had initially been used for winter pressures. It had been re-allocated to use at weekends

to support PES with transferring non-emergency patients to hospital. For example, if a rapid response vehicle (RRV) staffed by one paramedic had attended a patient who needed monitoring on route to hospital, the paramedic and the patient travelled on the PTS vehicle and the second member of the PTS crew would drive the RRV to the hospital ready for the paramedic to pick up. This meant that a frontline PES ambulance and crew did not have to be taken out of service to transfer a patient who did not need an emergency ambulance.

Access to information

- All vehicles were issued with hand held electronic devices that were booked out per shift to the relevant crew members who had their own pin numbers. These devices were referred to as mobile data terminals.
- The mobile data terminals were installed with a mobile application of the CADS. When staff logged on and entered their vehicle call sign, work allocated to that vehicle by the planners would download. Staff could contact control if they needed further details, for example if a risk had flagged up and they needed more information.
- Every vehicle had a folder on it containing key information, including telephone numbers for the control centre, local hospitals and PTS managers, safe working loads for stretchers, chairs and wheelchairs and a 'trouble-shooter' guide for the mobile data terminals. There was an action card for when PTS were the first to arrive on the scene of a major incident. The folder contained a copy of the patient charter, with information leaflets. Also included were instructions on how to deal with patient property, vehicle breakdown procedure, incident reporting guidance and infection prevention and control procedures, such as how to deal with a needle-stick injury.
- The trust communicated changes through regular bulletins and these were distributed to each ambulance station and put on display by the team leaders.
- Staff had restricted access to electronic policies and procedures because computers were shared by multiple members of staff who spent limited time at the ambulance station.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff said they received basic mental capacity act (MCA) training as part of mandatory training (mental health

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patient awareness training) but that the vast majority of patients without capacity would travel with an escort. Staff we spoke with had a general basic understanding, appropriate to their role.

- Staff had not received specific training on Deprivation of Liberty Safeguards (DoLS).
- A North West regional Mental Capacity Act joint protocol was in place. This document was developed by North West police constabularies and NWS to provide guidance for all ambulance staff in how to work in line with the MCA and DoLS. However, the protocol was due for review in 2013 and this had not taken place.
- Ambulance vehicles had information folders on board which included documentation to complete for mental capacity assessments. Staff said they would use these if they wanted to make a safeguarding referral for a vulnerable adult and did not have the patient's consent to do so.
- There was a unified do not attempt cardiopulmonary resuscitation (uDNACPR) North West policy issued in October 2014 which had been due for review by the regional group in April 2015, but was still in use.
- The presence of paper advanced plans of care and do not attempt cardiopulmonary resuscitation (DNACPR) orders were detailed in the electronic referral form. PTS crews were expected to check with nursing staff, the patient or escort that the correctly completed DNACPR forms were with the patient.
- We reviewed a moderate level incident concerning a photocopied DNACPR order sent with a patient. Only original documents could be actioned, however this was not clear in the policy. Staff were trying to manage this locally but there had been other similar incidents where original DNACPR documentation was not travelling with the patient. No actions had been put in place to address this, so it kept on happening. The service told us this issue was under discussion.
- All staff understood the need to include patients in decisions about their transportation.
- Staff told us they would request additional support if they had concerns about a patient's capacity to consent.
- All the staff we observed asked the patients permission in respect of using transport services.

Are patient transport services caring?

Good



We rated patient transport services (PTS) as 'Good' for Caring because;

- Patients were treated with dignity, compassion and empathy.
- We observed PTS staff responding to and anticipate people's changing needs and 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 and carers consistently told us the PTS ambulance staff explained information to them clearly during their journeys, and supported them fully. Patients felt safe and were treated with dignity and respect.
- NHS Friends and Family test results indicated 95% of patients would recommend the service to others.

Compassionate care

- During the inspection, we saw that patients were treated with dignity, compassion and empathy. Patients were transferred onto and off stretchers and chairs behind closed curtains, if appropriate; to make sure their dignity was maintained as far as possible.
- 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.
- Ambulance staff told us they respected patients' privacy. We observed patients being collected from their own homes and hospital settings. Patients were provided with blankets, if required. Staff explained when it was a cold day that the ambulance door may be open whilst picking up other patients.
- Patient experience questionnaires were on every vehicle for patients to complete if they wished. Between April 2015 and December 2015, 4,617 patient experience questionnaires were sent out to patients with 35% of these being returned. The highest number were in Lancashire at 43%, with 23% in Merseyside, 21% in Cumbria and 13% in Cheshire.

Patient transport services (PTS)

- The results of the patient questionnaires were reported as a trust overall figure and the highest score at 99% was that patients felt safe and reassured during their journey. The worst scoring question was that when they had booked the transport patients had been offered the option of a booking reminder, which scored 27%.
- As a result of this the trust was exploring two specific PTS Patient Experience schemes. One was to examine perceived patient benefits and related information and technology systems with text messaging alerts; and a wider provision of this service. The second was to analyse patient perspectives and expectations with lengthy outpatient waiting times. Related reports and action plans are on track with milestone targets.
- Patients gave positive feedback about the care they received. Patients and carers consistently told us the ambulance staff explained information to them clearly during their journeys, and supported them fully. Patients felt safe and were treated with respect. Staff ensured patients had with them all that was required for the appointment as well as keys to get back into their home on return.
- NHS Friends and Family test (FFT) information was provided by the trust for the period 1 April 2015 to 30 April 2016. The results showed that in Merseyside 95% of 552 respondents would recommend the service; 80% were taken through the assessment process and asked about medical conditions and mobility for hospital transport; 85% said they said they were informed of approximate waiting times; 93% of respondents said they were treated with dignity and respect.
- In Cumbria, 95% of 484 respondents would recommend the service; 79% were taken through assessment process and asked about medical conditions and mobility for hospital transport; 82% said they said they were informed of approximate waiting times; 96% of respondents said they were treated with dignity and respect.
- In Cheshire, 95% of 291 respondents would recommend the service; 73 % were not aware of a patient information leaflet or patient charter; 77% were taken through the assessment process and asked about medical conditions and mobility for hospital transport. 81% said they said they were informed of approximate waiting times; 94% of respondents said they were treated with dignity and respect.
- In Lancashire, 96% of 992 respondents would recommend the service; 65% were not aware of a

patient information leaflet or patient charter; 81% were taken through the assessment process and asked about medical conditions and mobility for hospital transport; 84% said they said they were informed of approximate waiting times; 95% of respondents said they were treated with dignity and respect.

- Staff had access to information about vulnerable patients through mobile data terminals or through the PTS control centre.
- Staff told us they tried to accommodate patients' preferences. One patient told us that they had built up a rapport with a regular staff member. However, managers told us it was not always possible to maintain continuity of staff for regular patients.
- The service had a culture of zero tolerance for abuse and patients were encouraged to respect each other.

Understanding and involvement of patients and those close to them

- Control staff explained to callers the eligibility criteria and service provision. Staff were able to redirect callers to alternative transport if they did not meet the eligibility criteria.
- We observed conversations between patients and PTS staff during journeys and staff took time to explain who they were and make sure patients understood where they were going. Crews ensured patients had what they needed, for example house keys and appointment letters, before leaving the house.
- We observed staff spending time to make sure that a patient was taken to the correct clinic for their appointment. Staff were able to reassure the patient and went out of their way to make sure another patient did not miss their own appointment.
- Staff we spoke with told us they had not encountered communication difficulties and would be informed in advance if a patient's first language was not English. The service had developed pictorial handbooks for PTS staff to use to support communication with patients.
- All patients we observed were accompanied to their destination after leaving the vehicle and assisted with booking-in at reception.
- 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.

Emotional support

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- We consistently observed good rapport between staff and patients whilst accessing the service.
- We saw staff being sensitive to one patient who was being transferred from hospital site to another and was not able to communicate. The staff were reassuring and supportive showing empathy towards the patient.
- Information provided by the service showed that systems and processes were in place for staff to follow if a patient died in their care.
- Staff were able to describe how they had supported a patient who they took home and would be alone before carers were able to arrive to support them. The staff described how they had made a drink and a snack for the patient and made sure they were warm and comfortable.

Supporting people to manage their own health

- Staff told us they tried to facilitate patients to be independent and asked if they required assistance with sitting or standing. Patients were encouraged wherever possible to use their own mobility aids when entering or leaving the vehicle.
- PTS eligibility assessment included signposting or referring callers who did not meet the ambulance service criteria to charities that may provide the transport required.

Are patient transport services responsive to people's needs?

(for example, to feedback?)

Good



We rated patient transport services (PTS) as 'Good' for Responsive because;

- The booking process for patients was easy to use.
- There was flexibility in the provision of the services in all geographical areas with the use of other transport services including private ambulances, taxis and volunteers.
- Planning of the journeys was scheduled in advance with the facility to make changes if required.
- For specific patients, such as those having haemodialysis, the hours of service availability were extended to provide a responsive service.

- Patient assessments considered their need for an escort and a family member could do this if the patient preferred.
- Translation services were available if they were required and the need for this would be identified prior to the service being provided.
- Staff were flexible in changing their planned work to ensure patients were not kept waiting when this was possible.
- Ambulance crews had access to specialist equipment and services so that individual needs, such as accessing the ambulance or communicating with staff, could be met.
- Patient information about how to make a complaint was available and easy to use.

However;

- Complaints were not acknowledged or resolved within the timescale the trust had set as the target.
- Complaints about patient transport were high within the service with most being about the timeliness of transport following an appointment or waiting for hospital discharge.

Service planning and delivery to meet the needs of local people

- PTS transport could be booked by patients, relatives, and health care professionals. PTS control centre staff used standardised assessment tools to ensure patients were provided with transport, as appropriate. Staff responsible for arranging transport had received training in how to complete the assessments.
- The service was meeting the demands of the patients by providing a service to all patients who were eligible in keeping with the commissioning contracts. Between 1 April 2015 and 23 March 2016, 66% of PTS activity was core work, 29% was EPS and 4% was non-standard, for example bespoke jobs.
- Private ambulances, taxis and volunteers were used to deal with an increase in demand, as necessary.
- Many of the ambulance journeys were scheduled in advance by planners who sent out job lists to the vehicle mobile data terminals ready for the crews to receive each morning. There was also the facility to send these via email to be printed out, if for any reason there was a problem with the mobile devices.

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- Transport to appointments for haemodialysis patients was available from 6am to 7pm seven days a week. This was often provided by private taxi firms during the weekends and on bank holidays.
- Transport was available for patients receiving treatment for cancer between Monday and Friday, including bank holidays.
- In Lancashire, telephone bookings could be made between 7.30am and 6.30pm on weekdays. There was also a twilight shift between 6pm and 1am, six days per week including bank holidays. The only night this was not available was Sunday. There were separate telephone lines for core and enhanced priority service (EPS) calls and if there were calls waiting, EPS patients jumped the queue.
- In Cumbria and Merseyside, PTS was available between 8am and 9pm Monday to Friday and 11am to 8pm on Saturday for dialysis patients only. Volunteer drivers were available from 6am for dialysis patients if that was the most suitable mode of transport. In Merseyside PTS was available from 6am for dialysis patients.
- Due to the very rural locations and resulting longer journeys in Cumbria there was a high reliance on volunteer car drivers to transport patients. Between 1 January 2016 and 23 March 2016, an average of 53% of journeys were by the volunteer car service compared to 11% for the whole of NWS.
- Ambulance liaison assistants (ALAs) working in the ambulance liaison offices allocated and de-allocated some of the work to ambulance crews.
- Staff we spoke with told us they had not encountered language difficulties and would be informed in advance if a patient's first language was not English.
- For patients who needed an interpreter, the service had access to language line via the control centre. There were pictorial guidebooks on every vehicle with basic pictures and sentences for those with other communication difficulties such as hearing loss. These included pictures and written sentences to introduce the ambulance crew, ask whether the patient was ok, explanations of activity, for example "we are going to use a wheelchair".
- We observed staff talking to a patient in Punjabi. Staff could also speak in Urdu and Makaton (signs and symbols).
- Staff were aware of particularly vulnerable patients and understood the need to communicate in a way that was supportive. Staff told us they had received awareness training for patients living with dementia.
- Wherever possible, vulnerable patients, such as those living with dementia or a disability could have a relative or carer with them if booked in advance.
- In Cumbria there was one ambulance which could be adapted to accommodate bariatric patients. (The World Health Organization describes people who have a body mass index (BMI) greater than 30 as obese, and those having a BMI greater than 40 as severely obese WHO, 2000). However, if this was required the stretcher had to be fitted at the workshop. The service mitigated this problem by using private ambulances when bariatric equipment was needed.

Meeting people's individual needs

- The eligibility process determined whether or not a patient could or should travel with an escort and they could choose who that was. For example, the patient's relative or carer was able to travel with them and, if this was not identified at booking, the ambulance crew worked flexibly to try and facilitate this at short notice.
- Ambulances had different points of entry, including sliding doors, steps and tailgates so that people who were ambulant or in wheelchairs could enter safely.
- The booking process meant people's individual needs were identified. For example, the booking process took into account the level of support required, the person's family circumstances and communication needs.
- We observed that nurse escorts or staff from care homes were able to provide specialist support, if required.

Access and flow

- People who booked their own transport told us the process was easy to use and they could make changes as required.
- Bookings were managed by telephone between the control centre, the ambulance liaison officer, the crew and patient or their representative. We observed that communication was quick and promoted a responsive service.
- All calls were recorded and control staff had set questions to ask which were used to identify the patient's eligibility for a service and what was required. Conversations were also recorded and reviewed in relation to staff responding to changes in requests and updated information from the crew or ALAs.

Patient transport services (PTS)

- New patients were contacted prior to the journey and crews asked patients who had used the service before whether the usual service was required.
- We saw that crews changed and swapped patients to ensure waiting and journey times were kept to a minimum. There were dynamic changes to the schedule throughout the day as and when work became available. Planned journeys did not always run to time, for example if paperwork or medication from the treatment centre was not ready.
- The service had recently launched the 'GoPTS' marketing campaign. The intention was to improve health care professionals' understanding of how to book the correct PTS transport.
- NWAS had produced and distributed a pictorial mobility guide to all hospitals and booking ward clerks in the region to help staff identify the correct form of transport to book for their patients
- Journeys for the following day could be booked up to 3pm the previous day using the computer aided despatch system (CADS).
- If there was an error with a patient booking, for example the ACAs were unable to find a patient's appointment; control staff would listen to a recording of the original call to clarify the details. It took between 20 and 30 minutes to load a call onto the system in order to listen to it again.
- In Cumbria, the PTS drivers and control staff told us there was a disproportionate amount of time when they were waiting for work. This was not captured in any performance data collected but we saw crew who had waited over two hours for their first journey. This had been fed back to the bureau managers.

Learning from complaints and concerns

- Between April 2015 and December 2015, there had been 576 complaints made about the patient transport service. Of these, the majority (495) were minor with 188 in Lancashire, 127 in Cheshire 89 in Cumbria and 87 in Mersey and just four in Greater Manchester.
- Patient transport service complaints were mostly low risk concerns where late transport had caused distress. This tended to be about delayed discharge following appointments. The patient experience team was represented on the PTS mobilisation group to ensure the patient experience was part of contract discussions.
- Information about the NWAS service which included how to give feedback was provided to all patients. Each

ambulance carried a stock of pocket sized leaflets with information about the service, including how to give compliments or raise concerns. These were given to patients on an ad-hoc basis or if they wanted to complain. It was noted that the print on these leaflets was small and difficult to read.

- The availability of patient experience forms, which were for patients to provide feedback to the service, was not consistent across the regions. We saw these were readily available in some vehicles whilst in others the staff would give them to patients who required one.
- Patients told us they felt able to raise concerns immediately, for example they said they had been told to ring the central number if they experienced a long wait for transport.
- Reports and meeting notes indicated complaints were raised to the executive management team, and senior management teams for PTS through monthly complaint reports.
- A service delivery manager told us complaints were dealt with quickly; however, quality reports showed they were not meeting their targets. The target percentage for acknowledgement within one working day of the complaint was 95% and none of the regions had met this target each month for the twelve months between May 2015 and April 2016. The best performing region was Cheshire where the target had been met eight times with the worst Cumbria where it was met five times.
- In Cumbria the target for 80% of complaints to be resolved within 40 working days of original complaint was met for nine of the eleven months between May 2015 and March 2016. This was the best performing region with Lancashire meeting the target in six of those months, Mersey in four and Cheshire not meeting the target any month.
- In PTS, complaints were investigated by the patient experience team and the system was robust with timely investigation and feedback to the patient. We saw, as a result of one complaint in Cumbria, appropriate action had been taken including additional training for staff involved.
- The service did not benchmark their response time to complaints against other providers.
- The data for the number of complaints and any themes was displayed on staff notice boards in the ambulance stations.

Patient transport services (PTS)

- Managers would discuss themes or changes to practice as the result of complaints at meetings or on a one to one basis if appropriate.

Are patient transport services well-led?

Requires improvement



We rated patient transport services (PTS) as 'Requires Improvement' for Well-led. This is because;

- At our last inspection we found an apparent disconnect between managers and senior staff across patient transport services (PTS). At this inspection we noted the pace of improvement had been slow and found there was still some disconnect between managers and staff. Senior managers acknowledged the challenges of working across such a large geographical area and the continued need to develop a greater cohesive approach to management practices and increase the visibility of senior managers.
- At this inspection we found there was still no vision or formal strategy for the patient transport service although we were provided with the service contract and operating model. We did not see any evidence of a project plan or timelines for the delivery and implementation of a PTS strategy.
- We found local systems were in place to review the quality, governance and risk management of the service. However we reviewed minutes of meetings where risk and quality was discussed and found there was a lack of senior PTS management attendance at these meetings. We were not assured that the PTS service had robust operation of its systems in place to provide assurance for governance and risk management of the service.
- Local culture was good in most areas and we found that the morale had improved in the control room in Chester immediately after the last inspection.
- Services were about to be decommissioned and transferred to another provider. The majority of staff spoken to at the control centre in Chester and in PTS in Cheshire were going through a period of uncertainty at the time of the inspection due to the transfer of services. Senior staff had consulted with staff at the earliest opportunity and continued to provide information as it was available throughout the de-mobilisation phase

ensuring staff were updated regularly. However managers told us NWAS was still awaiting information on the future delivery of the service from the new provider. Staff felt that they needed more support and would welcome more reassurance.

- We observed that volunteers did not have a specific dress code which meant they could wear clothing which made them indistinguishable from regularly employed NWAS staff. This meant patients did not always know the role, responsibilities and authority of the person escorting them.

However;

- We found examples of good local leadership where staff felt very supported.
- Public engagement mechanisms were in place in the form of patient experience feedback forms and social media.

Vision and strategy for this service

- At our last inspection the trust had a quality strategy for 2011 to 2015. This had been replaced with a quality improvement strategy 2015-20. This described the trust approach to quality across all service lines. This strategy included quality improvement aims for each trust service. Key objectives: for example, to ensure that the patient transport services (PTS) was able to deliver the right care at the right time were in place. These objectives had been applied across the service and measurable performance targets were set for each one, for example, patient arrival and collection times as part of the 'right time' objective. We found the PTS had an operating model and the direction of travel was to increase its business capacity. However, we asked and were not provided with a formal PTS strategy linked to the overarching trust vision and strategy.
- NWAS was decommissioning Cheshire PTS at the time of the inspection as this service was being transferred to another organisation on 1 July 2016. The Cheshire PTS was moving across as a complete service which included all PTS ambulance staff, direct managers and vehicles. At the time of our inspection staff stated they would welcome more consultation or information about the process.
- In Cumbria, there were concerns from the control centre managers about the increased use of private ambulances by the hospitals and the effect this had on the future of their service.

Patient transport services (PTS)

- The contract for NWS PTS in Cumbria had recently been awarded. The trust had conducted a costing exercise to determine what was required to deliver the new contract in Cumbria; however, this was not complete at the time of our inspection.
- Staff we spoke with in Cumbria were not aware of the vision or strategy for the service. The majority of staff in Merseyside were very aware of the contract changes and financial pressures on the service which may impact on the future of the service.

Governance, risk management and quality measurement

- Risks were managed at a local level but there was no strategic overview or central PTS risk register that included operational issues. The risk register we reviewed had seven risks documented, of which the two which focused on quality were related to a third party provider performance, as well as the core PTS service.
- Medium level risks were managed within the project plan for that piece of work, for example risks to the mobile data terminals were overseen within that project.
- Information provided by the trust showed that risks were discussed at three different meetings, the risk moderation management group, the performance committee and the quality committee. We could not discern the objectives of the different meetings. Senior managers we talked with could not describe the purpose of the different meetings.
- The local delivery managers led on all operational matters and any issues were escalated up through tiered management meetings. Different level supervisors and managers met either weekly or fortnightly. The delivery managers and the PTS general manager met fortnightly and were able to escalate concerns as appropriate.
- A senior team meeting was held in March 2016 attended by the general manager, head of service, assistant director for commissioning and the lead for quality and performance. There was an intention for this to become a monthly meeting in the future, once the new structure was in place; however, no progress had been made at the time of our inspection.
- The PTS service had been transferred to the finance division as part of the reporting structure arrangements.

We asked and did not see evidence of any meetings where the senior PTS operational staff met with the senior staff in the same division to share information and develop joint working.

- Team leaders told us trends or patterns to incidents were not identified and fed-back by the trust to PTS staff.
- A senior manager told us they received no safeguarding reports back from the control centre in Carlisle regarding PTS referrals and any learning or action plans from them.
- A manager told us the electronic computer aided despatch system (CADS) was two versions out of date but could not identify a named person responsible for managing the issue.
- The head of service told us that governance arrangements were under review to ensure that risks were identified and managed appropriately.
- We found that some processes were not being followed in line with trust policy. For example we found the process for maintaining all vehicles in good visual repair and replacing rusty items in a timely manner was not being managed effectively.
- The Savile recommendation suggested NHS trusts should have arrangements to ensure that volunteers are properly managed and operated within defined and acceptable parameters. We observed that volunteers did not have a specific dress code which meant they could wear clothing which made them indistinguishable from regularly employed NWS staff. This meant patients did not always know the role, responsibilities and authority of the person escorting them.

Leadership of service

- The head of service was in an interim role and the two new manager posts for quality, systems and processes and contract delivery (control, planning and booking) were being advertised. Senior managers told us until these posts were recruited to it was not possible to formalise any senior management meetings.
- The team leaders had weekly meetings with their senior team leader and there was a fortnightly meeting for all the team leaders, usually held at Broughton.
- The band 6 senior team leaders usually visited their regional stations on at least one day per week. They attended during the week if necessary, for example if someone was returning to work from sick leave and to offer support for staff.

Patient transport services (PTS)

- The delivery managers also visited the station regularly, particularly to sort out issues such as sickness reviews with staff. Ambulance care assistants (ACA) told us they were visible and staff knew who they were. However, staff in remote stations, such as North West Cumbria, told us they did not see any of the senior management team in these stations and some did not know the names of the senior managers for the service.
- There were monthly meetings at local sector level; however, staff told us they were not involved in any senior management meetings and did not receive feedback from these meetings.
- The delivery manager attended the staff forum which was held at least annually in each area. These were scheduled in the evening to allow staff to attend to have an opportunity to meet senior managers and raise any issues or concerns. The most recent one in Lancashire had taken place just after the service had been awarded the new service contract and did not finish until 9pm which allowed the crews finishing at 7pm to attend.
- Staff appreciated the face to face contact when there was an important development in the service, such as the new service contract. On the morning that this was confirmed, the senior team leader ensured that there was a team leader available in each station.

Culture within the service

- Staff were positive about their roles and said they were encouraged to develop professionally. There were annual 'going the extra mile (GEM) awards' where colleagues were nominated in various different categories, such as frontline member of staff of the year. Staff spoke positively about these.
- The Lancashire booking team told us they routinely achieved their key performance targets and had been awarded 'team of the year' in the 2014/15 GEM awards. They described good team spirit and took part in events to raise money for charity, such as 'dress down Friday'.
- The majority of frontline staff and managers in Cumbria stated they did not feel a part of the wider NWS due to the remote location and lack of involvement of higher management in their service.
- In Cumbria there were examples of disengagement with the service due to a lack of acknowledgement and action when issues or concerns were raised.
- The trust considered the health and well-being of their staff. For example, all staff were offered an influenza vaccination.

Public and staff engagement

- The trust had adopted the NHS culture of caring strategy values which included working together for patients, respect and dignity, commitment to quality of care, compassion, improving lives and everyone counts. This was in the early stages of development.
- The trust used a variety of mechanisms to engage with the public including surveys, social and other media, and community focus groups and events. We found the patient experience form was not readily available in all vehicles and the return rate was under 50% of those sent out. Therefore whilst this process did elicit patient's views it was limited in its scope.
- There was some staff engagement at a local level within Cumbria; however this was reliant on individual staff in that geographical area to support and provide this due to the distances between stations.
- Staff were informed of anything pertaining to their role through briefings or circulars.
- All staff had access to a staff suggestion scheme on the intranet and could communicate with the Chief Executive directly through the intranet or email. Some staff followed comments from the Chief Executive on social media.
- The 2015 NHS staff survey results showed overall results were better than the national ambulance service average in response to 17 questions, average for nine questions and fared worse in responses to six questions. The national average response rate was 35% with a trust wide response rate of 24%. The response rate for PTS was 17%. Examples of where the trust as a whole compared better than other ambulance trusts were: Percentage of staff satisfied with the opportunities for flexible working patterns (NWS 38% Average 34%); staff recommendation of the organisation as a place to work or receive treatment (NWS 3.5 Average 3.26); staff confidence and security in reporting unsafe clinical practice (NWS 3.48 Average 3.38); staff satisfaction with resourcing and support (NWS 3.17 Average 3.02); quality of non-mandatory training, learning or development (NWS 3.87, Average 3.83)
- The findings where the trust compared worse than or the same as other ambulance services were: percentage of staff reporting errors, near misses or incidents witnessed in the last month (NWS 73% Average 79%); support from immediate managers (NWS 3.33 Average 3.39); percentage of staff suffering

Patient transport services (PTS)

work related stress in the last 12 months (NWS 49% Average 49%); percentage of staff appraised in the last 12 months (NWS 57% Average 74%); percentage of staff experiencing discrimination at work in the last 12 months (NWS 19%, Average 19%).

- The main areas identified for improvement had been recognised within the trust and reflected within existing action plans. The trust had committed signing up to the MIND “Blue Light Pledge” and the launch of the health and wellbeing intranet site to ensure that available sources of support were more easily accessible for staff. The trust also had an agreement of a schedule of health promotion activities with Occupational Health and review of feedback mechanisms for complaints from staff.

Innovation, improvement and sustainability

- At this inspection we found the pace of improvement had been slow and issues identified at our last

inspection such as an improvement in incident management and a PTS wide approach to operational governance and management had not been sufficiently developed.

- The trust had introduced new technologies and we saw examples of staff 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. The trust had been able to retain the contract for patient transport services in April 2016 for Cumbria, Lancashire and Mersey. However, there was no change in the contract which would encourage improvement or innovation. The key aim was to reduce costs through better planning and usage, such as the more effective use of resources and application of the eligibility criteria.
- There was concern amongst staff about the sustainability of the service with the increased amount of work for the private ambulance service and the heavy reliance on the volunteer car service.

Emergency operations centre

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

Information about the service

The North West Ambulance Service NHS Trust provides year-round 24 hour accident and emergency services to those in need of emergency medical treatment and transport. The trust's emergency medical dispatchers (call handlers) based in Emergency Operations Centres (EOC) in Manchester, Liverpool and Preston received and triaged emergency calls from members of the public and other emergency services. Staff in the centres allocated and dispatched first responder staff, rapid response vehicles and emergency ambulances to patients who needed emergency and urgent care or transport to hospital.

The EOC provided advice to callers and dispatched ambulances when appropriate. Advice was provided to callers who did not need an ambulance response through the urgent care desk; a service known as 'hear and treat'.

Staff gave callers advice on self-care, how to make an appointment with a general practitioner (GP) or direct callers to other services. The EOC managed requests by health care professionals to convey people between hospitals or from the community into hospital. Between April 2015 and the end of March 2016 the EOC received more than 1.1 million 999 calls and dispatched ambulances to over one million of these.

Shared systems and processes enabled the three sites to work together as one virtual centre. This means that emergency calls were routed to the next available operator across the three centres. Liverpool dispatched vehicles to the Merseyside and Cheshire area; Preston dispatched

vehicles to the Cumbria and Lancashire area; and Manchester dispatched vehicles to the Greater Manchester area. Clinicians based in the three centres provided the 'hear and treat' service for the whole region.

The Preston site included the major trauma team. This team identified, dispatched, and provided support to ambulance crews across the whole of the northwest region attending incidents where patients may have sustained trauma injuries. The Helicopter Emergency Medical Service (HEMS) team, also in Preston, dispatched and co-ordinated the air ambulance support across the region. The HEMS team worked closely with the trauma cell and the other emergency services, including mountain rescue and police. The had access to three permanent helicopters operated by North West Air Ambulance (NWAA); one based in Blackpool, Lancashire and two based in Barton, Greater Manchester. Additionally the trust had access when required to a further two helicopters operated by Great North Air Ambulance covering North Cumbria and the North East. A clinical support desk, staffed by an advanced paramedic, was colocated with the trauma cell and the HEMS team. The clinical support team was able to provide additional help and advice to ambulance crews travelling to, or on-site, at incidents.

Our inspection took place between 23 and 26 May 2016 with an unannounced visit on 6 June 2016. We spoke with 128 staff across all three sites and listened to 63 calls. We reviewed a range of documentation, including 16 incident investigation reports, six serious incident reports, six full complaint files and a range of non-serious incidents and ongoing complaint investigations.

Emergency operations centre

Summary of findings

We rated Emergency Operations Centres (EOC) as 'Good' overall. This was because:

- There was thorough investigation of serious incidents and comprehensive learning from these with duty of candour being applied, where appropriate.
- Mandatory training levels were above the trust target.
- Staffing levels were adequate with few vacancies and a good skills mix.
- Good clinical escalation plans and major incident plans were in place. Senior staff were aware of, and familiar with the plans.
- There were good escalation and risk assessment tools in place to ensure that patients received the right level of response and clinical support was available, where required.
- Median call answering rates and call abandonment rate were better than the England average.
- There was good coordination and liaison with hospitals within the region.
- There was an effective system of communication between staff in the EOC and vehicle crews.
- Communication with callers was effective and reassuring. Staff were compassionate and reassuring and treated callers with dignity and respect.
- Frequent callers, who often had mental health issues or alcohol addiction, were supported to manage their own health and reduce the number of calls they made to the service.
- Services were planned to meet the needs of the local population and differing levels of demand across the region were managed because the service was run as a virtual operations centre.
- There was a clear governance structure and communication between EOC managers in the different regions and local leaders were visible and supportive.

- We saw good examples of engagement with the public to reduce the number of unnecessary emergency calls, including management of frequent calls and public education through the 'Make the right call' and '#Team999' campaigns.

However,

- Not all staff were clear on what should be recorded as an incident. Not all staff we asked told us they were trained on how to use the incident reporting system. Although staff we asked were unaware of shared learning between the three sites, the trust told us there was a formal process for sharing incidents between the sites and across the trust as a whole.
- The safeguarding policy was not embedded and not all staff were reporting safeguarding concerns in line with the policy.
- One of the sites was housed in a building that was cramped, dated and not suitable for any staff with reduced mobility. The environment was having an effect on staff morale.
- Staff had limited or no knowledge of the Mental Capacity Act and making a judgement on whether a patient lacked mental capacity. Initial training on the call triage system included scenarios on dealing with calls from people living with dementia or learning disabilities; however, there were no separate training modules for staff on these subjects.
- The sites had no plan in place as to how they would contribute to the trust's vision and strategy.
- The documents in which risk was recorded did not give a complete picture of the risks to each of the centres or to the service as a whole.
- Staff expressed concerns by the way that changes to procedures or announcements were communicated to them.
- The clinical escalation plan in use at the time of the inspection was dated July 2012. The escalation plan had been reviewed within the 12 months before the inspection, but was only in draft format when we inspected.

Emergency operations centre

- While there were processes to support deployment of the Hazardous Area Response Team (HART) we found inconsistencies between the procedure and system used.

Is emergency operations centre safe?

Requires improvement



We rated Safe as 'Requires improvement' because:

- Staff we spoke with were not clear on what should be recorded as an incident, so we could not be assured that every incident was reported. Some staff told us they had not been trained on how to use the incident reporting system so were unable to report incidents themselves.
- Although the trust told us there was a formal process for sharing learning from incidents between the three sites and across the trust as a whole, staff we spoke with were unaware of learning being shared between the three sites.
- We found there was an inconsistent approach taken by staff when dealing with safeguarding concerns. Not all staff were acting according to the safeguarding policy by reporting safeguarding concerns directly to the support centre in Carlisle.
- Due to a fault in the call handling software, tools for assisting call handlers, such as a tool for giving cardio-pulmonary resuscitation advice, were not available for every emergency call.
- Some calls made to NHS111 and referred to the EOC, because the NHS111 clinician who triaged it felt were not suitable for the NHS111 service, were re-triaged by urgent care desk staff. While only low priority calls were re-triaged there was a risk that an ambulance response, if needed, could be inappropriately delayed.
- The Liverpool building was cramped, dated and had limited accessibility for persons with reduced mobility as there was no lift.
- The clinical escalation plan in use at the time of the inspection was dated July 2012. The escalation plan had been reviewed within the 12 months before the inspection, but was only in draft format when we inspected.

However:

Emergency operations centre

- Serious incidents and incidents relating to the request and dispatch of vehicles were investigated thoroughly; there was clear evidence of learning from incidents and duty of candour was applied where appropriate.
- Mandatory training levels were above trust target levels, and protected learning time for staff was being piloted in Preston with a view to rolling this out across the three sites.
- Medicines and records were stored safely.
- The call handling system had inbuilt escalation and risk assessment tools to ensure that patients received the correct level of response.
- Staffing levels were adequate with few vacancies and a good staffing skill mix.
- The EOC had major incident plans and procedures. They had recently reviewed their major incident plans and conducted a walkthrough exercise in the event of a terrorist attack.

Incidents

- The service used an electronic system to report and record incidents. Between September 2015 and February 2016, 185 incidents were reported by the trust which involved the EOC.
- Incidents with a risk score of between three and five and which resulted in severe harm or death were classed as serious incidents. Data supplied by the trust showed that, from April 2015 to March 2016, there were nine serious incidents recorded across the three sites. However, none of the serious incidents were classified as never events (a never event is a serious, wholly preventable patient safety incident that has the potential to cause serious patient harm or death, has occurred in the past and is easily recognisable and clearly defined).
- We reviewed three serious incident investigation reports. All three had undergone a full investigation although only one had met the criteria to be reportable on the Strategic Executive Information System (StEIS). Two of these involved the death of a patient. The investigations were robust and had applied the National Patient Safety root cause analysis tools.
- We looked at the learning, reflection and follow-up actions of these serious incidents. We found this was very thorough and involved further training and auditing of calls, job shadowing on other teams including on vehicles and a walkthrough of the incident and reflection on it.
- The EOC had processes and systems for reporting and investigating incidents. Staff involved in or who witnessed an incident were encouraged to report it as soon as possible. Incidents could also be reported by a colleague or line manager on staff members' behalf. Incident reports were assigned to a senior member of EOC staff to review and investigate.
- Not all staff we spoke with told us they had received training on the electronic incident reporting system as part of the induction or mandatory training. Not all call handling staff had direct access to the reporting system; however, the trust told us staff could report incidents via their manager.
- There was no consensus across staff in all sites about what should be recorded as an incident. For example, staff across all sites told us they would not record an incident report for abusive callers. There were staff at all sites who told us they had never reported an incident. This meant there was a risk that not all incidents were reported.
- Incidents reported by either EOC or ambulance staff, about the dispatch of ambulances, were assigned to the sector manager or deputy sector manager to investigate. Any learning outcomes or actions identified for improvement, which were specific to an individual, were shared with them by their line manager. Systemic issues or learning was shared with managers and supervisors by a memorandum or training bulletin.
- The outcome of serious incidents was discussed at monthly management meetings. The clinical lead shared learning with staff from incidents on the urgent care desk.
- During our inspection we reviewed 18 incident reports where there was no, or low, harm. We saw evidence that investigations had been carried out and that learning had taken place. Warning notes had been added to the Computer Aided Dispatch (CAD) system, where this was deemed necessary. One of the incident investigations we reviewed, however, (relating to a frequent caller) had been closed with no reason given and no investigator assigned.

Emergency operations centre

- One type of incident related to ambulances being dispatched to nursing homes where a patient had experienced a fall and the nursing home had a policy of no lifting. The service found this was an incorrect use of ambulance crew resources. We were given an example of a particular nursing home company that made regular calls for paramedic assistance to support lifting patients following a fall. The trust engaged with the company and gave lifting and handling training to the staff, as a result of which the calls abated.
- Incidents that related to breaches in key targets relating to requesting and dispatching a vehicle were recorded and highlighted on the CAD system. The control manager investigated these breaches, looking at a timeline of the call and dispatch process to see how and why any delays had occurred, whether or not there had been any errors and if there were any training or learning issues. We were shown an example of a breach and it was evident that the delays had occurred because there had been an issue in getting the address or location of the patient.
- Although the trust told us there was a formal process for sharing learning from incidents between the three sites and across the trust as a whole; staff we spoke with were unaware of learning being shared between the three sites.
- Joint reviews of incidents took place with partner organisations such as other trusts, the police, the fire service, and the coastguard. We saw one example of a joint review with two other trusts following the death of a patient and another joint review with a prison following the death of an inmate.
- The duty of candour is a regulatory duty relating to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.'
- Managers and clinicians understood the duty of candour, and we saw evidence that senior staff met with patients and their families as part of the investigation of serious incidents. This was in line with the duty of candour regulations. Although the duty of candour was included in local training, call handling and dispatch

staff had a varying level of knowledge of its definition, including the trust's duties and responsibilities. However, all of those we spoke with understood the need to be open and transparent.

Mandatory training

- All EOC staff completed a programme of mandatory training, which ran from July to June each year. Mandatory training was also included in induction training for new members of staff.
- In 2015/16 staff completed electronic learning modules in: information governance; health and safety; fire safety; manual handling; risk management; conflict resolution; infection prevention and control; equality and diversity and Human Rights; fraud awareness; raising concerns at work; and protecting the public (safeguarding).
- The sites were planning to include role specific modules in mandatory training for 2016/17 including: dealing with first party suicidal callers; dealing with mental health callers and patient experience.
- Staff at each site were given time to complete mandatory training. The scheduling of mandatory training varied between the sites. Communication took place between the sector managers when staff had planned training so there was no shortage of call handlers or dispatchers across the three sectors. There was an anticipation that protected learning time for staff of two hours per month would be rolled out across the three sectors when the pilot at Preston was complete.
- At the time of the inspection, all eligible staff in Preston had completed their mandatory training for the current year. In Manchester 97%, and in Liverpool 98% of eligible staff had completed their mandatory training, which exceeded the 95% trust target.

Safeguarding

- All front-line staff had completed level one child and adult safeguarding training as part of their induction. Safeguarding training was part of the mandatory training for all staff to complete each year. New staff received face-to-face training and existing staff undertook annual e-learning.

Emergency operations centre

- The regional training manager told us the training was being reviewed for 2016/17. This would mean that parts of the training would be specific to different roles; for example staff on the telephone and staff dealing with face-to-face safeguarding concerns.
- The trust had a policy for safeguarding vulnerable persons, which covered both children and adults. The policy set out staff responsibilities if they identified a safeguarding concern, which included recording any relevant information and alerting the attending crew of the concern. Crews reported any concerns to the Carlisle support centre, who also had access to the live, call handling and dispatch system. The policy identified that EOC staff should discuss concerns with their manager and, if they had the required information and if they needed to make a referral, they should contact the support centre. The policy also stated that, if no ambulance was required, the call handler should decide if a referral was needed after speaking to their manager.
- Staff we spoke with in all three sites were aware of how to identify concerning situations, for example terminated calls or background noise. One member of staff told us that if they heard anything concerning they would add a warning note, pass any concerns to the ambulance crew, speak to their supervisor, and consider contacting the police. Staff had made very few safeguarding referrals and some had made none.
- We were given differing accounts by staff across all three sites about how they would refer any safeguarding concerns. Some staff believed that safeguarding concerns should be reported directly to the ambulance crew rather than to the safeguarding team in Carlisle. It was therefore evident the policy for referrals was not well embedded and that, on occasion, staff were being given advice that was contrary to the policy by the safeguarding team at the support centre. This meant there was no assurance that all safeguarding concerns were appropriately reported.
- Apart from ambulance crews' ability to subsequently report concerns to the support centre, there was no routine system in place to check if the crews had considered or acted on any safeguarding information passed to them from the EOC. However, the advanced paramedic on the clinical support desk told us that if a crew contacted the desk for advice on safeguarding,

they would aim to identify a senior clinician within the area who could attend to support the crew, if necessary. There was no formal monitoring or auditing of this in place.

- The EOC had a procedure in place for terminated calls. Although we did not observe any calls where it was necessary to implement the policy, the call handler would attempt to ring the caller back three times. If unable to speak to the caller on the third occasion, a message was left (if there was voicemail) to ask the caller to ring back. Staff could also arrange for a trace of the caller's address from the telephone number, and despatch a vehicle to 'drive-by'. This meant staff were able to take action if the call had been terminated.

Cleanliness, infection control and hygiene

- All three sites were visibly clean and workstations were clean and tidy at the time of the inspection. Antiseptic hand gel was available throughout the Liverpool and Preston sites and we saw antiseptic wipes for desks, keyboards and monitors in all three sites. Wipe-down cleaning was also carried out in the training/major incident room after use.
- The triaging system, Medical Priority Dispatch System (MPDS) used by emergency call handlers and urgent care desk staff did not have specific prompts to ask about infection control issues. However, staff told us they recorded any relevant information offered by the caller about infection control issues in the notes, which the dispatcher would pass on to the ambulance crew.
- However, if a call was to request a patient hospital transfer, the triage system did prompt staff to ask if there were any infection control issues. During our inspection we witnessed a call handler asking this question when a hospital transfer was being arranged.

Environment and equipment

- There was a variation in the quality of the working environment between the three sites.
- In the Liverpool site the call-handling and dispatch rooms were located on two floors connected by a staircase. The urgent care desk and advanced paramedics, who provided support to the dispatchers, were located in another part of the building. The building was visibly dated throughout; for example, there was staining on ceiling tiles in the corridors.

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Although the building had three floors, there was no lift. Stair-lifts and additional hand-rails had been fitted to some of the staircases, but not to the café and conservatory located in the basement. This meant that these areas were not accessible to people living with mobility issues.

- The call-handling room, dispatch desks and urgent care desks were cramped, with very little space around the desks and no room to add any additional or spare desks. Staff and managers told us the building and cramped working conditions had a negative impact on morale.
- There was nowhere for staff to go after dealing with a distressing call, and there was limited space for private meetings. This meant that staff who wanted to go to a quiet place would have to go to the car park or the staff room. A member of staff told us there was nowhere private to meet with supervisors to discuss feedback from their monthly call audits or to discuss a difficult call.
- The trust planned to move the Liverpool office to a new site. Although the trust had conducted a detailed option appraisal and were in the final stages of developing a full business case for approval by NHS Improvement in support of a fit for purpose office, no final date had been set for the move. Managers told us staff were frustrated that the centre had not relocated, as they had been told it would move for many years.
- The Preston site was a single level building and was accessible for people living with mobility difficulties, with ramps and hand-rails installed. The control area had recently been refurbished and consisted of two light and bright rooms. Call-handling teams, the trauma cell and the HEMS desk were located in one room, with dispatch teams and the urgent care desk in the other. The rooms were well laid out with sufficient room between banks of desks. Although staff told us it could get noisy during busy periods, we did not observe this; during our inspection the centre was calm and relatively quiet.
- As part of the refurbishment, work was ongoing to commission the real-time performance monitoring screens in the call handling and dispatch rooms. There was a delay in commissioning the screens due to a delay by the software supplier; however, senior managers expected this to be resolved by the end of June 2016. A temporary solution displayed real-time, call-handling performance in one room, and hospital admission delays in the dispatch room. However, staff could also monitor relevant performance information from their own terminals.
- In Preston, there was a separate adjoining training room, which doubled as the major incident control room. A 'Quiet Room' was also available for staff to reflect after a distressing call, although the room looked dated. However, staff told us they were also able to go outside into the grounds to reflect. The staff room had facilities for storing and making food and drink, with vending machines and a television. A number of other offices were used by senior managers and the training and administration teams and were available to use for private meetings with managers.
- The Manchester site was housed in a bright and airy modern office building on the ground and first floors. The building contained a lift to make it accessible for people with reduced mobility. The offices were quiet and roomy. There was a 'Reflection Room' where staff could listen back to calls and reflect after a distressing call or incident. There was also a meeting room that could become a command centre with immediate effect in the event of a major incident.
- Not all staff across the three sites had received a workstation assessment in the past year. However, we observed that reasonable adjustments, such as the provision of specialist chairs and height adjustable desks, had been made for staff who needed these.
- The three sites handled emergency calls from across the northwest of England in a 'virtual' environment. This meant that, if there was a total equipment failure in one of the sites, the other two centres could still answer the incoming calls. In the event of all three sites having a total equipment failure, calls were re-routed by the Telecommunications company to neighbouring ambulance services.
- In the event of the computer systems failing across all three centres, systems were in place to record and triage calls manually. Call handlers and clinicians on the urgent care desk followed the same triage questions but used the manual fall-back card index. A paper-based copy of the Manchester Triage System (was also available to each clinician as a fall-back in event of system failure).

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- We reviewed the fall-back box files for use by call handlers, dispatchers and clinical staff to be used in the event of a computer systems failure. Staff received training during induction in how to manually record information taken in calls. Staff we spoke with were confident about manually triaging calls.
- The sites had backup telephony and radio systems in place. All three sites had back-up generators for use in total power failure. The service had a business continuity policy in place, which could be implemented if system failures continued for a prolonged period.

Medicines

- Some medicines were stored at the Manchester site for use when the emergency and urgent care paramedics made non-urgent visits around Greater Manchester. Mild pain relief drugs were stored in a sealed case within the sealed equipment bags. Cardiac drugs were kept in a separate sealed emergency kit bag. We saw evidence that all drugs were fully stock-checked on a daily basis. Spare stores of drugs were kept in a locked cupboard. Drug expiry dates were all recorded and drugs past expiry date were identified. The service exchanged the out of date drugs for in-date medicines at a hospital.
- There were no medicines stored in the Preston or Liverpool sites.
- MPDS did not prompt call handlers to give advice to callers about self-medication. Staff told us they recorded a list of self-medication in the notes, if the information was offered by the caller. Call handling staff were not clinicians so were unable to give advice on self-medication except to advise that the patient should continue to take their medication, as prescribed, if this was appropriate.
- Clinicians on the urgent care desk gave self-medication advice, as recommended by the evidence based triage system (Manchester Triage System), and within their scope of practice. The triage tool was regularly reviewed in line with national and professional clinical guidelines and supported staff to give the correct advice.
- All patient records were stored electronically on the computer aided dispatch system used by the service. The same system was used to record the priority of calls triaged by the service and the response made to the triage.
- Although we found no evidence the service was carrying out specific audits of records, the system licensing conditions required individual user audits of call handling compliance with the system to be carried out. This meant incorrect usage of the triage system was highlighted and enabled additional training and coaching to be undertaken in order to keep patients safe.
- All calls were voice recorded and stored electronically in accordance with data retention guidelines. This meant they could be accessed later if they needed to be listened to again; for example, for audits, complaint investigation or a police investigation.
- All staff within the EOC could access the records attached to a call or address. Records created by staff were relayed to ambulance crews through display terminals within vehicles. Dispatchers also provided relevant information to ambulance crews from the records by radio.
- The computer aided dispatch system allowed staff to add notes to a patient's record. If there was any special information that ambulance crews or other staff should be aware of, a 'warning' note could be added to the incident record or address. This would add a yellow triangle symbol next to the record.
- Staff had a good understanding of the type of information to record as a warning note and gave us a number of examples. This included existing care plans, frequent callers, potentially violent patients, access problems, and dogs at the property.
- All staff received information governance training as part of their yearly mandatory training.
- Confidential waste bins were available at all three sites for any handwritten notes written by staff.

Records

Assessing and responding to patient risk

- EOC staff used MPDS to assess and prioritise emergency calls. MPDS prioritised and coded calls based on responses to questions asked by the call handler. The

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priority, or coding, of the call determined the risk to the patient and therefore the response sent by vehicle dispatchers. If someone called 999 a second time, the call handler was prompted to ask the questions again and the priority of the call was reassessed.

- MPDS had several inbuilt risk assessment tools, including a breathing tool, pulse taking tool, cardiac arrest tool, contractions (pregnancy) tool and stroke tool. The system prompted call handlers to ask the caller if the patient was alert and breathing. Use of these tools meant that a more accurate assessment of the patient's symptoms could be made. The cardiac arrest tool prompted the call handler to give cardiopulmonary resuscitation (CPR) advice over the telephone until ambulance staff arrived.
- We observed staff using these tools; however, staff were concerned that, due to a system process issue, the tools were not available when a second follow-up call had been made following an initial call from a healthcare professional or transferred from NHS 111. (NHS 111 is a telephone advice service for the public on what to do if they feel unwell or where to go to get treatment).
- In this scenario the call handler had to manually triage the call and input the code into the computer system. Because of this the call handler did not have access to the additional system tools, such as the breathing tool or cardiac arrest tools. This meant the call handler was not able to make as accurate assessment of the patient's symptoms and could not access the cardiac arrest tool if they needed to give cardio-pulmonary resuscitation advice. Despite staff concerns, there was no evidence to indicate this had contributed to any adverse incidents. However, although it had been highlighted to supervisors, it was not identified as an issue on the service's risk register.
- Specialist nurses and paramedics on the urgent care desk used the Manchester Triage System to assess and prioritise calls referred to them for triage. Calls triaged with a lower priority, by emergency call handlers, were passed to the urgent care desk. Staff on the urgent care desk then called the patient or caller back to carry out a further telephone triage. Staff then made an assessment on whether or not they could give advice over the telephone ('hear and treat'); if there was another service that was more appropriate (for example, using a walk-in

centre); or if an ambulance was needed and if so what priority response was appropriate. The urgent care desk also triaged calls transferred from NHS 111 in periods of high demand.

- Calls made to NHS 111 were triaged using a different triage system (NHS Pathways). If those calls required an ambulance they were transferred to the EOC with the response priority assigned by the NHS 111 service. Lower priority calls were then passed to the urgent care desk to complete a telephone triage. Some staff told us they had concerns about this procedure as the calls had already been triaged by a clinician at NHS 111. This meant there was a risk that an ambulance response, if needed, could be inappropriately delayed.
- For certain types of calls, MPDS prompted the call handler to stay on the line with the caller to repeat relevant questions in order to check on the welfare of the patient and for any changes in their condition. These were generally patients who were very unwell or vulnerable. During our inspection, we observed calls where the call handler stayed on the line with the caller. These calls were handled appropriately and staff provided reassurance to the callers until the ambulance crews arrived.
- The service had a policy for providing welfare checks for callers in periods of high demand. This set out details, dependant on the priority of the call, when a caller should receive a call back. The policy was in use during our inspection and we observed call handlers appropriately making these types of calls.
- The computer aided dispatch system held a record of all of the available ambulances and other responders in an area and the skills of the crew or responders.
- The dispatchers told us they dispatched the nearest crew available to an incident. However, if the nearest crew did not have the appropriate skills, dispatchers would allocate a rapid response vehicle with the appropriate skills to support the crew. For example, a rapid response vehicle with a paramedic would be dispatched to support an ambulance crew of two emergency medical technicians, if this was the closest crew to an incident.

Staffing

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- Staffing levels were adequate for managing the calls received and for dispatching emergency vehicles. Managers predicted and planned staffing levels using a tool which monitored the volume of calls for each hour of every day of the week. The staffing rota for each of the sites was planned three to four weeks in advance, based on the predicted demand. Each of the sites were responsible for resourcing their share of staff for each week, depending on the number of desks for call handlers.
- Each site had five shift patterns, four of which covered 12 hour shift periods in rotation. The fifth shift varied between sites; in Liverpool and Manchester the fifth shift acted as reserves for gaps in the other shifts; and in Preston the fifth shift worked an eight hour family-friendly shift pattern. Family friendly shifts were available in Manchester and Liverpool for those who requested them. Each shift had a designated duty manager supported by supervisors and performance managers.
- Meal and comfort breaks were scheduled by supervisors and the performance managers to ensure a consistent level of staffing throughout each shift. We observed staff taking their allocated breaks. Staff were given additional breaks, if needed, after particularly distressing calls. Additional breaks were at the discretion of supervisors. A member of staff told us they were given a break after a call involving a child death.
- The urgent care desk in Liverpool and Manchester was open from 6am until 2am. It was staffed by specialist nurses and paramedics and was supported by advanced paramedics. The urgent care desk in Preston was staffed by two dispatchers and a clinician. This was a 'spoke' extension of the other urgent care desks and worked in the virtual environment. As such, although available between 6am until 2am, a clinician was not always present in Preston.
- The trauma team and the HEMS desk were each staffed by a dispatcher supported by a senior paramedic and an advanced paramedic within the clinical support desk. The trauma team dispatchers provided cover for the HEMS desk between 7am and 8.30am.
- On 1 March 2016, Liverpool had 62.3 whole time equivalent (WTE) call handling staff in post, with 9.3 WTE vacancies; and 52.8 WTE dispatchers with 0.3 WTE vacancies. At the time of the inspection, eight new call handlers were receiving induction training. It was expected that Liverpool would have met its full establishment of call handlers once these staff were in post.
- On 1 March 2016, Manchester had 102.4 WTE call handling staff in post, which was 16.5 WTE staff over the establishment level. The over-establishment had been authorised to mitigate against expected staff losses through call handling staff progressing to become dispatchers, moving to other roles outside the EOC (six staff were waiting for training to become road crew), or leaving the service entirely. At the same point, Manchester had 59.6 WTE dispatchers in post with 5.9 WTE vacancies.
- On 1 March 2016, Preston had 54 WTE call handling staff in post with 3.4 WTE vacancies, and 45.9 WTE dispatch staff with 10.7 WTE vacancies. At the time of the inspection, this had improved to being over-established in call handling roles, with 7.5 WTE vacancies in dispatch roles.
- In Preston, a monthly recruitment meeting oversaw recruitment and retention of staff in the centre. At the time of the inspection, there were 7.5 WTE band four grade vacancies; however, the centre was also over-established in band three grade staff.
- Vacancy levels for the sites were collated by the heads of service and reviewed on a monthly basis as a standing agenda item of the trust's recruitment meeting. This process was conducted with senior workforce and organisational development team managers.
- We reviewed the staffing level data in one of the sites for the four weeks prior to our inspection; this compared the planned staffing levels per hour per day with the actual number of staff on duty. During this period, an average of 94% of call handling shifts were filled; an average of 100% of dispatch shifts were filled, and an average of 91% of managerial shifts were filled. The impact of unfilled shifts was minimised due to the virtual working nature of the three sites. In addition, dual-skilling of staff on call handling and dispatch enabled flexibility in meeting staffing needs.
- Senior staff told us the three centres were in the process of moving towards a regional staffing plan. An 18 month

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training contract was introduced to improve staff retention within the EOC; however, senior managers recognised that the majority of staff who left the centre did so to move into operational roles.

Anticipated resource and capacity risks

- The trust had adopted the National Ambulance Resilience Unit's Resource Escalation Action Plan. This was used by ambulance services across the country to monitor and plan for different challenges, including changes in demand, weather, supply chain disruption, security threat, hospital issues, staff absence, fleet issues and infrastructure problems. The plan had four levels (steady state, moderate pressure, severe pressure, and extreme pressure), and set out trigger levels and the action to be taken at each level. The level at the time of our inspection (moderate pressure) was clearly displayed across all three sites.
- The EOC had a number of local procedures to manage foreseeable risks to the service. Staffing levels were increased when large public events, or holidays, were scheduled. A clinical escalation plan set out the different actions the EOC should take to deal with increases in demand. There were plans to manage higher volumes of emergency calls and manage higher demand for ambulance responses. The urgent disconnect policy set out the actions that could be taken to manage higher volumes of emergency calls. These actions included terminating calls after basic information was taken; the enablement of administrative staff to take basic calls; and, the ability for the service to transfer calls to neighbouring ambulance services.
- The clinical escalation plan set out the actions that could be taken if there was a delay in dispatching ambulances. The six-stage plan set out the triggers for each stage of escalation; who could authorise the escalation; the action that could be taken; and, how often the escalation level would be reviewed. There was a range of actions that the service could take under the plan. These included not responding to certain types of calls; triage of red priority calls by the urgent care desk; call backs to patients to re-triage less urgent green priority calls and to reallocate emergency vehicles; dispatch of ambulances from neighbouring trusts; and, deployment of staff from across the organisation to be used on the road. The escalation plan had been implemented during our inspection because of the high volume of calls.
- The clinical escalation plan in use at the time of the inspection was dated July 2012. The escalation plan had been reviewed by the trust's Medical Director and EOC regional planning manager within the 12 months before the inspection, but was still in draft format when we inspected.
- The three sites handled emergency calls from across the region in a 'virtual' environment. This meant that, if there was a loss of facilities or infrastructure in one site, the other two sites would continue to answer incoming emergency calls. Calls could be diverted to neighbouring ambulance services, if there was a loss of facilities in all three sites.
- Each of the three sites monitored the number of ambulances waiting at hospitals to handover patients and the times taken to do this. This information was displayed on screens within the dispatch rooms. When the handover waiting time increased, dispatchers contacted the ambulance liaison officer who would work with the hospital to free up crews. The regional operational coordinating centre (ROCC) desk at Manchester could also contact hospitals and divert ambulances to other hospitals.
- Dispatchers across all three sites were trained to answer emergency calls and there was some dual skilling of call handlers to dispatch. This meant the sites had flexibility to divert staff if there were disruptions to staffing levels. In Liverpool and Manchester, staff could be recalled from leave if there was exceptional and significant disruption to staffing levels. A broadcast system was in place in Preston to ask staff to attend work, and administration staff were trained in basic call handling skills, at times of extreme demand.
- A mass gathering register was maintained across all three sites. This helped to ensure awareness of large events in the region, such as sporting events and festivals, even when ambulance support was through private providers. This meant the service could plan to ensure sufficient staff were available.

Response to major incidents

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- The trust had a guide for handling major incidents. This was based on the Joint Emergency Service Interoperability Programme's (JESIP) METHANE and Joint Decision models. These were recognised models for passing incident information between services and their control rooms. This enabled service commanders across all the emergency services to reconcile different objectives and make effective decisions. The guide used major incident cards, which gave detailed instructions on procedures and staff roles. We observed that the major incident cards were available and staff across the EOC had a good understanding of their role in a major incident.
- A critical incident manager was based in each of the sites for every shift. This manager was responsible for reviewing and managing incidents, which could cause harm to patients.
- There was a dedicated operational co-ordination centre in each site, which would be used in the event of a major incident. This was a separate room from the main call handling and dispatch area, which was used when the site required operational management. In the event of an incident, the co-ordination centre was operated with staff from command role functions, who were responsible for coordinating the service's response. This meant that call handling and dispatch staff could focus on their core responsibilities.
- In November 2015, marauding terrorist firearm attack training was held for staff in all three sites. The training included discussion about staff roles in the event of an attack and mock scenarios. Since the Paris and Brussels attacks, marauding terrorist firearm attack training was added to the induction programme for new call handling staff. Scenario-based exercises for these types of attacks were held in all three sites and learning from the exercises was fed back to staff. This meant that staff practiced the skills needed during this type of incident.
- Hospital trusts in the Greater Manchester area were part of a Mass Fatalities Group that planned for any major incident resulting in mass fatalities or injuries. The North West Ambulance Service was part of this planning group.
- The trust had a communicable diseases policy, which set out the role for staff in the event of an outbreak of

disease. The policy listed the major envisaged outbreaks; how outbreaks may be identified in the triage system used; and, the specific questions call handlers would ask.

Is emergency operations centre effective?

Good



We rated Effective as 'Good' because:

- Staff were well-trained and confident in using the Medical Priority Dispatch System (MPDS).
- Clinical support and advice was available to staff when required.
- The urgent care desk carried out telephone triage assessments to assess a patient's need. This meant more patients were treated safely in their own home or in the care of a community based service and reduced unnecessary admissions to emergency departments.
- The median time for the trust to answer 95% of calls was between three and four seconds between April 2015 and January 2016, which was better than the England average.
- The proportion of calls abandoned before being answered was better than the England average and always lower than one per cent of all calls.
- There were processes to support appropriate deployment of the Hazardous Area Response Team (HART).
- There was good co-ordination and liaison with hospitals in the region, facilitated by the Regional Operational Coordinating Centre (ROCC) team. The ROCC provided a dedicated 24 hour Regional Health Care Desk facility to coordinate effective liaison and escalation with healthcare partner agencies on behalf of the urgent and emergency care service.
- There was an effective system of communicating warnings or medical information between staff in the EOC and vehicle crews via use of special notes on the MPDS system.

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- Calls were comprehensively audited for call handling staff to ensure consistency and compliance with the triage scripts. Learning from the audits were shared with staff.

However:

- The service reported that, in February 2016, only 54% of call handling and dispatch staff had received an appraisal within the previous year.
- The strict prompts and script used by the MPDS system meant that call handling staff were not able to make a judgement about whether or not a patient (or caller) had mental capacity. Any response sent was based on the priority code determined by the system.
- While the Mental Capacity Act was mentioned in the induction training module about the Mental Health Act, most of the staff we spoke with across the centres had limited or no knowledge of the Mental Capacity Act.
- Not all emergency call handling staff we spoke with were aware they could access clinical advice from the clinical support desk if needed.
- Although the trust told us core induction training included elements relating to calls from children, people living with mental health issues, and people feeling suicidal; staff told us they felt they had a lack of training in handling calls from people in these groups.
- While there were processes to support deployment of the Hazardous Area Response Team (HART) we found inconsistencies between the procedure and system used.

Evidence-based care and treatment

- Emergency operation centre (EOC) staff used Medical Priority Dispatch System (MPDS) to assess and prioritise emergency calls. The International Academy for Emergency Dispatch (the academy), a standard setting research based non-profit organisation, oversaw the creation, development and updates of the emergency protocols.
- Staff on the urgent care desk used the Manchester Triage System for the telephone triage of certain calls. The Manchester Triage System is a triage system used by emergency clinicians worldwide. The trust used the

latest version of the system. Relevant National Institute for Health and Care Excellence (NICE) guidelines were extracted and embedded into the prompts and advice in the triage tool.

- Clinical staff working in the EOC provided advice within their scope of practice, and in line with both NICE and the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidance. Staff told us that, on occasions, they were asked to provide advice on situations that may not be covered by the guidance. Staff discussed these situations with the trust's Medical Director.
- Clinical advice was available at each of the sites from either an on-site advanced paramedic or the urgent care or clinical support desks during the hours they were open. While clinical advice was available, not all emergency call handling staff we spoke with at the Liverpool site were aware they could access it and one member of staff told us not all staff were comfortable asking for clinical advice.
- Senior paramedics on the clinical support desk at the Preston site also took calls and provided clinical advice to ambulance crews. This also included pre-alerting hospitals to incoming vehicles carrying patients with higher clinical needs.

Assessment and planning of care

- MPDS used strict prompts and scripts so call handlers could assess the needs of a patient, which determined whether or not an ambulance would be dispatched or whether the urgent care desk would call back. If an ambulance was dispatched the answers given would determine the priority of the ambulance.
- If a call handler identified mental health problems as the main presenting complaint they followed the script and prompts on the system, which determined the level and priority of response to be sent. Clinicians on the urgent care desk followed the prompts on the card for patients presenting with mental health problems to determine the advice to be given and response to be sent.
- Section four of the Mental Health Act (1983) allows an approved mental health practitioner in an emergency to detain someone in hospital for an assessment of their mental health. Sections 135 and 136 of the Mental Health Act allows a police officer to move a person they

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think is mentally disordered and 'in immediate need of care or control' from a building or public place to a place of safety. The EOC had a procedure for staff handling requests under these sections of the Mental Health Act and also a joint procedure with the local police forces and British Transport Police agreeing the respective roles.

- MPDS did not give a call handler the discretion to recommend pain relief. However, the Manchester Triage System, used by clinicians on the urgent care desk, included a pain ladder used to assess the severity of pain. The system set out advice about pain relief that could be given to patients who were in pain. We observed a clinician appropriately following the prompts on the system and recommending pain relief to a patient.
- MPDS had standard evidence based advice that call handlers gave to callers about food and drink whilst waiting for an ambulance. Call handlers followed a script that advised callers not to give the patient any food or drink until the ambulance arrived.
- Dispatchers had procedures which gave guidance on what type of vehicle to dispatch to which emergency calls. Dispatchers understood the restrictions for which types of ambulance response could be sent to each incident.
- Staff had access to a map with a record of defibrillators (also known as an automated external defibrillator or AED) across the region. A defibrillator is a device that gives the heart an electric shock when someone's heart has stopped. This meant staff could give advice to callers about the location of nearby defibrillators if someone was having a suspected cardiac arrest. If the call was made from a building with a defibrillator on site, EOC staff were able to give the caller the location of the defibrillator and who was trained to use it.
- The trust used community first responders to provide life-saving support to patients in their workplace or community until the arrival of an emergency ambulance. Dispatchers in each of the sites were responsible for deploying community first responders where they would be able to arrive at a scene before an ambulance. Dispatchers did not deploy community first responders as an alternative to an emergency ambulance.

- The trust had arrangements with fire and rescue services as first responders for suspected cardiac arrest in Merseyside and Cheshire, Lancashire and Greater Manchester. The fire and rescue vehicles were fitted with defibrillators and oxygen and were able to use blue lights to attend an incident. Dispatchers sent an ambulance response as well as a fire and rescue response.
- The trust used 'green' cars, also known as ambulance avoidance cars, to send to incidents which did not require an ambulance. These were located at the Liverpool and Manchester sites and could travel within a 15 mile radius. These were used for patients who did not need to be admitted to hospital or had fallen in their own home but did not require emergency or urgent care.
- The urgent care desks dispatched urgent care service cars and non-emergency ambulances provided by volunteering ambulance organisations. These were dispatched to calls which did not require an emergency ambulance, and were not staffed by paramedics.

Response times

- The trust had a target of answering 95% of emergency calls within five seconds. Between 1 April 2015 and 22 March 2016, the EOC answered 94.9% of calls within five seconds, just under the target.
- Between April 2015 and January 2016 the median time to answer an emergency call was one second. This was the same as the England average. Overall, the trust answered 95% of its calls within three to four seconds.
- The proportion of calls abandoned before being answered was better than the England average and always lower than one per cent of all calls. Data between April 2015 and July 2016 showed the trust only had a higher abandonment rate than the England average in one month, April 2015. In the same period the trust had the third lowest abandonment rate out of the 11 ambulance trusts in England. This was a significant improvement from April 2014 and August 2014 when 4.5% of callers hung up before their call was answered. This improvement coincided with the move to 'virtual' working where calls were routed to the next available call taker, irrespective of location.

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- Between April 2015 and January 2016, the proportion of patients who contacted the service again (following discharge of care by telephone) within 24 hours was lower (better) than the England average every month. Over the same period, the average proportion of patients who contacted the service again was 4% compared to an England average of 6.6%. The trust was the fourth best performing ambulance trust for this indicator. This was a significant improvement from April 2014 to August 2014 when 11% of patients contacted the trust again within 24 hours of having called 999 and been offered clinical advice over the telephone. This had been achieved through improvements to site operations and communications on the urgent care desks, which meant that increased numbers of appropriate patients were triaged by a clinician and given advice. This resulted in fewer re-contacts by discharged patients.
- The urgent care desk had an audit and peer review procedure to ensure compliant use of the Manchester Triage System. A sample of calls each month was audited by urgent care desk staff trained to audit calls. Feedback and learning from the audits was shared with members of staff. An advanced paramedic also peer reviewed five calls per month per clinician.
- Clinical staff we spoke with confirmed they were given clinical supervision, and were peer review audited on a monthly basis. Clinical staff also told us they were given time to work on revalidation of their registration with the professional bodies
- The North West trauma network undertook patient outcome audits for the trauma team. Learning was shared between the network and the service through weekly meetings.
- Staff told us it was difficult to measure patient outcomes for the HEMS service, as a helicopter was not necessarily allocated to every potential incident. However, effectiveness was assessed by reviewing individual incidents. Any relevant information was fed back to staff in one-to-one meetings. Audit records of HEMS incidents were sent to the Air Operations Manager and Air Medical Director.
- The percentage of emergency calls resolved by hear and treat had increased. Between April and August 2014, the percentage of patients treated over the telephone was 3.6%. Between April 2015 and January 2016, the number of calls resolved by hear and treat were consistently higher than the national average of 10%. Between 1 January and 22 March 2016, 9.7% of patients were treated over the telephone through being given advice to self-care or to access a community based service. This meant more calls were resolved by the EOC and more patients were treated safely in their own home or in the care of a community based service. This reduced unnecessary admissions to hospital emergency departments.
- While there were processes to support deployment of the Hazardous Area Response Team (HART) we found inconsistencies between the procedure and system used. An EOC procedure set out the process for deploying HART resources to an incident. The procedure said that the computer aided dispatch system would display an automatic pop-up for incidents in which

Patient outcomes

- The EOC carried out a comprehensive audit programme of emergency calls. The EOC had a dedicated audit team, made up of former call handlers who received training from the academy. This team audited a sample of calls across the three sites. The audit programme was part of the licensing agreement to use the MDPS system. The audit team was hoping to become a 'Centre of Excellence' within the next year, and in order to do so they needed to audit 1% of all emergency calls received.
- The audit policy set out the actions taken for dealing with non-compliance with the call script and action identified by the system to be taken. The results of the teams' performance in audits were published on noticeboards in the EOC sites. These were also shared at audit meetings. The audit team gave us an example of a trend they had identified with call handlers not repeating back the address on 999 calls and the action taken.
- Dispatch staff told us the time taken to dispatch a vehicle was audited, although the 'quality of dispatch' (whether the correct vehicle and crew had been sent to an incident) was not routinely audited. This was only done as part of the investigation of complaints or concerns in order to determine if staff had taken correct actions in identifying and dispatching appropriate vehicles.

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HART could be used; however, there was no evidence that this function was available. Staff we spoke with said they identified potential HART incidents from the details recorded in the call and from the system generated dispatch code. Staff would then speak to their manager about dispatching HART resources for incidents which they could be used for. The manager would contact the HART team to confirm it was appropriate for them to be used.

Competent staff

- In February 2016, the trust reported that only 54% of EOC staff had received an appraisal within the previous 12 months. While this figure was low, this was an improvement on the previous year of 39%. In February 2016, 78% of urgent care desk staff had received an appraisal within the previous 12 months.
- Staff in all three sites said the frequency of one-to-one meetings with their manager varied. Some staff told us they had one-to-one meetings as regularly as monthly, whereas other staff had a one-to-one meeting every three to six months. The meetings were used to discuss performance, new policies or procedures and any other matters raised by the manager or team member.
- The service had processes to challenge and deal with poor staff performance. If a call handler had not performed well against their monthly call audits, there was a process for increasing the number of calls audited until improvements were made. If improvements were not made an action plan would be put in place with the training team. If an audit identified a serious error, the call handler would not be able to answer further calls until they had received audit feedback from their supervisor.
- The urgent care desk used audit and peer review procedures to monitor the performance of staff. In addition to the monthly call audits, the urgent care desk monitored the percentage of calls that each clinician resolved without needing an ambulance or other response from the trust (hear and treat) and the percentage of calls where the priority was increased following the telephone triage. This meant the trust ensured clinicians were triaging calls consistently.
- Each of the sites had two dedicated trainers who oversaw the training of call handlers and dispatchers. Training and induction programmes were delivered at each of the sites. The induction programme for call handling staff was five weeks long and included a mixture of classroom training, listening to emergency calls and an observation day with an ambulance crew. The course covered training on all of the systems and procedures used in the EOC, as well as a range of topics including basic life support, safeguarding, major incident training and the Mental Health Act.
- Staff were expected to complete an assessment at the end of their induction to ensure they had met the competencies. If someone did not pass the assessment they were given additional support before retaking the assessment. If they did not pass the resit they were unable to start in the role.
- Although core induction training included elements relating to calls from children, people living with mental health issues, and people feeling suicidal, staff we spoke to in all three sites told us they felt they had a lack of training in handling calls from people in these groups. Senior staff and the training team recognised that this was an area of weakness and were planning to develop and deliver mental health training for staff within the next year. It was noted that the planned cycle of mandatory training included training on dealing with suicidal callers.
- There was no specific training for staff on supporting and working with child callers. There was a risk of staff being unable to communicate with children while they followed the triage prompts. However, MPDS took into account the responses given to prioritise and code the response to the incident. For example, if more 'unknown' answers were given the system would determine a higher priority response. Both triage systems used by the service were designed to triage people of all ages.
- There were career pathways in the EOC, which meant staff could progress, develop and have the opportunities to do different jobs. Emergency call handlers had progressed to become supervisors, dispatchers and work in the audit team. Before taking permanent positions, staff were given opportunities to work as supervisors or dispatchers on a temporary basis. The trust told us that, in all areas, staff could also work on a three month secondment to the local

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complaints team. Staff also had opportunities to move outside of the EOC to work on emergency ambulances as emergency medical technicians, subject to satisfactory assessment and employment checks.

- Nursing staff on the urgent care desk told us development within the service was limited because, as they were not trained as paramedics, they were unable to carry out face-to-face triage of patients. The service drafted an induction course and core competency framework for the role of Urgent Care Practitioner; however, a decision about whether or not this would be implemented had not been made by the executive management team by the time of the inspection.
- The computer aided dispatch system used by dispatchers held a record of the skill levels and competencies of vehicle staff to ensure the correct staff were dispatched to an incident. A member of staff showed us the different skill sets of the crews that were available to him at that time.
- The HEMS team were specifically trained, and worked closely, with the trauma cell team. Training included a one day Civil Aviation Authority course; training on the trust's HEMS policy and procedures; and the Joint Aviation Requirement Operations Manual (JAR-OPS). Paramedics were seconded to the HEMS service for two years, and at the time of the inspection, there was a waiting list of paramedic staff to join the HEMS crews.
- Senior managers were in the process of self-assessment against the standards of the National Ambulance Resilience Unit (NARU) for the management of major incidents, and were due to attend external commander training in September 2016. Senior managers attended silver command meetings bi-weekly interspersed with bi-weekly teleconferences.

Coordination with other providers

- The EOC pre-alerted hospitals of patients who are being conveyed to them. The EOC had a policy for passing information from ambulance crews to a hospital. The crew would give specific information to the dispatcher who would then contact the hospital with this information. This meant the hospital was prepared with appropriate equipment and staff for the arrival. We observed staff recording information from the crew and passing it to the hospital.

- The triage system used by emergency call handlers had a specific pathway for requests from health care professionals or transfers between hospitals or facilities. This meant the call handler did not need to ask all of the triage questions they would if the call was from a member of the public. Calls from health-care professionals or hospitals were answered by the next available call handler rather than being handled by a specific desk.
- The trust had a Regional Operational Coordinating Centre (ROCC) which was based at the Manchester site. The ROCC provided a 24 hour Regional Health Care Desk facility to coordinate effective liaison and escalation with healthcare partner agencies on behalf of the urgent and emergency care service. The team had office-based staff as well as ambulance liaison officers who were based across the North West region and could move between hospitals. The team's aim was to identify delays and capacity issues at hospitals early to provide solutions to ease the pressure. They focused on building relationships with hospital emergency departments, bed managers and other key personnel.
- The urgent care desk had a directory of services for each of the areas covered by the service. The directory of service listed opening times for GPs, out of hours GPs, condition specific referral schemes, walk-in centres, minor injury units and urgent care centres. This meant that urgent care desk staff could refer a patient to more appropriate local services available at that time. The version of the directory we reviewed had been updated within the same month.
- The HEMS team worked closely with the fire and police services, the coastguard and the mountain rescue teams across the whole North West region. Where a dispatcher at another site identified a possible need for helicopter support, they called the HEMS team. Clinicians worked with the HEMS dispatcher to identify which helicopter had the appropriate clinical skill mix for the crew to meet the patient's needs. The HEMS dispatcher also contacted the relevant authorities if it was identified that the flight path of the helicopter could take it into or close to restricted airspace. We observed effective working between the HEMS team, the community responder dispatch, and the airport dispatcher to co-ordinate a response to a patient with chest pains in a rural location.

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- In conjunction with monitoring incidents reported via the emergency call service, the HEMS dispatcher regularly monitored the police radio channel to identify incidents that may require an air ambulance response. An electronic notification system provided a link between the trust, the police and mountain rescue teams. This meant the HEMS team could also monitor situations where mountain rescue needed an air ambulance to attend.
- The trust had a policy for handling calls for ambulances outside of the North West area and for ambulances assisting with incidents outside of the area. If emergency calls were made within the area covered by the service but for an incident that had happened outside this area, the service would contact the neighbouring ambulance service to ensure the most appropriate ambulance was dispatched. Each dispatcher's telephone had a direct line to each of the neighbouring ambulance services.
- The trust worked closely with the other emergency services. Staff from the EOC attended.
- The trust worked collaboratively with fire and rescue services across the north west region to develop first responder schemes, the first of which started in August 2015. At the time of the inspection, schemes were operating in Cheshire, Lancashire, Manchester and Merseyside, and discussions for a similar scheme were ongoing in Cumbria. The trust was arranging to trial a similar partnership working with the police in areas of Greater Manchester so that they could also be used as first responders.
- Call handling and dispatch staff in all the EOC worked closely with the police. The EOC and the police had a joint protocol for requesting ambulances, which meant the police only needed to give limited information to the call handler. This included details about the presenting problem, approximate age of the patient, level of consciousness, breathing status, presence of chest pain and severity of bleeding. We listened to a number of calls made to the EOC from the police where an ambulance was required. We also observed dispatchers contacting the police to arrange a joint response to incidents where there were on-site safety issues, such as when the patient was potentially violent or had a weapon.

- Information about 'at risk' locations was shared between the emergency services. This was managed by the trust's safety and security team.
- The service's frequent caller team worked with GPs, other local professionals, and the individual callers to create bespoke care plans with the aim to reduce the number of calls made.

Multidisciplinary working

- The computer aided dispatch system used by the EOC enabled all staff to have access to information about all emergency calls and activity across the trust. This assisted different teams in working together as this meant they had up to date information about other teams' work as well as their own.
- We were told that, at 9am every day, a conference call took place between the three control room duty managers to discuss anything happening in their sector that day (such as appraisals or staff sickness) that may require cover from another site.
- There were handover meetings at all sites between performance managers and duty managers before the start of each shift. We observed one handover at Liverpool and Preston and saw that resources, problems and specific incidents were discussed and a record of the handover was kept.
- Dispatch staff worked closely with staff across the trust, including the crews, first responders, the air desk and HART teams.

Access to information

- The computer aided dispatch system enabled staff to review previous calls made to the service. This meant they could identify duplicated records to avoid duplicate calls or responses. We observed a call handler identifying a duplicate call where the caller's telephone had previously cut out. This also allowed clinicians on the urgent care desk to review records of previous calls and action taken before a telephone triage.
- Warning notes were accessible by staff to see specific information about a patient or the address. Callers with a warning note were easily identified by a symbol on the incident log. This information was accessed by dispatchers to pass on relevant information to the ambulances or responders attending an incident. Staff

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were also able to alert ambulance crews of an immediate safety concern by sending a 'warn crew' computer message to the ambulance, for example if there was a risk of violence to crew members.

- Warning notes or special notes were added onto the system by the Gazetteer Team. They added notes about violent behaviour or risks identified at addresses, such as dogs or tripping hazards. They also added any medical information received from GPs and community staff, via an online reporting system, such as, where a patient's care plan was located and the existence of a do not attempt cardio pulmonary resuscitation (DNACPR) document in place. The team were also responsible for updating changes to and adding any new build properties to the system.
- Staff told us they had problems accessing information when the original call had been made to NHS 111 but where NHS 111 staff considered the call needed an emergency response. NHS 111 used a different triage system, which meant the information transferred was not transposed in an easily readable way. Although all the information was provided, EOC staff had to scroll through pages of duplicated text before finding the relevant information. Staff we spoke with were not aware of any plans in place to resolve this issue.
- The trust had a policy for handling frequent callers and a dedicated frequent caller team. Frequent callers were identified if there were five or more calls from an address or person within a month or 12 or more calls within three months. Frequent callers were identified on the computer aided dispatch system with a symbol next to the call. This enabled the team to review previous calls and their outcome in order to determine if the advice or treatment given, or transportation to hospital was appropriate or had contributed to the pattern of calls. New referrals to the frequent caller team were picked up from a report of callers who had met the frequency triggers, produced by the informatics team on a weekly basis.
- In response to NHS England's 2015 'Patient Safety Alert: Harm from delayed updates to ambulance dispatch and satellite navigation systems', the service carried out an update programme to the satellite navigation system for

all vehicles. This was completed in October 2015. The trust also made funding available for an IT technician to update the fleet with satellite navigation software during routine maintenance services.

- The sites were testing a system called 'Sharepoint' where electronic copies of all policies and procedures were kept. Staff were able to access this system from their operational desks without the need for internet access.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The strict prompts and script used by the MPDS system meant that call handling staff were not able to make a judgement about whether or not a patient (or caller) had capacity. Any response sent was based on the priority code determined by the system.
- The Mental Capacity Act (2005) was mentioned in the induction training module about the Mental Health Act. Of the staff asked, none had good knowledge of the Mental Capacity Act.
- The trust had a joint protocol with the local police forces for requesting police support for patients who needed restraint because of threatening or violent behaviour, patients refusing treatment, patients at risk or causing further harm to themselves or other reasons. We observed staff using this protocol to request police assistance.

Is emergency operations centre caring?

Good



We rated Caring as 'Good' because:

- We observed compassionate and reassuring staff who treated callers with dignity and respect and kept patients and callers calm.
- There were many examples of EOC staff receiving letters of thanks from patients or their families citing the care staff had provided in a time of great distress.
- We witnessed effective communication with callers. Staff gave reassurances and for urgent cases they stayed on the line until paramedics arrived on the scene.

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- Staff showed kindness, respect and empathy for those experiencing mental health crises.
- The trust had a Frequent Callers Team who supported frequent callers to manage their own health and reduce the number of instances they contacted the emergency operations centres. The team had been successful in reducing the number of calls made by the frequent callers who were referred to them and had assisted people to receive the right support and treatment elsewhere using increasing levels of support.

However,

- Staff told us they felt the strict system prompts and scripts restricted what they said to callers and prevented them from being as caring with callers as they would like to be on occasions.

Compassionate care

- We observed staff demonstrating compassion to all callers. We listened to 63 emergency calls and calls from clinicians on the urgent care desk. In every call we listened to we found staff to be respectful, considerate and caring. We observed calls where patients were seriously ill and staff treated callers with dignity and respect. This included a call from an elderly patient expressing significant medical concerns, who lived alone. The call handler stayed on the line, providing calming reassurance until the crew arrived.
- The service had a policy for handling abusive calls from the public. The policy set out how a member of staff would escalate an abusive call to their supervisor and manager. A caller would be given three warnings about their behaviour before a call would be terminated. Staff told us they felt supported by their managers in dealing with abusive callers.
- Formal debriefing sessions were available to staff, if requested, following abusive or distressing calls. Staff were also able to request counselling if necessary.
- We saw letters of thanks from patients and their families and these demonstrated that staff had been caring and compassionate when dealing with their call.
- Call handling staff gave 'ring-back' calls to those patients who were waiting for non-urgent transport to provide reassurance and check on their welfare.

- Call handlers used an electronic triage system which gave them prompts and scripts to follow, depending on the answers given to the questions by the caller. This meant they were restricted in what they said to callers. Some staff told us they were frustrated by having to follow the script and were worried about receiving negative feedback in audits. Staff told us they felt this prevented them from being as caring as they would like to be on occasions.

Understanding and involvement of patients and those close to them

- Staff communicated with patients and callers effectively. We listened to staff repeating information back to callers to ensure they had correctly understood what callers had told them. This ensured the correct response would be sent to the right address.
- The electronic system had standard evidence based advice that call handlers could give to callers on what they should do whilst waiting for an ambulance. This ranged from keeping someone warm and comfortable to giving cardio pulmonary resuscitation advice. The system also gave specific advice for callers in preparation for leaving their house when the ambulance arrived, such as putting pets away.
- Call handling staff, following the prompts on the electronic triage system, were able to deviate from the pre-defined script when there was an understanding that the caller had learning difficulties, was living with dementia or was a child. In these instances, the call handler could deviate from the script when they had asked the caller once and there was no understanding of the question. For other callers, the call handler would ask a question three times and if there was no understanding from the caller then they could ask a clinician to assist them in explaining what was required and ascertaining the patient's condition.

Emotional support

- We listened to staff providing support to callers and patients who were very distressed. Without exception staff remained calm and clearly gave the advice prompted by the system. While staff told us they were unable to tell callers exactly when an ambulance would arrive (for example because it may develop a fault or be re-routed to a higher priority call) they gave reassurance that help was on its way.

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- For the most unwell patients the system prompted staff to stay on the telephone until an ambulance arrived. We listened to calls where staff stayed on the line with callers who were very distressed, keeping them calm while an ambulance arrived. During this time, staff continued to ask questions about the welfare of the patient.
- Staff showed kindness, respect and empathy for those experiencing mental health crises. We listened to a call in which a clinician on the urgent care desk provided compassionate support to a patient in crisis. The clinician spent time listening to the caller and their concerns.

Supporting people to manage their own health

- The Manchester Triage System was used by clinicians on the urgent care desks and included evidence based self-care advice that could be given to callers who did not need face-to-face treatment. Staff provided advice on managing symptoms, medication, and where to go to if the symptoms persisted. The advice given depended on the responses callers gave to the questions asked.
- Call handlers continued to follow the system script and prompts for calls received from identified frequent callers. This meant that if a frequent caller did require an emergency ambulance it would be dispatched, based on the priority required.
- The urgent care desks had a directory of services setting out the services available for callers who did not need an emergency ambulatory response. The directory listed GPs, out of hours, condition specific referral schemes, walk-in centres, minor injury units and urgent care centres. The directory also listed what times the different services were open. Clinicians could give advice to callers about which services they could access to manage their own health.
- The trust had a Frequent Callers Team who supported frequent callers to manage their own health and reduce the number of instances they contacted the emergency operations centres. The team consisted of two band six paramedics for the Greater Manchester area and one band six paramedic for each of the other areas covered by the trust. There was also a band seven Project Manager on the team. The team was initially funded under the commissioning for quality and innovation

(CQUIN) programme for two years, from October 2013, but was subsequently now funded by the clinical commission groups and the trust was in the process of developing a bid for increased staffing on the team. Many of the callers had alcohol or mental health conditions and consideration was being given to adding mental health clinicians to the team.

- The team had three stages of support for patients. At the first stage the service user would be contacted by phone to ask them what they could do to further support them, for example, contacting their GP. If the service user was still triggering a frequent caller alert after a month, the team would visit them at home to look at their home environment and put in place whatever support they could with other stakeholders. The third stage of support was put in place if the first two stages had not helped the service user and this involved having a multidisciplinary meeting with all parties who may be able to put a support network in place to manage the health of the service user.
- The team had been successful in supporting people to seek the right help to manage their conditions. We were told that, in some cases, Antisocial Behaviour Orders (ASBOs) or Acceptable Behaviour Contracts (ABCs) had been put in place for persistent frequent callers and that prosecutions had been carried out when these orders were breached.

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

Good



We rated the Emergency Operations Centres (EOC) as 'Good' in the Responsive domain. This was because:

- The EOC demonstrated it planned services to meet the needs of the local population. Clinical staff were able to triage patients who may require medical help but not need to be taken to hospital. In the major cities, clinical staff could dispatch a paramedic from the urgent care teams to 'See and Treat' the patient.

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- There was excellent event contingency planning for 'mass gatherings' across the region with careful planning of the resources and equipment required to provide adequate medical coverage at events.
- Differing levels of demand in various localities across the region did not impact on the service due to the virtual nature of the operations centres. Calls were routed to the first available call handler in any of the centres.
- The EOC had facilities in place to deal with callers whose first language was not English, who were deaf, partially sighted or blind, or who were bariatric patients (patients living with extreme obesity).
- Access and flow of calls was continually monitored, as was capacity and pressures at emergency departments throughout the region. Performance meetings took place regularly throughout the day so that managers were aware of what was happening and could mitigate increasing pressures on the service.
- Complaints were investigated thoroughly with learning shared with any staff involved. A local complaints team that was set up with staff seconded from front-line roles, cleared a backlog of complaint investigations in a short period of time.

However:

- Initial training on the call triage system included scenarios on dealing with calls from people living with dementia or learning disabilities; however, there was no separate training modules for staff on these subjects. This meant there was a risk that services might not take account of the needs of patients or callers living with dementia or learning disabilities.
- Staff told us they would like more training in mental health, specifically in handling calls from people with mental health problems.
- Dispatch staff could only identify if a bariatric suitable vehicle was needed if the caller or patient told the emergency call handler, who would record it as a warning note. There was therefore a risk that an unsuitable vehicle or staff without an appropriate skill set could be sent to an incident with a bariatric patient if this information was not offered during the initial emergency call.

- Staff recorded any relevant information about communication needs that was shared by the caller in the call notes. However, emergency call notes were recorded against an address or location rather than against an individual person. This meant there was a risk that previously recorded communication needs would not automatically be reflected in later unrelated calls by the same caller.

Service planning and delivery to meet the needs of local people

- The emergency operations centre (EOC) had a number of different specialist clinical services designed to meet the needs of the local population. These included the 'hear and treat' service, where the urgent care desk triaged and assessed patients who required medical help but did not need an emergency ambulance.
- The HEMS desk worked closely with the mountain rescue teams and coastguard to respond to emergency incidents in remote and rural locations. This included the ability to use a helicopter based near Penrith for incidents in the North Cumbria area.
- The EOC developed and reviewed the triage system to reflect the needs of the local population. This meant the service was able to change the response code for certain types of calls based on the answers given. For example, the trust increased the types and number of calls which were passed to the urgent care desk to be telephone triaged. The impact of the changes was evaluated and reviewed by the trust.
- The EOC supported the trust's resilience department's planning for major events in the region. This ensured wider awareness of planned events and provided technical and escalation arrangements, which had been developed in conjunction with local resilience forum stakeholder organisations. We reviewed event contingency plans for events taking place at local stadia and a register of mass gatherings for the region. The plans were comprehensive. The plans took into account a range of information including the type of event, the expected crowd numbers, and demographics of event attendees. This enabled the service to determine the numbers of trust resources, voluntary sector resources, on-site medical team resources and the type of equipment required at the event. For example, at a major stadium concert the trust deployed, as a

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minimum, an incident commander; four bronze officers; a communications officer and loggist (a person responsible for recording the decision making process during a major incident); 16 to 19 paramedics within the stadium; four paramedic ambulance crews; and two nominated drivers. The plans also identified primary, secondary and specialist receiving hospitals in the event of patients requiring transportation to hospital.

- HART rapid response vehicles (RRV) were used in Liverpool and Manchester as a normal resource, if they were not being used for HART incidents. If a HART RRV was being deployed for another job, staff would send the other HART vehicles. The vehicle would then travel to the HART incident once it had cleared the previous job. Staff were aware of the types of incidents where a HART resource was required.
- There were no HART teams or vehicles located within the Cumbria and Lancashire region; however, staff in Preston had received training on recognising and dealing with calls that may be relevant to HART or chemical, biological and radiation incidents. Preston dispatchers and trauma team staff told us they were able to request a HART response from the Merseyside or Manchester regions if, needed. The request would be made via the site performance manager, with the decision on deployment made by the HART team leader. However, the trust told us its HART assets form part of the national critical infrastructure response arrangements. Logistical distribution of HART assets was pre-determined by the National Ambulance Resilience Unit (NARU) and formed part of a national Emergency Preparedness, Resilience and Response network of providers beyond the trust's control. The trust told us frontline emergency personnel in all areas of the trust had undergone additional training and form a Special Operations Response Team (SORT) in line with NHS England requirements. Dedicated staff volunteered their services to undertake this role in support of HART operatives as part of the trust resilience contingency plan and were deployed when the distance of HART from the incident scene may result in the potential for a prolonged response. It also said SORT personnel may be deployed to scene when HART are pre-committed to emergency incidents..
- As the three sites took calls from across the region, differing levels of demand in various localities across the

region did not have an impact on the service. Each site was responsible for dispatching vehicles in their areas. As staff in all sites had access to the same information on the computer aided dispatch system they could see ambulances and other resources outside their area. If there was an increase in demand in a locality, dispatchers could use out of area resources. However, dispatchers had to speak directly to the neighbouring site in order to allocate an ambulance that was outside their area but closest to the patient.

Meeting people's individual needs

- The electronic referral and information sharing system (ERISS) enabled information to be securely shared with the service by other healthcare professionals (such as GPs) and service providers. This meant existing care plans could be shared for patients who may need to access the emergency service; for example, patients who had 'do not attempt cardiopulmonary resuscitation' (DNACPR) order in place, or who were at risk of falls.
- Initial training on the call triage system included scenarios on dealing with calls from people living with dementia or learning disabilities; however, there was no separate training modules for staff on these subjects. This meant there was a risk that services might not take account of the needs of patients or callers living with these conditions.
- Staff received training in relation to the Mental Health Act as part of their induction. However, although the trust told us core induction training and call triage system training included elements relating to calls from people living with mental health issues, there was no specific training for staff on mental health. A call taker would stay on the line with someone living with mental health problems until an ambulance arrived, if the triage system prompted them to do so. Staff felt more training about mental health, specifically in handling calls from people with mental health problems, would be beneficial.
- The service had access to eight vehicles in the region for transporting bariatric patients (patients living with extreme obesity). The service could also access additional support from a voluntary section ambulance service and the fire service, if required. As the MPDS system did not prompt the call handler to ask about

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bariatric needs dispatch staff could only identify if a bariatric suitable vehicle was needed if the caller or patient told the emergency call handler, who would record it as a warning note. There was therefore a risk that an unsuitable vehicle or staff without an appropriate skill set could be sent to an incident with a bariatric patient if this information was not offered during the initial emergency call.

- Interpreting services were available for people whose first language was not English. The service also had technology in place to receive emergency calls in other ways, including from internet-based telephone systems. This included an emergency text service for callers who were deaf, hard of hearing or had speech impairments. It also received calls via the Text Relay service. Staff across all three sites were familiar in the use of these services.
- If a caller or patient was identified as being hard of hearing, deaf, partially sighted or blind, staff added a warning note to the computer aided dispatch system. This information was passed to the ambulance crew by the dispatchers.
- The accessible information standard was introduced with the aim to make sure that people who have a disability or sensory loss get information they can access and understand, and any communication support that they need. By 1 April 2016, all organisations that provide NHS care needed to identify and record information and communication needs with people who used the service. Staff recorded any relevant information about communication needs that was shared by the caller in the call notes. However, emergency call notes were recorded against an address or location rather than against an individual person. This meant there was a risk that previously recorded communication needs would not automatically be reflected in later unrelated calls by the same caller.
- The trust's website complied to World Wide Web Consortium (W3C) Web Content Accessibility Guidelines, enabling text size to be increased, a high contrast version, and was designed to work with screen reader technology. Easy read information was provided on how to make enquiries, provide feedback, and make a complaint.
- Performance meetings were held daily within each site, which meant that senior and operational managers in each sector were able to consider and mitigate changing demands of the service through adjusting and flexing staffing levels, as required.
- These meetings identified if there were any delays in patient handovers at hospitals, anything that may affect staffing numbers required or performance, particularly response times, relocation or re-routing of vehicles. For example, we observed, in one meeting, that intelligence had been received about a large funeral taking place which could congest one of the main arterial routes. This information was passed to crews so they could take remedial action, if necessary.
- The computerised triage system generated a priority code from the answers provided by the caller to questions asked by the call handlers. Dispatch staff allocated the relevant type of response, and the skill mix of the crew, based on this code.
- Electronic screens, in each of the sites, displayed the number of calls answered, the number waiting to be answered, and performance against the target of answering 95% of calls within five seconds. Screens in the dispatch rooms displayed the day's performance for dispatching ambulances by the assigned code, and also the number of ambulances waiting in hospitals to handover patients, including the times taken to handover patients.
- The majority of monitoring screens in Preston were not commissioned due to a software supplier problem following the recent refurbishment. However, a temporary solution was in place to show the real-time call performance figures; the permanent solution was expected to be in place by the end of June 2016.
- Access to this data meant that supervisors were able to put measures into place if call handling performance fell; for example the procedure for disconnecting calls. Similarly dispatchers could respond by moving resources to different areas of the region. Dispatchers could also escalate delays in crews being released at hospitals to the ambulance liaison officer or the regional operational coordinating centre. During the inspection, we observed a large wait for ambulance crews to handover patients at one of the hospitals in the region,

Access and flow

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with the longest wait of 240 minutes. Staff told us that an ambulance liaison officer was to be sent to the hospital with the aim of improving handover and decreasing the waiting time.

- All managers had access to the live performance and daily performance information on the trust's intranet site. The data could be filtered by area or time period. This meant managers could respond if performance dropped; for example, by implementing the clinical escalation policy if appropriate.
- A performance manager and critical incident manager were based within each site to improve flow by monitoring response times, minimising delays at times of high demand, and by ensuring ambulance resources were allocated appropriately. For vulnerable patients, the critical incident manager ensured all appropriate actions were taken and clinical support provided, including contacting the patient's GP, if required. An operations manager was also based in the Preston site to assist with operational issues from ambulance crews, including hospital turnaround times.
- A red and amber pre-alert system was in place for notifying hospitals of incoming emergency vehicles. We observed this being used. However, staff in the trauma team told us there were sometimes challenges in responding to major trauma incidents due to availability of emergency ambulances. This was compounded by delayed handovers at local hospitals.
- HEMS team performance was monitored by a bespoke system. The Air Desk Information Sheet was planned and developed internally by one of the trust's HEMS desk dispatchers. The system provided quick and easy access to resources needed by the HEMS dispatchers, including relevant telephone numbers for other emergency and local services, and enabled each incident to be logged and notes added. This meant that managers were able to monitor HEMS performance.

Learning from complaints and concerns

- The trust's website provided information to callers or patients about how to complain, including details of a complaints advocacy service to support people who wanted to complain. The information was also available in an easy read format. Complaints could be made using the online complaint form, or in writing, by email or by telephone to the patient experience team.
- The trust's central complaints team logged each complaint about the EOC on the electronic incident reporting system. The complaint was then allocated to the relevant site sector manager or deputy sector manager for evidence gathering and investigation.
- Depending on the nature of the complaint, the recorded call was reviewed and the electronic logs of the triage and dispatch records were audited. This was to ensure the triage scripts were adhered to, that the trust's protocols were followed and that dispatchers and ambulance crews had responded correctly. If appropriate, staff involved in the incident were asked about their actions. When the investigation was concluded the response letter was drafted and sent to the complainant.
- Learning from complaints was shared with the individuals involved, by their line manager. Learning from systemic issues was shared with managers and supervisors by a memorandum or training bulletin. Although staff across the sites were aware of the general complaints process, none of the staff we spoke with were able to give us specific examples of changes that had made because of complaints.
- In Preston, the training team worked closely with staff when errors were identified from complaints and incidents. The training team provided bespoke coaching and protected learning time training plans for individual staff who were also supported and monitored by mentors.
- We reviewed six complaint records in the Preston EOC. The majority of these related to delayed arrival of ambulances. The records indicated that robust investigation with root cause analysis of each complaint was carried out. Identified mistakes were fed back to, and discussed with, the staff members involved irrespective of whether or not the complaint was upheld. Apologies were provided, where appropriate, and actions taken by the service were explained.
- In Manchester, a local complaints team was set up. This was initially on a trial basis to investigate a backlog of 50 complaints with staff seconded for a three month period. The team included a complaints manager, an

Emergency operations centre

experienced call handler and an experienced dispatcher. The team cleared the original backlog of complaints and, since April 2016, the team had received a further 63 new complaints.

- The team was in the process of setting up dashboards to highlight trends in complaints received and to identify themes that may involve learning for all staff. As the team had been successful, and had enhanced their understanding of complaints, it was expected there would be a local complaints team in each of the EOCs using staff seconded for approximately three months at a time.

Is emergency operations centre well-led?

Good



Although we found a regulatory breach relating to concerns with risk registers, we rated Well-led as 'Good' because:

- The service had a clear governance structure with accountable roles for staff and managers. An effective management structure led by the head of service for each area had been in place for approximately four years. This was supported by the area managers for each of the EOCs who met monthly with the deputy director of operations, business support manager and training manager at the EOC regional business management group.
- Detailed plans were in place for the future development of the urgent care desk, which were linked to the trust's strategy and understood by the desk's managers.
- A frequent calls group from across the trust's regions reviewed complex cases and, where appropriate, presented these to the clinical leadership team to approve actions to be taken. Staff told us feedback from frequent callers was positive.
- The impact on staff of changes to processes and procedures was assessed and monitored. Changes were implemented between Tuesdays and Thursdays, avoiding the busiest periods of the week, and reducing the impact on staff.

- Local leaders of the services were visible, approachable and very supportive. Staff told us they were confident in how the service was being led and felt supported at a local level.
- We saw good evidence of public engagement and education. The trust attended university fresher's weeks throughout the North West to educate new students and reduce the number of unnecessary emergency calls made to the service by students in their first few weeks at university.
- The service developed and implement public information campaigns, including 'Make the right call' and '#Team999' to educate people about the services available to them, and about the changing role of the ambulance service.
- The service introduced a 'Telehealth' scheme which enabled suitable patients to record their own vital sign measurements at home, and upload these through a secure internet service. The urgent care desk staff monitored the readings and would arrange a response to the patient if necessary.

However,

- Although the trust had an overall clear vision and strategy, there was no separate vision or strategy for the three EOC sites or plan for how they would contribute to the trust's vision and strategy. Not all staff understood the trust's strategy, how the trust's vision was to be delivered or how they individually contributed to it.
- Risks for the EOC were recorded in different documents but did not give a complete picture of the risks to each individual site or to the whole EOC service. The documents we reviewed did not provide assurance that all risks to the individual sites or to the EOC service as a whole had been clearly identified and mitigated.
- Most of the staff we spoke to in the Liverpool site did not know who the executive team were. Staff felt the executive team were not visible.
- Sickness rates in all three centres were higher than the trust average, with a consistently higher rate of sickness in Liverpool than the other sites.

Emergency operations centre

- There was inconsistency between the sites in the way that changes to procedures or announcements were communicated to staff. Some staff felt there was a risk they did not receive important communications.

Vision and strategy for this service

- Although the trust had an overall clear vision and strategy, there was no separate vision or strategy for the three sites or plan for how they would contribute to the trust's vision and strategy. An EOC manager told us the focus over the next year was to develop understanding about how staff contribute to the goals of the organisation.
- Staff in all three sites were aware of the overall vision of the trust of delivering the right care, at the right time in the right place. However, not all staff were clear about how they individually contributed to the vision, nor did they have an understanding of the strategy or how the trust planned to deliver the vision. Although staff were recruited against the trust values, senior management recognised the challenge faced by staff in understanding how to put the values into action.
- Managers at the urgent care desk had a clear vision and strategy for future development and understood how it contributed to the trust's strategy. The urgent care desk had detailed plans to develop its service, which were linked to the trust's vision. We attended a staff forum and all staff and managers clearly understood and could articulate the strategy for the urgent care desk.

Governance, risk management and quality measurement

- The service had a clear governance structure with accountable roles for staff and managers. The head of service for each sector had responsibility for their respective sites and emergency crews. This structure had been in place for approximately two years.
- Sector managers from the three sites met monthly with the deputy director of operations, the business support manager, training manager and other staff as deemed necessary at the EOC regional business management group. In between these meetings, weekly teleconference calls were held between the sector managers.
- Senior managers met monthly to discuss incidents, audits, performance and safety.

- A frequent calls group from across the trust's regions provided governance of the process and reviewed complex cases. These cases were presented to the clinical leadership group to approve actions where paramedics may need to treat a patient outside the JRCALC guidelines. Staff told us that feedback from frequent caller patients had been positive, and callers felt they were listened to.
- Monthly meetings were also held with local hospital acute trust directors, senior commissioners, and service improvement managers from NHS Improvement, who were involved in patient care.
- Risks for the EOC were recorded in different documents but did not give a complete picture of the risks to each individual site or to the EOC service as a whole. For example, some of the risks we identified on the inspection, such as an error on the call handling system which in-built tools could not be used were not on any of the risk documents. Other risks such as the EOC not being able to handle calls and dispatch vehicles because of technical problems or staffing issues were also not recorded. We could not be assured that all appropriate risks for the sites had been identified or mitigated.
- There was an ongoing EOC action plan that also evidently held risks as well as planned improvements and developments. The plan did not appear to differentiate between elements that were general improvements and those that were related to risks, and there did not appear to be any indication of pre and post risk scoring following agreed actions. However, the plan was clear about actions, responsibilities, review and completion dates and was updated on a regular basis and discussed at EOC level three sector meetings.
- Risks related to the HEMS desk were fed into the main risk register; these included delays to the dispatch of helicopters which was being mitigated through the desk's ability to monitor the radio channels for other emergency services.
- The urgent care desk held a risk register separate to the EOC action plan. This meant the urgent care desk were able to track risks affecting the triage process, the hear and treat, and the see and treat services.

Emergency operations centre

- Dispatch staff told us that the volume of calls and lack of resources was the single biggest risk for control room staff.
- There was an Urgent Care Development Team who were driving improvements in the urgent care and clinical hub teams. Demonstrable improvements had been made in 'hear and treat' of patients so that the trust had gone above national ambulance quality indicator targets in this area.
- Quality measurement took place against national ambulance quality indicators and statistics against the indicators could be extracted from a daily to a yearly basis.
- In Liverpool, staff told us new changes to procedures or policies were generally printed and put on their desks to read. Staff said that if they were working on a night shift the information may have been removed from their desk by the time they started their shift. There was a risk they may miss important information. Some staff told us that they would prefer face-to-face information about changes rather than printed information left on their desks.
- In Manchester small procedural changes were sent out to staff by the Departmental Business Support Manager and staff signed a document to show they had read through the changes. New guidelines and procedures were initially shared with the sector managers and training managers who in turn shared them with call handling and dispatch 'champions' on the teams for review. Feedback was given to sector managers for approval and the Departmental Business Manager finalised any changes before sending out the changes to EOCs. The Training Manager delivered bigger changes on a face-to-face basis with staff.
- In Preston, each staff member had a file for storing policies and procedures. Updated policies and procedures were printed and distributed directly to staff by the training lead. Staff were asked to sign they had received the updated document, and the previous version was collected for secure destruction. Protected learning time was also used, where appropriate, for staff to familiarise themselves with new information.
- Staff in Liverpool and Preston told us the executive team usually visited the sites over the Christmas period, which was a particularly busy time for the service. However, staff felt they were not visible and those that we asked had difficulty in recalling who the executive team were.
- Staff in Manchester told us the trust board were visible. Letters of thanks were sent to staff for coping with winter pressures. One staff member told us that, when they had been off long-term, the Chief Executive had sent their good wishes.
- All of the staff we spoke with said the local leaders of the services were visible, approachable and very supportive. Staff told us they were confident in how the service was being led.
- The leaders were skilled in all elements of the call handling and dispatching process and this was demonstrated during our inspection when leaders stepped in to enable staff to meet with us.
- The majority of staff felt supported by their direct line managers. Managers of call handlers and dispatchers sat with the staff they managed. We observed they were available to staff to provide help and assistance. Emergency call handlers said they felt supported by their supervisors when they had difficult or distressing calls.
- However, staff told us they did not always feel part of a wider team with the other centres.
- Senior staff were aware that the current ethnic mix of management and workforce staff in the Preston site was not reflective of the local population.
- Senior managers told us the trust was aware that it needs to consider how to deliver change to staff. Impact on staff was assessed and monitored through the 'piloting' of changes to processes and procedures. Changes were implemented between Tuesdays and Thursdays, avoiding the busiest periods of the week, and reducing the impact on staff.

Culture within the service

Leadership of service

Emergency operations centre

- In Liverpool many of the staff said that staff morale was affected by the building which was cramped with teams located in different rooms. This was compared to the other two sites which had been recently built or refurbished.
- Staff and managers also told us about allegations of bullying by managers in the past. However, staff said there had been a change in the culture of the service since new leadership came in.
- The combined average sickness rates across all three centres varied between 5.7% and 8.2% between April 2015 and January 2016. The individual sickness rates at all three centres were consistently higher than the trust average. Liverpool consistently reported the highest sickness rate of the three sites, with between 8% and 11.5% days lost to sickness each month for the same period.
- Senior staff in Preston told us morale had improved following the refurbishment of the centre, with improved engagement of staff. Staff were currently involved in the design and development of a 'word cloud' design for wall art in the centre. This focused on what was important to staff in their jobs. A staff communication board displayed a range of bulletins on operational and wellbeing information.
- Staff in Manchester told us that the Manchester site was a nice working environment and friendly. They said they felt well supported in their work and when off sick and they felt able to speak to a manager who would offer them some time out when they had taken a distressing call. Staff told us there were a lot of staff who had worked in the centres for a long time, which they felt was testament to a positive working culture.
- Staff suggestion boxes were in place. Suggestions were reviewed at the sector partnership meetings.
- Staff at every EOC site told us the audit process was stressful and affected morale. They said audits were 'too picky' and staff were concerned about saying anything outside the system prompts in case they would fail their audit. This often resulted in increased supervision and audits.
- The service launched an information campaign called 'Make the Right Call' to educate people about the services available to them if they or their family members or friends were unwell. The campaign included a website and online videos.
- Volunteer groups visited the centre to see and build an understanding of the work undertaken by the EOC. Carers had also been encouraged to visit the centre.
- The service engaged in a number of public events, including Mela events (a celebration of Asian culture) with trust stands promoting cardio-pulmonary resuscitation; community first responder events; lesbian, gay, bisexual and transgender pride events; and visiting local schools.
- The trust had recognised that, when there was an influx of new students to the region's universities, there was a rise in the number of emergency calls made to the service. The trust had been proactive in minimising the numbers of unnecessary emergency calls by attending university fresher's fairs with the aim of encouraging new students to register with a GP, inform them when it appropriate to call 999, introduce the NHS 111 service, teach CPR and defibrillator skills and share useful literature.
- Staff were also involved in the trust's '#Team999' campaign. The campaign aimed to educate the public about the changing roles of the ambulance service through the use of social media.
- The EOC held staff forums for call handlers, dispatchers and urgent care desk staff. Staff had an opportunity to ask leaders of the services any questions. We observed staff forums in both EOC Liverpool and EOC Manchester; managers were open and gave staff an opportunity to suggest ideas, for example about a new rota design for urgent care desk staff.
- A monthly staff newsletter was launched in December 2015 for EOC Liverpool staff. This was displayed on noticeboards in the EOC.
- We found that methods of communication with staff on procedural or policy changes varied in quality between the three EOCs.
- Staff in 999 call handing and dispatch teams in EOC Liverpool did not routinely have team meetings. Staff

Public and staff engagement

Emergency operations centre

told us information would be shared with them in different ways. Call handling teams had designated safety champions who shared important information, such as changes to the systems.

- Staff were recognised in the trust's 'Going the Extra Mile' (GEM) awards, and within the EOC for no critical or major deviations from MPDS call triage script. However, one staff member told us managers were 'quick on negatives not on positives'.
- A copy of compliments, thank you letters and cards and accompanying commendations were given to the appropriate staff member by senior managements. These were also copied to the Head of Service. An 'I've delivered a baby' certificate was presented to any staff member who had helped a family to deliver a baby while waiting for the emergency vehicles to arrive.
- Staff audit performance was recognised with bronze, silver and gold badges given to staff who had achieved a determined number of audit commendation letters within a year.

Innovation, improvement and sustainability

- In 2015/16 the service was involved in a pilot where clinicians from the urgent care desk were seconded to

police force control rooms to triage police incidents that would ordinarily be passed to the service and would generally require an ambulance to respond. The clinicians had access to the service's systems and triage tools.

- In January 2016, the service started a 'Telehealth' scheme. Patients identified as being suitable for the scheme were given equipment to record their own vital signs such as blood pressure, oxygen saturation, pulse and weight. These measurements were uploaded to a secure internet server each day by mobile telephone and monitored by urgent care desk staff. When there was an alert, urgent care desk staff would arrange a response.
- Emergency call handlers were awarded certificates for outstanding performance in monthly call audits. We saw certificates displayed on a noticeboard with the names of staff who had performed well.
- The Preston EOC planned to expand the availability of support on the clinical support desk, with the aim of introducing mental health, pharmacy and midwifery expertise. The aim was to provide more streamlined advice to crews for specialist incidents.

Outstanding practice and areas for improvement

Outstanding practice

In Emergency and urgent care services

- The HART teams in both Manchester and Merseyside were delivering an excellent service to patients. They were proactive in their approach to gaining new skills and forging relationships with other emergency services, to ensure the smooth running of rescues in difficult areas. Their co location with the fire service training headquarters in Merseyside afforded them and all NWAS staff excellent and unique training opportunities. This ensured that they were equipped to deal with and manage a wide range of hazardous emergencies and undertaken formalised de briefs in a multidisciplinary manner.
- The service had community care pathway designed to share information across services and ensure ambulance clinicians were aware of pre-existing care plans for patients being managed by community services. This included when it was most appropriate for patients to be treated at home, involving other professionals or conveyed to an alternative care setting than an emergency department. This was also supported in some areas by the long term conditions teams based at local hospital trusts.
- The community engagement manager was in the process of implementing an electronic application

initiative called 'Good SAM'. This application could be downloaded onto mobile devices and alerts users who have been vetted and checked to a nearby cardiac arrest. Through this initiative the manager had also mapped all defibrillators in the North West area and from August 2016, this information would be available to call centre staff so that they could direct members of the public attending cardiac arrests to these devices.

- All staff we observed were exceptionally caring in their approach and went above and beyond their duty to provide compassionate, supportive care.

In Emergency operations centre

- The introduction of the Manchester local complaints team, operated by seconded experienced staff, cleared the backlog of complaints. As part of this the team was developing dashboards to highlight complaint trends and to identify themes that may involve learning for all staff. The team had been successful, and had enhanced their understanding of complaints, it was expected there would be a local complaints team in each of the EOCs using staff seconded for approximately three months at a time.

Areas for improvement

Action the hospital MUST take to improve

In Emergency and urgent care services

- The service must ensure staff are given adequate opportunities to report incidents and safeguarding issues.
- The service must ensure that staff are reporting all adverse incidents in line with NWAS policy.
- The service must ensure all staff receive the required level of mandatory training.
- The service must ensure that all staff receive the required level of mandatory safeguarding training and ensure that there is a mechanism to check that staff have completed this training.

- The service must ensure all community first responders have the required level of training to undertake their role including how to recognise and act on safeguarding issues.
- The service must ensure that vehicle log books are completed fully and that checks undertaken by managers reflect the true content of the log books.
- The service must ensure that all equipment used in the delivery of patient care is subject to the appropriate and required checks, including that held by the community first responders.
- The service must ensure that vehicles receive deep cleaning when required.

Outstanding practice and areas for improvement

- The service must ensure that controlled drugs are stored, managed and checked in line with trust policy and national legislation.
- The service must ensure that all staff involved in the administration of medical gases, for example Entonox, have received the required level of training to ensure they are competent to undertake this duty.
- The service must ensure there are adequate numbers of suitably qualified staff deployed in all areas.
- The service must ensure that all guidelines and policies used in the delivery of patient care are reviewed and updated at the frequency required.
- The service must ensure that patients have timely access to care and treatment in line with national targets.
- The service must ensure all staff received their annual appraisal.
- The service must ensure all staff have received the required level of training to ensure they are able to exercise their duties in line with the Mental Capacity Act (2005).
- The service must ensure that the consent policy and guidance on mental capacity assessments issued to staff is in line with the Mental Capacity Act (2005) code of practice. The service must ensure that there is specialist equipment and training for staff to safely manage the care of bariatric patients.
- The service must ensure that staff received back up when requested in a timely way.
- The service must ensure that risks are appropriately documented, reviewed and updated.
- The service must ensure that any allegations of bullying are taken seriously and managed appropriately with support provided to the staff involved.
- The trust must ensure that all risks on the risk register are fully completed and updated with clear actions identified.

In Emergency operations centre

- The service must ensure that staff are reporting all adverse incidents in line with NWAS policy and ensure all staff have received appropriate training on the incident reporting system.
- The service must ensure lessons learned from incidents and complaints are shared across the three sites.

- The service must ensure that all safeguarding concerns are reported in line with the NWAS policy and must improve staff awareness of the safeguarding policy.
- The service must ensure all staff receive their annual appraisal.
- The service must ensure that risk registers clearly document short and long term risks local to each emergency operations centres (EOC) site as well as to the EOC service as a whole, including control measures that have been identified and implemented, and planned.

In Patient transport services

- The service must ensure that investigation reports fully reflect the actions taken during an investigation and provide a summary of the root cause of the incident and the lessons learned, in line with trust policy.
- The service must ensure patient information is kept confidential. The management of patient information provided to volunteer drivers did not promote confidentiality.
- The service must finalise its existing PTS structure and quality reporting framework to ensure that there is a clear oversight of escalation and monitoring of governance, risks and performance of the service.

Action the hospital SHOULD take to improve

In Emergency and urgent care services

- The service should consider implementing systems to ensure that feedback from incidents and investigations is consistent and accessible to all staff including community first responders.
- The service should ensure that communication aids for patients with visual or mental capacity impairments are available.
- The service should consider providing training to all frontline staff on the Duty of Candour and their responsibilities in relation to this.
- The service should consider ensuring that staff with level three safeguarding training are available for staff to access for advice and guidance.
- The service should consider providing training on key safeguarding subjects which crews may come across such as female genital mutilation, radicalisation recognition and human trafficking.

Outstanding practice and areas for improvement

- The service should consider implementing a system to ensure the key codes to access keys in the ambulance stations are changed regularly.
- The service should ensure that all records are completed fully and legibly.
- The service should consider implementing a system by which all staff members involved in the care of the patient can sign for the care they have delivered.
- The service should consider ways to improve staff compliance with the use of patient pathways and care bundles.
- The service should ensure that patients can be provided if necessary with information on how to feedback about the service.
- The service should ensure that complaints are dealt with consistently and in line with trust policy.
- The service should ensure that staff are aware of the trust vision and values.
- The service should consider implementing a more consistent way of monitoring of performance and quality across the regions.
- The service should improve staff engagement and address areas of low morale.

In Emergency operations centre

- The service should improve EOC staffs' skills in managing calls from children or from people who may have mental health problems, those who may be in crisis, and those living with dementia or learning disabilities.
- The service should improve communication across all EOC teams, including those working night shift patterns, of changes to procedures or announcements.
- The service should improve accessibility, and readability, of information transferred by the system to the EOC from NHS111, including the reduction of duplication of information.
- The service should raise awareness among all EOC staff on the trust's vision and strategy and how they can contribute to it.
- The service should consider how the environment at the Liverpool site can be improved, including what reasonable adaptations may be needed for staff who have reduced mobility.
- The service should review the policy for deploying the HART team and how it reflects the way in which the triage and dispatch system operates in practice.

- The service should review the use of the MPDS system in terms of the tools not being available when a second follow-up call is made.
- The service should review the procedure where lower priority calls referred to the EOC by NHS111 are re-triaged by urgent care desk staff.
- The service should review the Mental Capacity Act (2005) training for all staff.
- The service should complete the review of the clinical escalation plan.

In Patient transport services

- The service should ensure all staff have timely access to a computer in order to submit electronic incidents or safeguarding referrals.
- The service should consider facilitating ambulance crews to meet regularly to ensure new developments and lessons learned from local, trust wide and national incidents can be shared and discussed.
- The service should explore that all recorded safeguarding incidents have been appropriately referred and that PTS staff are aware of what constitutes abuse or neglect and that they are all clear about the referral process.
- The service should review the staff training requirements for the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) guidelines to provide a common understanding of how patients are cared for in accordance with their best interests.
- The service should review its process for maintaining all vehicles in good visual repair and that rusty items are replaced as quickly as possible.
- The service should review its process for reviewing and updating policies and procedures as appropriate.
- The service should consider implementing regular refresher driving courses or skills checks for PTS drivers.
- The service should review the process for ensuring that DNACPR documentation travelling with the patient is in the appropriate format.
- The service should review the process for responding to and investigating complaints to improve the timeliness of this procedure.
- The service should review its process for including operational issues within a strategic overview or central risk register related to internal risks.

Outstanding practice and areas for improvement

- The service should review its PTS operating model to produce a formal vision and strategy for PTS linked to the overarching organisation vision and strategy.

Requirement notices

Action we have told the provider to take

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

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 11 HSCA (RA) Regulations 2014 Need for consent

Regulation 11 (1)(2)(3) HSCA 2008 (Regulated Activities) Regulations 2014 (Part 3)

In Emergency and Urgent Care:

- Consent was not always sought from the patient themselves and due consideration to mental capacity was not given when making these assessments.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulation 12 (1)(2) (a)(b)(c)(e)(g)(h) HSCA 2008 (Regulated Activities) Regulations 2014 (Part 3)

In Emergency and Urgent Care:

- Incidents were not always reported and feedback from these was inconsistent.
- Staff were not given time to report incidents.
- Mandatory training levels were low.
- Vehicles were not deep cleaned at the required times.
- Infection control log books were not completed consistently.
- Equipment used by first responders was not checked consistently.
- There was not sufficient equipment to manage bariatric patients on all vehicles.
- Staff experienced delays in receiving requested back up.

This section is primarily information for the provider

Requirement notices

- The trust was not meeting the national targets for response times for emergency calls.

Regulated activity

Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulation 13 (1)(2)(3) HSCA 2008 (Regulated Activities) Regulations 2014 (Part 3)

In Emergency and Urgent Care:

- Staff were not given protected time to refer adult safeguarding issues.
- First responders did not receive any safeguarding training.
- The safeguarding training provided for staff did not have any managerial oversight and therefore there was no way to confirm how many staff had undertaken the training.

Regulated activity

Regulation

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulation 17 (1)(2)(a)(b)(c) HSCA 2008 (Regulated Activities) Regulations 2014 (Part 3)

In Emergency and Urgent Care:

- Risks on the risk register were not completed or updated and actions were not clear.
- Some records were incomplete or contained errors.
- One policy was three years overdue for review.

Regulated activity

Regulation

Treatment of disease, disorder or injury

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulation 18 (1)(2)(a) HSCA 2008 (Regulated Activities) Regulations 2014 (Part 3)

This section is primarily information for the provider

Requirement notices

In Emergency and Urgent Care:

- There were high numbers of vacancies in certain staff groups.
- The percentage of annual appraisals was low in all areas.
- Staff reported feeling bullied and isolated.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 (Part 3)

Safe care and treatment

In Emergency operations centre:

How the regulation was not being met:

People who used the emergency operations centre (EOC) service were not protected against risks associated with unsafe care and treatment. This was because, during our inspection of the service:

- Incidents aware not always reported and feedback from these was inconsistent.
- Staff were not given time to report incidents.
- Lessons learned from incidents were not consistently shared across the three EOCs.

This was a breach of Regulation 12(1)

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2014 (Part 3)

Safeguarding service users from abuse and improper treatment

In Emergency operations centre:

Requirement notices

How the regulation was not being met:

People who used the EOC service were not protected against safeguarding risks of abuse and improper treatment. This was because, during our inspection of the service:

- The safeguarding policy was not embedded and not all staff were reporting safeguarding concerns in line with the policy.
- There was no routine system in place to establish if the crews had considered or acted on any safeguarding information passed to them from the EOC.

This was a breach of Regulation 13(1)(2)(3)

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 (Part 3)

Good governance

In Emergency operations centre:

How the regulation was not being met:

The EOC systems and processes were not operated effectively across sites to ensure the assessment, monitoring and improvement of the quality and safety of the services provided This was because during our inspection of the service

- The risk registers in use did not give a complete picture of the risks to the individual centres or the EOC as a whole.

This was a breach of Regulation 17(1)(2)(a)(b)

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Requirement notices

Regulation 17. (1)(2) of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014:

Good Governance

In Patient transport services

Systems or processes must be established and operated effectively.

How the regulation was not being met:

The service did not adequately monitor the quality and safety of service provision to identify or manage risks in order to assure people's welfare and safety. Systems for monitoring and reviewing the service were not robust and embedded within the service.

Risks identified within the organisation were not always identified and those that had been identified were not always managed effectively.

The management of patient information provided to volunteer drivers did not promote confidentiality.

Regulation 17 (1)(2) (a)(b) (d)(f)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

The table below shows why there is a need for significant improvements in the quality of healthcare. The provider must send CQC a report that says what action they are going to take to make the significant improvements.

Why there is a need for significant improvements	Where these improvements need to happen
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Start here...

Start here...