

South Central Ambulance Service NHS Foundation
Trust

South Central Ambulance Service NHS Foundation Trust

Quality Report

Unit 7-8 Talisman Business Centre

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Date of inspection visit: 3-6 May 2016 and
unannounced 13 and 16 May 2016

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This report describes our judgement of the quality of care at this provider. It is based on a combination of what we found when we inspected, other information 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



Summary of findings

Letter from the Chief Inspector of Hospitals

South Central Ambulance Service covers the counties of Berkshire, Buckinghamshire, Hampshire and Oxfordshire. There are also NHS 111 services in Luton and Bedfordshire. This area covers approximately 3,554 square miles with a residential population of over four million.

South Central Ambulance Service NHS Foundation Trust (SCAS) is part of the National Health Service (NHS). They were established on the 1 July 2006 following the merger of four ambulance trusts. On 1 March 2012, the trust became a foundation trust. The emergency operations centres handle around 500,000 emergency and urgent calls each year.

The trust provides an accident and emergency (A&E) service to respond to 999 calls, a 111 service for when medical help is needed fast but it is not a 999 emergency, patient transport services (PTS) and logistics and commercial services. The trust also provides Resilience and Specialist Operations offering medical care in hostile environments such as industrial accidents and natural disasters including a Hazardous Area Response Team (HART) based in Hampshire.

Services are delivered from the trust's main headquarters in Bicester, Oxfordshire, and a regional office in Otterbourne, Hampshire. Each of these sites includes an emergency operations centre (EOC) where 999 and NHS 111 calls are received, clinical advice is provided and from where emergency vehicles are dispatched if needed. There is a PTS contact centre at each EOC. The trust also works with air ambulance partners; Thames Valley and Chiltern Air Ambulance (TVAA) and Hampshire and Isle of Wight Air Ambulance (HIOWAA).

The trust also offers the following services: First Aid Training to organisations and the public, a commercial logistics collection and delivery service for our partners in the NHS, and Community First Responders (volunteers trained by SCAS to provide life-saving treatment).

We inspected this location as part of our planned, comprehensive inspection programme. Our inspection took place on 3 to 6 May 2016 with unannounced visits on 13 and 16 May 2016. We looked at three core services: access via emergency operations centres, patient transport services and emergency and urgent care including Resilience and Specialist Operations. The 111 service provided by the trust was inspected separately. The logistical and commercial training services were not inspected as these do not form part of the trust's registration with the Care Quality Commission (CQC). During the inspection we visited both ambulance premises as well as hospital locations in order to speak to patients and staff about the ambulance service.

Overall, we rated this location as requires improvement. We rated, emergency operations centre (EOC) as good and emergency and urgent care and patient transport services as requires improvement.

Overall, we rated the trust as being good for caring and responsive services and requires improvement for safe, effective and well led services.

Our key findings were as follows:

Are services safe?

- Staff were clear about their responsibilities to report incidents and there was a culture of learning from incidents that was promoted in the trust. However, not all staff received feedback from incidents or had the time to report incidents when they happened, particularly in patient transport services (PTS).
- Processes to protect people from harm, such as infection control, the cleanliness of vehicles, the safe handling of medicines and equipment and vehicle safety checks were being followed, although this was inconsistent in some areas.
- Patients were appropriately assessed and appropriate action was taken in response to risk.
- Patient records were accurately kept and special notes were kept for patients with specific conditions. Records were stored securely.

Summary of findings

- Staff were aware of safeguarding and how to recognise and report abuse or neglect. The trust however, did not have formal systems to ensure safeguarding alerts were sent in a timely way out of hours or at the weekend. If issues were urgent, then the police would be informed.
- Overall, levels of compliance for statutory and mandatory training did not meet trust targets. This was mainly due to operational pressure, although in some areas time allocated to training had not been broadened to include this essential training. The trust was affected by the national shortage of paramedics and had staffing vacancies across all services, in the operations centres and in patient transport services. Action was being taken on recruitment and bank, agency and independent providers were being used to fill staffing gaps. However, many staff were working long hours, some without breaks and they were working under pressure to meet performance targets. Staffing rotas had been changed to meet peaks in demand, but this was affecting staff work /life balance. The trust was working to introduce new rotas to improve the work life balance of staff, whilst continuing to meet the challenge of rising demand.
- The ambulance service was classified as a Category 1 responder under the Civil Contingencies Act 2004. Category 1 responders are the organizations at the core of a major emergency response. The trust understood their duties under the Civil Contingencies Act 2004 and staff were of their responsibilities. The trust worked with partners to improve the ways in which police, fire and ambulance services worked together at major and complex incidents. Pre-identified high-risk sites in the region were identified so there could be an effective coordinated response in a local area, there were joint training events with other services, such as the police and fire services, and the trust participated in emergency plans and rehearsals to be able to respond to chemical, biological, radiological, nuclear or explosive incident scenarios.

Are services effective?

- Care and treatment for patients was planned taking account of current evidence based guidance, standards and best practice. Clinical and medical protocols were used to ensure standards met national practice guidelines.
- The trust monitored national ambulance quality indicators in emergency and urgent care services. There was less evidence of the routine use of clinical audit to monitor standards of care.
- The average time to respond to emergency calls was worse than the England average and the trust had some of the longest call waiting times. The trust was taking action on this. The proportion of the calls abandoned before being answered had decreased and was now better than the England average.
- The proportion of the calls abandoned before being answered had decreased and was now better than the England average.
- The trust was performing above the England average for emergency calls resolved by telephone advice and support only ("hear and treat").
- The trust performed above the England average for the number of patients managed without need for transport to hospital, referred to as 'see and treat'. The re-contact rate for patients, that is, for patients who called the services within 24 hours of their first call, was similar to the England average.
- Response targets for 999 emergency services for patients with life threatening or urgent conditions were not being met. The trust had an improvement plan in place.
- Following a cardiac arrest, the Return of Spontaneous Circulation (ROSC) (for example, signs of breathing, coughing, or movement and a palpable pulse or a measurable blood pressure) is a main objective for all out-of-hospital cardiac arrests, and can be achieved through immediate and effective treatment at the scene. Percentage of patients with ROSC at time of arrival at hospital was better than England average. However, using the Utstein Comparator Group (a more comparable and specific measure of the management of cardiac arrest) the percentage of patients with ROSC at time of arrival at hospital was worse than England average.
- A response targets for the transport of mental health patients in crises who needed a place of safety (section 136) within 30 minutes was being met for 74% of patients. The trust was above the England average of 62% (range 31% to 90%).

Summary of findings

- Most patients who had suffered a stroke received an appropriate care bundles. However, patients who had suffered a heart attack did not always receive an appropriate care bundle. The trust was implementing a recovery action plan to improve this.
- The trust was above national targets for using care bundles for hypoglycaemia, limb fractures, and febrile convulsion. The trust had not met the target for asthma care.
- New contracts had extended the operating hours of the patient transport service (PTS), to support the development of a seven-day service. However, key performance indicator data for 2015/16 showed PTS target times had not consistently been met for the arrival and collection of patients following hospital outpatient appointments or discharge. Transport times for renal patients in general met national standard times and had significantly improved from the previous financial year.
- There was effective coordination of services with other providers and good multidisciplinary working to support seamless care, admission avoidance and alternative care pathways. For example, hospital ambulance liaison officers and hospital liaison officers were viewed positively by hospital staff to coordinate emergency ambulance services and patient transport services respectively.
- Staff had good induction procedures and access to training. The trust was supporting staff to enhance their roles, for example, specialist paramedics. However, many paramedic staff identified difficulties with accessing training and qualification opportunities.
- Many staff did not receive regular supervision although, most staff had an appropriate annual appraisal. Some staff in PTS services had not received a recent appraisal.
- Staff followed consent procedures. Many staff did not have a clear understanding of the Mental Health Act, although this had improved for staff working in emergency 999 services and there was support for staff from mental health practitioners.

Are services caring?

- Staff across all services were caring, compassionate and treated patients with dignity and respect. Patients were positive about the service they received and the way they were treated.
- Staff supported patients to cope emotionally with their care and treatment. They were also supportive and reassuring when dealing with patients who were distressed.
- Call handlers took time to ensure callers understood the advice and to explain treatment or expectations to callers in a way the callers could understand.
- Ambulance crews explained treatment and care options in a way that patients understood and involved them and their relatives in decisions about whether it was appropriate to take them to hospital or not.
- Care was outstanding in patient transport services where patients reported well developed supportive and caring and trusted relationships particularly regular users, such as renal or mental health patients. Patients appreciated this personal approach and the respect shown by staff for their social and emotional needs.
- Patients could receive advice from clinicians to manage their own health. Clinicians would also provide information to patients about managing conditions if symptoms worsened and would signpost patients to alternative services non-emergency services such as their GP or local urgent care centres.
- There were only a few examples where patients had highlighted being treated inappropriately and without care.

Are services responsive?

- The trust had developed services in order to meet the needs of the local population and respond to the increasing demand for emergency and patient transport services. Many services were being introduced to manage demands on the service, avoid hospital admissions and refer patient to alternative non-urgent pathways of care.
- The emergency operations centres had clinical specialists, for example, in mental health, and support staff. More community first responders (CFR) and co-responders were being used to respond to emergency calls.

Summary of findings

- Prolonged delays at some acute hospital's emergency departments had reduced the capacity of front line staff to respond to patient's needs. The number of long waits for an ambulance had steadily increased.
- Action was being taken to address the increasing demand for emergency ambulance services. There were demand practitioners in post to manage frequent calls and provide patients with individual care plans. Services were being developed to ensure waiting times for an ambulance arrival met national targets, for example, more resources were being identified to support GPs calling for an ambulance calls. More specialist paramedics had been employed who could treat patients at the scene or at home in order to avoid hospital admission.
- The air ambulance services could respond to calls within their region within 15 minutes. In addition, night flying had commenced (until 2am) to meet the demand of the service.
- Patient transport services (PTS) had been extended to operate over seven days. The service was accessible to all eligible patients irrespective of any additional needs. Staff could identify patients who needed prompt transport, for example, if they had significant pain, a chronic illness or were to receive a home care package from the detailed notes. However, the electronic systems did not flag patients as a priority for collection to ensure this happened in a systematic way.
- Patients and staff experienced delays when calling the contact centres to identify when transport would be available. Call response times were not met. A new on line PTS booking system had been introduced to try to reduce delays. The online 'book ready' system was also introduced to prevent vehicles being sent when a patient was not ready for collection. The system also allowed hospital staff to see the estimated time of arrival. Patients could access this information through the 'my booking' section of the trust website.
- There was support for vulnerable patients, for example, people with a mental health condition, a learning disability and those living with dementia. Staff told us they had more awareness of meeting the needs of vulnerable patients.
- There was provision to provide ambulance transport for bariatric patients.
- Staff had access to translation and interpreter services for people whose First language was not English. Callers also had access to services that supported patients with hearing and speech impairments
- There was a clear process for the management of complaints, staff were aware of their responsibilities, and complaints were investigated at local level. However, information and learning from complaints was not always shared effectively in PTS services. The trust was not routinely responding to complaints in a timely manner.

Are services well-led?

- Services had a clear vision and strategies were being developed or revised to take account of increasing numbers of emergency admissions and changes to patient transport services.
- Staff were engaged with the trusts vision and strategy and displayed the trusts values in their own work.
- Many staff were positive about their local leadership and felt supported within their teams. Team leaders were given support and training to do their roles
- Staff were proud to work for the organisation, although staffing pressures were affecting staff moral and wellbeing. Staff in all areas were working long hours and under pressure with late or missed meal breaks. Many staffing cited disruptions to their work/ life balance. The trust was recruiting to all roles including overseas recruitment for paramedics. They were also supporting staff development and training some emergency medical technicians to paramedic level.
- Governance arrangements to monitor the quality and safety of services were in place. The level of staff involvement and understanding, the feedback and sharing of information and the monitoring of services through audit varied. Staff in frontline emergency 999 services had an awareness of risk but sometimes lacked knowledge on the progress being made and the action being taken to manage locally identified risks.
- The trust could demonstrate some improvements to the service following the last inspection in September 2014.
- Not all staff groups were given the opportunity to attend team meetings and some did not have time to attend team meetings. This did limit opportunities for some staff to raise concerns, share in learning or contribute to service development.

Summary of findings

- There was a focus on improving the health and wellbeing of staff and the trust had recognition and reward schemes for staff.
- Services could demonstrate innovative practices.

We saw several areas of outstanding practice including:

- A smartphone triage app had been produced in conjunction with the Wessex Trauma Network. This meant clinicians could use the triage tool to identify if their patient needed to bypass a local hospital and be conveyed directly to a major trauma centre, and which one was the closest.
- The trust had introduced demand practitioners and emergency care practitioners (specialist paramedics) to support patients to manage their own health conditions at home and to treat patients without the need for hospital admission.
- The trust uses a mobile simulation vehicle which offers an innovative approach to training for staff.
- Mental Health practitioners are in control contact centres at weekend peak times. They are piloting direct referrals to Samaritans and local mental health teams. This has improved timely patient access to mental health services.
- The Berkshire Hub connects services together as a single point of access location. The Hub includes out of hours, community, minor injury and illnesses and mental health services. There are shared records and special patient notes for patients. The Hub has increased access to NHS, GP, dental, pharmacy, mental health and labour line services.

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

Importantly, the trust must ensure:

- Staff in urgent and emergency care are supported with their development through supervision
- Response times for emergency and urgent care services are met.
- Governance arrangements in emergency and urgent care services must ensure that staff are aware of risks and safe practices are consistently applied.

In addition the trust should ensure:

- Staffing levels across all services meets planned levels identified by the trust.
- Review compliance with appraisals and mandatory and statutory training, including safeguarding training, to ensure that staff are supported to complete the required training in a timely.
- Ambulance response bags are appropriate for use and are replaced when necessary.
- Noise levels in Northern House are reviewed to minimise the risk of missing, miss-hearing or delays in recording patient information.
- Escalation procedures for the immediate handover of emergency patients are developed and agreed with all hospital trusts.
- The process for making safeguarding referrals to local authorities is reviewed and referrals happen in a timely manner to ensure safety of vulnerable patients outside of normal working hours.
- All medicines must be safely managed at all times, particular attention must be given to the safe management of controlled drugs.
- All staff should have adequate training in mental health and dementia awareness, which is updated at regular intervals to ensure that mental health knowledge is current.
- All complaints should be investigated and responded to in a timely manner in line with the trust policy.
- The structure of team meetings should be in place for all staff groups to ensure staff are given the opportunity to attend, share information and raise issues or concerns.
- The processes for sharing the learning from incidents, safeguarding and complaints with staff is reviewed to ensure staff are using this information to improve the quality of care provided to patients.
- Health and safety risk assessments are completed at resource centres.

Summary of findings

- Rest breaks for all ambulance staff should be planned into their schedule, compliance monitored and action taken to ensure staff well-being.
- Staff comply with hand hygiene and infection control policies with regular infection control audits to check compliance across the PTS.
- The risks associated with lack of connectivity for PTS staff working in rural areas is reviewed and ensure staff, particularly lone workers, are able to summon help through their PDAs in an emergency, and the reliability of this system is monitored.
- There is clarity in the standard operating procedure and policy for the administration of oxygen to patients by frontline PTS and this process is clearly understood by staff.
- Current systems for PTS are reviewed so patients with the greatest need are more easily identified as priorities for patient transport.
- There is a standard approach to record minutes for meetings across the PTS. These should be in sufficient depth and recognised as being a formal document, with the content written in a style to reflect this.
- Improve the recording of the authority to administer or supply a medicines under a PGD
- Medicine modules are managed correctly, and tamper evident tags are consistently recorded.
- All patient records are kept securely and disposed of in line with trust policy.
- Staff are given the time and opportunity to report incidents in emergency and urgent care services and they have appropriate feedback.
- The time allocated for staff to complete vehicle checks at the start of each shift is reviewed and actioned appropriately so that staff have sufficient time to complete the task.
- The current recruitment drive continues, while monitoring and taking action on the health and wellbeing of the current work force, including the impact of shift rostering and any changes implemented.
- Continues to work with commissioners and other providers to improve response times and their ability to meet their key performance indicators and national targets..
- The reasons for staff turnover and low morale across all services is continually addressed.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Emergency and urgent care services

Requires improvement

Rating



Why have we given this rating?

Overall we rated emergency and urgent care services as requires improvement. We found the service requires improvement for effective and well led and was good for safe, caring, responsive services.

Front-line 999 services provided an emergency response to people with life threatening emergency or urgent conditions. The service had met its emergency response times for calls to be responded to within eight minutes up until May 2015. Since then there had been a decline in performance, and the target times had not been met. The national target time for patients to have ambulance transport to hospital within 19 minutes was also not met. The number of patients discharged, after treatment at the scene or who had onward referral to an alternative care pathway rather than a hospital “see and treat” was above the England average.

The trust used a Resource Escalation Action Plan (REAP) in order to plan for additional resources in the event of operational pressure being experienced . There was moderate pressure on the service during our inspection and the trust was communicating effectively with hospitals to align conveyancing decisions against waiting times and the capacity to receive patients. There was effective coordination of services with other providers and good multidisciplinary working to support seamless care, admission avoidance and alternative care pathways

The service followed safety procedures overall, but needed to improve the consistency of mandatory training, incident reporting, infection control, medicines management, and vehicle checks. The service was affected by a national shortage of paramedics within the NHS and in some areas there were a high number of vacancies. Active recruitment had been undertaken in Australia and Poland during the previous year and this had improved the situation, as well the use of bank and agency staff

Summary of findings

and independent providers to fill gaps. However, some staff we spoke with reported that they sometimes finished late, or missed meal breaks. Many staff reported being frustrated and tired.

National evidence-based guidelines were used to assess and treat patients. National ambulance quality indicators were being used. However, clinical audit needed to be further developed to monitor standards of care. Patients experiencing a stroke received an appropriate care in line with the England average. However, patients who had a heart attack were transported quickly to centres for treatment but did not always receive an appropriate care by ambulance staff. The trust was implementing an action plan which was being monitored by commissioners. Patients with a mental health condition that required a place of safety were being transported within 30 minutes to a designated location.

Staff reported that they felt extremely well supported by their local management teams and they had access to clinical advice although this was sometimes difficult to obtain in a timely way. However, the trust was not reaching its targets for the completion of mandatory training and staff reported that face to face training was cancelled when there was insufficient emergency cover. Staff were positive about the appraisals but many had not received appropriate trainee mentorship, supervision or a current appraisal. New staff had received appropriate induction and support.

Staff were caring and compassionate to patients and people that were important to them. They gained consent for assessment and treatment and explained treatment options in a way that the patient could understand. Patients and their relatives and carers received good emotional support.

The trust was dealing with an increasing number of emergency calls and was developing alternative pathways to transport to hospital. Long waiting times for an ambulance was steadily increasing and the trust was developing services to reduce these and increase its use of community first responders, identifying further resources for GP ambulance calls,

Summary of findings

and employing specialist paramedics to who could treat patients at home in order to avoid hospital admission. The trust was above the national average for treating people without the need for further transport. Demand practitioners were working to reduce the number of inappropriate calls and frequent callers to the service. The air ambulance services could respond to calls within their region within 15 minutes. In addition, night flying had commenced (until 2am) to meet the demand of the service.

There was support for vulnerable patients, for example, people with a mental health condition, a learning disability and those living with dementia. Staff told us they had more awareness of meeting the needs of vulnerable patients. Complaints to the service were mainly about delays and these were handled appropriately but were not being responded to within the trusts' own target of 25 days.

The trust was revising its strategy for the service to take account of operational demands. There was still an emphasis on providing mobile healthcare and to coordinate care in hospital, the community and people's homes. Staff were supportive of the strategy and told us they worked well together in teams and with their managers. Governance arrangements were in place to monitor performance and quality and to manage risks. Although these needed to further improve to ensure consistency across the service. Staff reported low morale. However, staff engagement was improving and work had started to address staff concerns, particularly around shift patterns and rotas. Staff received support in terms of their health and wellbeing. Patient and public engagement was developed through a variety of channels, such as social media and community liaison work. There were many examples of innovation and improvement.

Summary of findings

Patient transport services (PTS)

Good



We rated patient transport services (PTS) as good overall. We found the service to be outstanding for caring, good for effective, responsive and well-led and requires improvement for safe

All feedback from patients and hospital staff was positive about the care patient transport services (PTS) staff provided to patients. Patients told us staff treated them with kindness, were caring and went above and beyond to meet their needs. Staff treated patients with dignity and respect, encouraging patients to be involved with their care. Staff understood the importance of supporting patients' emotional needs and patients valued the personal approach of staff.

The service was able to meet the individual needs of patients and was accessible to all patients who met the eligibility criteria by commissioners and national criteria for renal dialysis patients. There was good use of risk assessments to keep patients and staff safe, with information stored electronically so it was easily accessible. Staff though did not always feel confident to meet the needs of patients with mental health problems.

Services were planned to meet the needs of local people. New contracts had extended the operating hours of the service. Staff felt involved with PTS and able to make suggestions on how the service could be improved and developed. PTS had introduced a number of innovative changes, to improve the quality of the service but also to consider the future sustainability.

Staff working for PTS told us they enjoyed working for the trust, as they provided a good standard of care to patients. They felt well supported by the team they worked with and their manager. We observed good multidisciplinary working and co-ordination with other providers to deliver good quality care to patients.

Senior managers understood the importance of the commercial aspect of the service and the current competitive market for PTS. Key performance indicators (KPIs) were used effectively to monitor compliance with contracts but patient care remained the overall focus.

Summary of findings

However:

We found that staff did not always report incidents as sometimes they did not receive feedback or learning was not shared at team meetings. Senior staff took appropriate action to respond to and investigate complaints. However, the learning from the investigations were not always shared with staff at a local team level.

Practices to keep staff and patients safe were not always identified or concerns acted upon. This included lack of clarity for staff around the administration of oxygen to patients, concerns around requesting emergency assistance when working in rural areas due to variable connectivity, Some vehicles were also not appropriately maintained and staff did not follow best practice guidance for infection prevention and control.

In PTS, some staff groups were below the trust target for compliance with mandatory training and appraisals.

The service struggled to meet some of the performance indicators set in the commissioner contracts as part of the quality monitoring of the service. In particular telephone calls were not being answered quickly enough and there were delays in patients being collected before and after their appointment.

The introduction of new contracts had been a challenging time for staff and had extended working hours. In some areas there remained issues with recruitment of staff, particularly frontline staff, in the Thames Valley area. Private providers were being used to cover vacant shifts.

Emergency operations centre

Good



Overall, we rated the emergency operations centre (EOC) as “good”. We found the service to be good for safe, effective, caring, responsive and well led.

Staff used evidence-based systems to provide care, advice and treatment to patients. Clinicians worked to national guidance and standards when providing advice over the phone. Calls were monitored for consistency and to ensure advice was in line with clinical protocols.

Summary of findings

Emergency operations centre services were delivered by caring and compassionate staff. We observed good examples of staff treating patients and callers with dignity and respect.

Staff had good awareness of how to ensure vulnerable patients including children were safeguarded and there was a dedicated team who ensured safeguarding referrals were appropriately made. However, there was not a direct referral route to local authority safeguarding teams outside of normal working hours, although when urgent the police would be informed.

The service had an escalation plan for when calls exceeded capacity and action was taken to shorten calls if safe to do so. There was organisational and individual learning from incidents and complaints, staff told us they received learning through feedback from managers.

Staffing levels were a concern and staff worked long hours, often without breaks. There were a number of staff vacancies and staff were working under pressure.

The average time to respond to emergency calls was worse than the England average and the trust had some of the longest call waiting times. The trust was performing better than the England average for the proportion of emergency calls resolved by telephone advice and support (hear and treat). The proportion of the calls abandoned before being answered had decreased and was now better than the England average. The trust participated in the ambulance quality indicators, which enabled it to monitor performance.

There had been delays in sending emergency response vehicles to emergencies. This frequently happened due to excessive hospital handover times when ambulances were being held because hospital emergency departments did not have sufficient capacity.

The trust were not routinely responding to complaints in a timely manner. They were not always meeting their own target of investigating and responding to complaints within 25 days.

Summary of findings

There were clear governance processes in place, risk registers were regularly reviewed, and managers were able to describe the current risks to the emergency operations centre. The service managed risk appropriately and performance was measured through monthly staff audits, management meetings, and reports to the board. There was a long-term strategy for the EOC and staff were aware of the trust's vision and strategy.

We saw that staff received appropriate induction and training. Staff were trained in the NHS pathways, (the process for assessing the calls received into the call centres) so that patients could be triaged appropriately. Staff were supported to identify good and poor practice and learn about how to handle emotional calls in a sensitive and caring manner.

Requires improvement



South Central Ambulance Service NHS Foundation Trust

Detailed findings

Services we looked at

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

Detailed findings

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Background to South Central Ambulance Service NHS Foundation Trust

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Services are delivered from the trust's main headquarters in Bicester, Oxfordshire, and a regional office in

Otterbourne, Hampshire. Each of these sites includes an emergency operations centre (EOC) where 999 and NHS 111 calls are received, clinical advice is provided and from where emergency vehicles are dispatched if needed. There is a PTS contact centre at each EOC.

The trust also offers the following services: First Aid Training to organisations and the public, a commercial logistics collection and delivery service for our partners in the NHS, and Community First Responders (volunteers trained by SCAS to provide life-saving treatment).

We inspected this location as part of our planned, comprehensive inspection programme. Our inspection took place on 3 to 6 May 2016 with unannounced visits on 13 and 16 May 2016. We looked at three core services: access via emergency operations centres, patient transport services and emergency and urgent care including Resilience and Specialist Operations. The 111 service provided by the trust was inspected separately. The logistical and commercial training services were not inspected as these do not form part of the trust's registration with the Care Quality Commission (CQC). During the inspection we visited both ambulance premises as well as hospital locations in order to speak to patients and staff about the ambulance service.

Our inspection team

Our inspection team was led by:

Detailed findings

Chair: Andy Welch, Medical Director Newcastle upon Tyne Hospitals NHS Foundation Trust

Head of Hospital Inspections: Joyce Frederick, head of Hospital Inspections Care Quality Commission

The team of 51 included CQC inspectors and inspection managers, an analyst and inspection planner and a variety of specialists: The team of specialist included

nurses working in accident and emergency departments, paramedic staff including an advanced paramedic and a Clinical Supervisor and Clinical Development Manager, Emergency Medical Technicians (EMT), managers with an operations role, a head of governance, a pharmacist, a safe guarding lead, people with a role in an operation centres and staff from patient transport service (PTS).

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 took place from 3 - 6 May with unannounced visits on 13 and 16 May 2016.

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about the South Central Ambulance Service. These included local clinical commissioning groups (CCGs); local quality surveillance groups; the health regulator, Monitor; NHS England; Health Education England (HEE); College of Emergency Medicine; General Dental Council; General Medical Council; Health & Safety Executive; Health and Care Professions Council; Nursing and Midwifery Council; National Peer Review Programme; NHS Litigation Authority; Parliamentary and Health Service Ombudsman; Public Health England; the medical royal colleges; local authorities, local NHS Complaints Advocacy Service; local Healthwatch groups; and local health overview and scrutiny committees.

During our inspection, we spoke with a range of staff in the organisation including call handlers, dispatchers, paramedics, ambulance technicians, emergency care assistants, emergency care practitioners, community first responders, patient transport services (PTS) staff, the lead pharmacist, the safeguarding lead, the infection prevention and control lead, the mental health lead, operational managers, emergency operation centre managers, resilience staff and staff at director level.

We visited 20 ambulance stations including numerous stand points, the northern and southern operation centres operation centres where we listened in to calls and observed dispatchers for the emergency service and PTS. We also visited 10 acute hospitals. At these hospitals, we observed the interaction between ambulance staff and hospital staff in the accident and emergency (A&E) areas, direct admission wards, outpatient areas and discharge lounges. We noted how people were being cared for and spoke with patients using the emergency ambulance service and PTS. We spoke with staff from the hospitals we visited about the ambulance service. We rode and observed on 13 emergency ambulances and seven patient transport vehicles. We spoke with in the region of 350 members of staff from the ambulance trust.

We would like to thank all staff, patients and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment provided by the South Central Ambulance Service NHS Foundation Trust.

Facts and data about South Central Ambulance Service NHS Foundation Trust

South Central Ambulance Service: Key facts and data

1. Context

Detailed findings

- Service covers - Berkshire, Buckinghamshire, Hampshire, Oxfordshire and Milton Keynes. The NHS 111 Service also covers Luton and Bedfordshire.
- Area covers - 3,354 square miles (Significant rural areas) with a population of approximately 4.6 million.
- Health Summary: Health of population generally better than England average; Deprivation is lower than average; life expectancy is higher than the England average.
- The service has 40 sites; 27 ambulance stations; 607 ambulance vehicles of which approximately 400 are frontline ambulances; operates two Air Ambulance helicopters; and 226 PTS ambulances and 16 cars.
- The services covers 12 acute hospital sites, 2 Major Trauma Centres, 7 specialist site, 6 mental health trusts.
- Staff: 3,000.
- Community First Responders & co-responders: 1,271
- Volunteer car drivers: 107
- The total income for the service was £175.5million in 2015/16 (£120.3m on emergency services; £21.1m PTS; and £15.7m on 111 services). The trust had a £3.7m deficit for the year in 2015/16. Income for 2016/17 £175.9m expected deficit £1.9m.
- Cost improvement programme: Historically trust had achieved CIP targets. £6.4m savings target set in 2013/14 Trust achieved CIP target for 2013/14 in 2015/16.

2. Activity

- Calls to 999: 541,080 (2015/16)
- Calls to 111: 1,238,568 (2015/16)
- Patient Transport service Journeys: 513,787 (2015/16)

3. Safe

- **National Reporting and Learning System (NRLS reporting):** Between March 2015 and February March 2015, 16 serious incidents were reported by the trust. No Never Events.
- **Staff survey:** Worse than average for questions relating to % of staff witnessing potentially harmful errors, reporting of errors and near misses; Better than average for the % of staff reporting potentially harmful errors, reporting of errors and near misses.
- **Central Alert System:** 40 alerts (2015/16); 31 acknowledged within 2 days (78%). Of the 40 alerts 3 related to SCAS. Of these, 2 (67%) acknowledged within deadline of 2 working days; 2 (67%) were closed within deadline.

4. Effective

Ambulance clinical performance indicators (comparison between trusts) (Apr 2014 – Oct 2015)

- Return of spontaneous circulation (ROSC) at time of arrival at hospital (Overall) (%) : Better than England average
- ROSC at time of arrival at hospital (Utstein Comparator Group*) (%) : Worse than England average
- Cardiac arrest - survival to discharge - overall survival rate (%) : Better than England average
- Cardiac arrest - survival to discharge –(Utstein comparator group *) survival rate (%) : Variable above and below England average
- % of patients suffering a STEMI who are directly transferred to a centre capable of delivering PPCI and receive angioplasty within 150 minutes of call. Similar to England Average
- % of patients suffering a STEMI who receive an appropriate care bundle. Worse than England average
- % of FAST positive stroke patients who arrive at a stroke unit within 60 minutes of call. Slightly below England average
- % of suspected stroke patients who receive an appropriate care bundle. Similar to the England average

Category Red calls (2015/16)

- Emergency response
- Red 1: 75% of calls within 8 minutes - Target not met overall ; comparable to England average
- Red 2: 75% of calls within 8 minutes - Target not met overall; above England average
- Vehicle capable of transporting a patient at the scene
- Category A calls (Red 1 and Red 2) - 95% in 19 minutes - Target not met overall but above the England average.

Treatment

- Telephone Advice: **Hear and Treat.** Percentage of emergency calls resolved by telephone advice - Below the England average (July 2014 – August 2015) for emergency calls dealt with by telephone advice only. Above the England average (August 2015 – January 2016). The percentage of emergency calls resolved by telephone advice and support (hear and treat) had increased. Between April 2015- March 2016, the percentage of patients treated over the phone had increased from 6.1% to 13.5%.

Detailed findings

- **See and Treat.** The number of patients discharged, after treatment at the scene or who had onward referral to an alternative care pathway rather than a hospital(“see and treat”) was above the England average (July 2014 – August 2015). However, numbers were declining from 39% in April 2015 to 35.9% in March 2016. The trust have identified the decline is correlated to the rise in “hear and treat” rates

5. Caring

Hear and Treat survey 2013/14* national NHS survey programme.

25 questions on call handling, clinical advice, outcome and overall service.

- 24 questions - similar to other trusts
- 1 question - Positive outlier - Listened to what the patient had to say

6. Responsive

- **Time to answer calls:** Majority of calls answered within times that are better than other trusts; however median (average) time to answer a call worse than other trusts.
- **Call abandonment rate:** - July 2014 – August 2015 worse than England average; September 2015 to January 2016 - Above the England Average.

- **Re-contact rate:** Proportion of patients who re-contacted following discharge of care, by telephone within 24 hours - Similar to other trusts
- **Conveyancing:** Proportion of emergency and urgent incidents managed without the need for transport to A&E - below the England average (July 2014 – August 2015) Above England average (August 2015 – January 2016)
- **Patient Transport Services:** Trust transport contract target times not met overall.

7. Well led

- NHS Staff Survey (2015). (32 questions). Overall trust was similar to other trusts. 13 questions were better than average and 7 questions were below average.

8. CQC inspection history

- Five inspections had taken place at the trust since its registration in April 2010.
- Compliant at last inspection in October 2013.
- ‘Must’ and ‘Should’ actions as part of the pilot Wave 1 comprehensive inspection for ambulance trusts in September 2014.

Our ratings for this service

Our ratings for this service are:

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

Emergency and urgent care services

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

Information about the service

The emergency and urgent care service respond to emergency 999 calls, 24 hours a day, 365 days a year. The South Central Ambulance Service NHS Trust (SCAS) works closely with other emergency services including the police and the fire services to provide emergency services in response to major incidents. The SCAS emergency and urgent care service has 1,480 ambulance staff including paramedics, emergency medical technicians (EMTs) and emergency care assistants (ECAs) working on the front line services.

The trust operates approximately 600 ambulance vehicles out of 40 sites across Hampshire, Berkshire and Buckinghamshire. SCAS serves a population of 4.6m across these counties, conveying to 12 acute hospitals, two of which are major trauma centres. It also provides paramedic services for two air ambulance charities, one based at RAF Benson in Oxfordshire and the other at Thruxton Airfield in Hampshire.

On average SCAS responds to 44,450 calls per month. This can increase during certain times of the year such as New Year's Eve and other significant events for example in March 2016 calls increased to 48,860 due to Easter. SCAS supports the work of voluntary community and emergency first responders across the region who give basic lifesaving interventions prior to the arrival of the ambulance crew; this is co-ordinated by SCAS.

During the inspection we visited a 20 ambulance stations and numerous stand by points across all counties, in both towns and rural areas, and we spoke with over 200 staff in

various roles including paramedics, trainee paramedics, emergency medical technicians, emergency care assistants, team leaders, emergency services managers, senior managers and members of first responder groups. We rode and observed on 13 emergency ambulances. In addition, we spoke with support staff including cleaners and those who deep cleaned ambulances. We observed ambulance crews treating patients. We spoke with over 60 patients, where appropriate to do so, and their relatives. These patients had used the service in their own homes or for conveyance to emergency departments. We visited 10 acute trusts.

We conducted focus groups with staff prior to and during our inspection to hear their views about the service. This included frontline ambulance staff, community first responders, clinical tutors and support staff.

We inspected ambulances and reviewed patient report forms. We visited hospitals in each county 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 surgical and medicine admission units about their experience of working with SCAS.

Emergency and urgent care services

Summary of findings

Overall we rated emergency and urgent care services as requires improvement. We found the service requires improvement for effective and well led and was good for safe, caring, responsive services.

Front-line 999 services provided an emergency response to people with life threatening emergency or urgent conditions. The service had met its emergency response times for calls to be responded to within eight minutes up until May 2015. Since then there had been a decline in performance, and the target times had not been met. The national target time for patients to have ambulance transport to hospital within 19 minutes was also not met. The number of patients discharged after treatment at the scene or who had onward referral to an alternative care pathway rather than a hospital, known as “see and treat”, was above the England average .

The trust used the national Resource Escalation Action Plan (REAP) in order to plan for additional resources in the event of operational pressure being experienced. There was moderate pressure on the service during our inspection and the trust was communicating effectively with hospitals to align conveyancing decisions against waiting times and the capacity to receive patients. There was effective coordination of services with other providers and good multidisciplinary working to support seamless care, admission avoidance and alternative care pathways

The service followed safety procedures overall, but needed to improve the consistency of mandatory training, incident reporting, infection control, medicines management, and vehicle checks. The service was affected by a national shortage of paramedics within the NHS and in some areas there were a high number of vacancies. Active recruitment had been undertaken in Australia and Poland during the previous year and this had improved the situation, as well the use of bank and agency staff and independent providers to fill gaps. However, some staff we spoke with reported that they sometimes finished late, or missed meal breaks. Many staff reported being frustrated and tired.

National evidence-based guidelines were used to assess and treat patients. National ambulance quality

indicators were being used. However, clinical audit needed to be further developed to monitor standards of care. Patients experiencing a stroke received an appropriate care bundle and this was in line with the England average. However, patients who had a heart attack were transported quickly to centres for treatment but did not always receive an appropriate care bundle by ambulance staff. Patients with a mental health condition that required a place of safety were being transported within 30 minutes to a designated location.

Staff reported that they felt extremely well supported by their local management teams and they had access to clinical advice although this was sometimes difficult to obtain in a timely way. However, the trust was not reaching its targets for the completion of mandatory training and staff reported that face to face training was cancelled when there was insufficient emergency cover. Staff were positive about the appraisals but many had not received appropriate trainee mentorship, supervision or a current appraisal. New staff had received appropriate induction and support.

Staff were caring and compassionate to patients and people that were important to them. They gained consent for assessment and treatment and explained treatment options in a way that the patient could understand. Patients and their relatives and carers received good emotional support.

The trust was dealing with an increasing number of emergency calls and was developing alternative pathways to transport to hospital. Long waiting times for an ambulance was steadily increasing and the trust was developing services to reduce these and increase its use of community first responders, identifying further resources for GP ambulance calls, and employing specialist paramedics to who could treat patients at home in order to avoid hospital admission. The trust was above the national average for treating people without the need for further transport. Demand practitioners were working to reduce the number of inappropriate calls and frequent callers to the service. The air ambulance services could respond to calls within their region within 15 minutes. In addition, night flying had commenced (until 2am) to meet the demand of the service.

Emergency and urgent care services

There was support for vulnerable patients, for example, people with a mental health condition, a learning disability and those living with dementia. Staff told us they had more awareness of meeting the needs of vulnerable patients. Complaints to the service were mainly about delays and these were handled appropriately but were not being responded to within the trusts' own target of 25 days.

The trust was revising its strategy for the service to take account of operational demands. There was still an emphasis on providing mobile healthcare and to coordinate care in hospital, the community and people's homes. Staff were supportive of the strategy and told us they worked well together in teams and with their managers. Governance arrangements were in place to monitor performance and quality and to manage risks. Although these needed to further improve to ensure consistency across the service.. Staff reported low morale. However, staff engagement was improving and work had started to address staff concerns, particularly around shift patterns and rotas. Staff received support in terms of their health and wellbeing. Patient engagement was developed through a variety of channels, such as social media and community liaison work. There were many examples of innovation and improvement.

Are emergency and urgent care services safe?

Good



By safe, we mean that people are protected from abuse and avoidable harm.

Overall, we rated safe as 'good':

- Staff knew how to report incidents and there was a good culture of incident reporting. Root cause analysis of serious incidents was robust.
- Staff used the Joint Royal Colleges Ambulance Liaison Committee's guidance (JRCALC) 2016 to assess patients and responded appropriately to risk.
- Procedure were in place for deep cleaning of ambulances. Policies and processes were in place and standards of cleanliness, infection prevention and control were followed.
- Staff were aware of safeguarding processes and reported appropriately.
- The trust used an external contractor for the 'Make Ready' teams, these teams cleaned, prepared and re-stocked ambulances.
- Overall, medicines were stored and managed appropriately; ambulance bags had red tags to denote stock of medicines had been replenished.
- Daily vehicle and equipment checks were carried out by crews.
- The trust was using an electronic patient record system which frontline staff could access via a handheld tablet. These were secured with passwords. Paper records were also used. All records were completed correctly.
- The trust was affected by the national shortage of paramedic staff. Bank and agency staff as well as independent healthcare providers were being used to maintain staffing to planned levels.
- The trust was actively recruiting and developing all grades of staff.
- The trust used the national Resource Escalation Action Plan (REAP) in order to plan for additional resources in the event of operational pressure being experienced. There was moderate pressure on the service during our inspection and the trust was communicating effectively with hospitals to align conveyancing decisions against waiting times and the capacity to receive patients.

Emergency and urgent care services

- Overall, the trust was prepared in the event of a major incident, there were appropriate plans and staff had appropriate training; a mock exercise had taken place in April 2016. There was a comprehensive and effective command structure across the trust to respond to major incident risks.

However,

- Staff did not always have time to report incidents during their shift and did not always receive direct feedback if they did report.
- There were examples when medicines were not stored and managed safely and infection control practices were not consistently followed.
- Staff essential education or mandatory training, was not always undertaken because of operational pressures.
- Staffing levels were a concern and staff were working longer hours and working under pressure, for example, working without meal breaks, doing vehicle and equipment checks prior to the start of a shift and meeting challenging handover times for patients from a single crew to dual crew or at a hospital.
- One resource centre had not stored paper records securely prior to shredding.
- Some ambulance response bags were in visible need of repair and some should have been replaced.
- Two of the 12 vehicles that would be required in the event of a major incident would not have been ready if they had needed to be deployed quickly.
- Staff were able to demonstrate how they would report an incident. Recent examples were medicines errors, incorrect stocking of drug bags and abusive patients. Missing equipment was reported as being a problem, however staff rarely reported this as an incident.
- There was a culture among all staff to report incidents, including near misses and low harm incidents. However, there was no allocated time to complete incident reports. Staff told us they often had to do incident reports after the end of their shift, this meant they would sometimes not do it as they wanted to go home. For example, a member of staff reported that they had arrived at an emergency incident to find they did not have the necessary equipment. Although, they had not completed an incident report in this case they had spoken directly to the 'make ready team' to ensure they were aware.
- The trust produced two bulletins called 'SCAScade' and 'Hot News' to specifically distribute key and clinical information to staff. These contained key information about specific incidents where information needed to be shared. These were circulated to all stations. Although staff told us that they did not always receive direct feedback about incidents they reported, which resulted in a disincentive to complete a report.
- Hazardous area response team (HART) and air ambulance staff confirmed they received feedback about incidents they reported. They received acknowledgment the reported incident had been received, feedback about findings of investigations into incidents and actions taken in response to the investigation. Incident reports evidenced incidents were reviewed, analysed and actions taken to promote learning from the incidents.
- The incident reporting system showed the HART team reported identified safety risks to the national ambulance resilience unit (NARU), such as vehicles that were out of service being repaired, to ensure there was a current picture of HART resources available to respond to incidents nationally.
- Records and discussion evidenced that staff followed formal review processes after incidents and planned exercises. Records showed these were multidisciplinary reviews, including all departments involved in the incidents (control centre, urgent and emergency care service, HART, air ambulance) and other emergency and health care providers such as neighbouring ambulance

Incidents

- There were 184 incidents reported for emergency and urgent care. This amounted to 22% from March 2015-February 2016 and varied between one to 26 incidents per month. There were no never events in the service over the same period. Never events are serious, largely preventable patient safety incidents, which should not occur if the available preventative measures have been implemented
- Staff reported incidents using the trust's electronic reporting system. The line manager then graded and decided if an investigation was required. Staff could access the system from a computer at a station or the hand held tablet carried on the vehicles.

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providers, police and fire services and local acute trusts. The review process looked at what went well, what could have gone better and lessons learnt from the incident or exercise.

- Records from team meetings for both HART and air ambulance services evidenced lessons from incidents within SCAS and nationally were reviewed and discussed.
- Air ambulance staff attended regional trauma Morbidity and Mortality meetings. This promoted reflective practice and peer reviews of the treatment and care of patients.
- Independent ambulance crews were able to report incidents using a paper based reporting system.
- 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. The trust's policy on 'Being open and duty of candour' reflected the Duty of Candour legislation.
- All managers we spoke with understood the term Duty of Candour and when to apply the principles. There was some variability among frontline staff regarding their understanding of this duty. Risk team and governance leads reviewed incidents daily. Any considered to be moderate or above were further reviewed and a decision made on Duty of Candour. The governance leads would discuss the incident and Duty of Candour with the appropriate managers and support them with the process.

Mandatory Training

- The trust had a training policy in place that detailed what was classified as mandatory and the frequency attendance or completion was required such as annually for infection prevention and control, fire safety, information governance, safeguarding, business continuity, major incidents, basic life support (BLS) and advanced life support (ALS). HART staff completed mandatory training specific to their role as specified by 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. Air ambulance paramedic mandatory training included subjects relating to air safety.

- Mandatory training was delivered by a mix of e-learning and face to face training. Agency staff were required to complete and record mandatory training and used a system called 'skill stream'. Staff would not be permitted to book shifts without having a complete record of up-to-date training
- Staff received an email 50 days prior to expiry to alert them their training was due, it was the responsibility of the individual to book and complete training. If training was overdue it was followed up by the team leader at meetings with staff or appraisal.
- Staff reported challenges with the completion of mandatory training via eLearning. There was no protected time for staff to carry out mandatory training, they were required to fit this in between calls on shift, at the end of a shift or in their own time at home. Staff reported difficulties with remote IT access at home. Some staff used the time after face to face team training days to complete their mandatory training.
- All ambulance stations, including both HART and the two air ambulance stations, had computer facilities where staff could complete their online mandatory training. HART staff reported and records evidenced that all of their mandatory training was up to date. HART staff said they had sufficient time to complete mandatory training. Air ambulance paramedics told us they completed mandatory training in the periods they were not called upon to attend incidents.
- Medical staff, who worked with the air ambulance crew, completed mandatory training at the trust they worked at. A named member of the medical staff was responsible for ensuring medical staff completed this training. However, there was no mechanism for the manager of the air ambulance service to gain assurance medical staff were compliant with mandatory training.
- Data provided by the trust for March 2016 showed that compliance with mandatory training varied across the frontline staff. The percentage of staff that had completed their training ranged from 60% to 88%. The overall compliance rate for frontline staff was 74%; the compliance rate including HART and air ambulance was 82%. The trust target across all aspects was 95%.

Safeguarding

- All staff we spoke with had a good understanding of safeguarding and when they would report an incident. Staff were aware of the trust safeguarding lead and said

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they completed safeguarding referrals routinely, for example when attending a family where there was obvious or known drug abuse and there was a child present.

- The trust had a procedure to allow frontline staff to raise a safeguarding concern by completing a form via the electronic patient record (ePR) at the scene of an emergency call. This would be sent to a single point of access that would pass it to the relevant local authority. Staff we spoke with could show us the form and discuss cases where they had used this process. A paper form was available that could be faxed to a 24hr single point of access if the ePR was not available.
- Delays could occur with safeguarding referrals as forms were checked by administrative staff to ensure the correct information was included and staff were not present out of hours, over the weekend or on bank holidays. If a safeguarding was urgent, frontline staff would refer details to the police. There has never been any incidents of the police not responding. The trust was planning for safeguarding referrals to be done automatically and sent to the local authority later in the year. The trust had acquired six ePR tablets to be used by staff.
- The ePR also had a prompt about identifying signs of radicalisation for a child, and also prompts regarding female genital mutilation (FGM).
- Emergency department staff told us concerns were usually raised by the ambulance crews, however some issues only came to light after admission, such as domestic violence.
- The trust had made safeguarding awareness a hot topic for staff. In the 12 months prior to our inspection they had introduced both e-learning and face to face training packages, which included PREVENT (anti-terrorism and anti-radicalisation of vulnerable people] and FGM awareness.
- All staff we spoke with including both HART and Helicopter Emergency Medical Service (HEMS) commented they rarely received any feedback on safeguarding reports. This meant they did not know what action had been taken to protect the vulnerable adult or child, and they were not provided feedback as to whether the alert was appropriate.
- Data provided by the trust (March 2016) demonstrated that 88% of frontline staff had completed safeguarding

adults training level 1 and 88% had completed safeguarding children training level 1; 80% of staff had completed safeguarding adults and children training level 2. The trust target was 95%.

Cleanliness, infection control and hygiene

- All vehicles we inspected were visibly clean.
- Staff in vehicles had access to hand sanitiser gel, however, on observation we found that some staff did not always use this appropriately. All vehicles, including the air ambulances, had routine personal protective equipment (PPE) such as gloves, aprons, eye protectors and hand cleansing facilities and staff were seen to be using them appropriately. For example when inserting a cannula (putting a tube into a vein).
- The majority of staff used gloves appropriately when conducting examinations. However we observed some staff not using gloves despite the risk of contamination from bodily fluids.
- Ambulance crews were in visibly clean uniforms and adhering to the uniform policy of the trust. Staff were responsible for ensuring their uniforms were clean.
- The trust had adopted a 'bare below the elbows' clothing policy for all clinical staff in uniform stating that they should not wear wrist watches and wrist bands should be removed. This was aimed at preventing the spread of infection from contaminated sleeves and to aid effective hand-hygiene procedures. The trust policy stated that wrist watches may be worn if they are fully washable and are removed prior to washing of hands. Although most staff had fully washable watches, we observed some staff that had watches including with metal faces or fabric straps that did not comply with this policy and did not remove watches when washing their hands.
- Frontline staff were able to wash their hands at hospitals and we observed most staff did this after handover of a patient.
- The 'Make Ready' teams were run by a contractor. The Make Ready teams cleaned, prepared and replenished stock in ambulance vehicles. There was a check list in place to ensure each vehicle and it's equipment was checked appropriately. Most make ready crews worked early morning to midday to clean and prepare vehicles.
- Ambulance vehicles were deep cleaned on a 12 week programme by the make ready teams. Vehicles displayed a disc in the windscreen that showed when the vehicle was next due for the deep clean. We found

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that the deep clean date for some vehicles had expired. The trust was aware that the deep clean scheduled had not been maintained and were actively taking steps to address this.

- An audit tool was used by station managers to check the effectiveness of cleaning in line with the trust infection prevention, control and decontamination policy (June 2015). We saw records that audits were carried out as per the trust policy with outcomes recorded and actions detailed appropriately.
- There was a colour code policy in place for mops and buckets to reduce the risk of cross-infection. In most ambulances stations we saw this adhered to. The infection control policy required mop heads to be changed every week and we were told this was followed.
- Hospital staff reported the ambulance staff would alert the emergency department in advance if there was a patient arriving with a suspected infectious condition that would require isolation.
- Ambulance staff used universal sanitising wipes and detergent for routine cleaning. There were separate processes and disinfectant for body fluid spillages and known infection. During inspection we observed staff cleaning equipment and surfaces inside the ambulance between patients.
- There were arrangements with the local hospitals for depositing of used linen and restocking with clean.
- HART staff were responsible for the cleaning of their vehicles (with the exception of vehicles located at other ambulance resource centres). Staff used a detailed vehicle check lists to ensure that vehicles were clean. All vehicles we inspected were visibly clean.
- HART staff followed the trust policy for managing clinical waste. Staff told us that where possible clinical waste was disposed of at acute hospitals.
-
- The trust had an infection prevention and control (IPC) lead. Team Leaders and Clinical Mentors formed part of the wider IPC team. They audited stations, vehicles and clinical compliance such as Hand Hygiene. The trusts resilience service included vehicles and equipment to manage infections and contaminations including Chemical, Biological, Radiological, Nuclear and Explosives (CBRN-E) incidents. This included specialist protective suits for HART staff and the 10% of front line staff who were trained to support the HART team responding to CBRN-E incidents.

Environment and equipment

- Equipment in ambulances and rapid response vehicles (RRV) we inspected was visibly clean and well maintained. For example each ambulance and RRV we saw carried two handheld radios, a radio battery charger and two spare charged batteries for them to ensure good access to communications at all times.
- If a piece of equipment was found to be faulty during a check of the vehicle at the start of a shift (or if a fault developed during the shift) the crew would call the clinical support desk. This provided them with the ability to talk through the fault with the equipment and carry out basic troubleshooting. If the item was found to require repair, advice would be sought from the emergency control centre. If the equipment was essential, the crew would be taken out of service while they either changed vehicles or reported to the nearest resource centre to have the problem resolved. Staff were confident that they could get a faulty item of equipment changed or fixed quickly.
- Resource centres had dedicated restock areas and cupboards. 'Make ready' teams were trained to restock vehicles and there were diagrams and guides to inform them what equipment should be in each vehicle and response bag. Items we checked were found to be current and in date.
- Equipment was cleaned and replenished by the Make Ready teams. This included all disposable equipment and medical supplies. When a make ready team was not on duty, ambulance staff were responsible for restocking their own vehicles from top-up stores.
- Ambulance crews were allocated 6 minutes at the start of their shift to conduct checks on the vehicle and equipment. Some crews told us that the restocking by the 'Make Ready' team was not always accurate and sometimes equipment was missing. These omissions were sometimes reported as incidents and there had been improvements, but staff told us the checks were essential.
- Vehicles were taken off the road for repair when needed, and labelled to ensure that staff were aware. There was a rolling programme of vehicle replacements in place.
- Existing monitoring / defibrillator devices were being replaced across the trust with a newer model which allowed frontline crews to carry out more detailed

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investigations when attending patients. The replacement programme was being carried out with a phased approach, with training provided to crews as they received the new kit.

- Staff waiting for the new equipment had to go out with old equipment that had some parts missing. For example, this included a monitor / defibrillator that could not record a blood pressure reading or measuring end-tidal carbon dioxide (a measurement used to assess breathing). There was manual equipment available to undertake these observations so any possible risk was mitigated and managed.
- The ambulances we inspected were fully equipped, with disposable single use equipment stored appropriately and in-date.
- There was provision for the conveying of children. There were seat belt straps on the rear facing seat and the stretcher could be used for children as well as adults as it could be fitted with additional straps that were carried in all vehicles.
- Most equipment that was carried on ambulances was standardised across the trust. We found paramedic response bags to be in varying degrees of repair. Some response bags were a newer design that allowed them to be wiped clean. These bags were smaller in design than the older bags and had a single shoulder strap. Older bags were a larger, rucksack design which meant they were more comfortable to carry. However these older bags were in a poor state of repair, and had been repaired multiple times. Some response bags we saw were visibly worn and some had zips that had been repaired, with cable-ties being used as make-shift zip tags. Staff told us that this could make the bags difficult to open at times when attending a patient. We were not advised by the trust of any plans to replace the older style bags.
- There were satisfactory records of vehicle and equipment checks. For example, there were appropriate procedures to ensure that ambulance vehicles were serviced and had Ministry of Transport (MOT) test certificates. Mechanical equipment was serviced and labelled to show the date of the last service and when the next service was due. The electronic fleet management system was updated with records of repairs and maintenance, there was also a paper copy file for each vehicle. The trust kept maintenance and service logs in line with legislation. For example, there were records kept at resource centres that showed that ambulance vehicle tail lifts were checked every 6 months under the lifting operations and lifting equipment regulations.
- The staff had received training on ensuring that vehicles were fit to convey patients in mental health crisis. Staff told us that they would remove scissors and obvious items with which a patient could self-harm whilst being conveyed.
- On some ambulances, there was a cupboard where the door would not close because the cupboard was the wrong size for the evacuation chair stored within it. This meant that the cupboard fell open when the vehicle was moving. Staff had mitigated this risk by holding the door shut with tape.
- It was reported that the team leader cars were not checked by the make ready team and the responsibility was the team leaders to check their equipment. On one team leader car there were three bags of spare equipment. On checking a number of items of out of date equipment were found. This was raised with the local management team and the stock was replaced.
- Each ambulance resource centre had secure clinical waste disposal bins. Ambulance vehicles and response bags had clinical waste bins and sharps disposal bins for the safe disposal of clinical waste and were changed two weekly or before if needed. However, rapid response vehicles were not fitted with clinical waste bins. This meant that staff would have to use a bag which could spill contaminated contents.
- The HART team had 12 vehicles located at the HART unit, available to deploy in the event of a major incident. This included vehicles to carry equipment, a command vehicle, a vehicle to transport crew, an all-terrain vehicle, a van to carry breathing equipment and rapid response vehicles.
- As part of the resilience service there were vehicles stationed at resource centres throughout the SCAS region with the purpose to mobilise large amounts of medical supplies and large casualty treatment tents to the scene of a mass casualty incident. Staff told us these were located at the Portsmouth and Newbury resource centres. They told us the resource centres where the vehicles were stationed were responsible for ensuring the vehicles were ready to be mobilised quickly.
- However, we saw two such vehicles located at Basingstoke resource centre that were not in a situation to be mobilised quickly. The first was unlocked, allowing

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unrestricted access. The vehicle was not plugged into the electric supply. This meant one of the two batteries on the vehicle was flat. The flat battery was the one that powered the blue lights. It took 5 minutes for the battery to charge before the blue lights worked. There were medical kits in bags whose zips had rusted and perished so that the bags were very difficult to open. There was also out of date medical kit on the vehicle.

- We asked a member of staff to start the second vehicle, this took 45 minutes. The key to operate the tail lift of the vehicle had snapped off the key fob. This meant equipment in the rear of the vehicle was not accessible.
- Both vehicles were meant to be driven to the scene of a major incident by any member of staff qualified to drive under emergency conditions. However, neither were in a position to be deployed straight away. Once on scene one vehicle would not be able to be used due to not being able to access the rear of the vehicle.
- Staff followed detailed vehicle check lists to ensure all equipment was present, in date and in working order on the vehicles stationed at the HART base. This equipment included suction machines, defibrillators and oxygen cylinders.
- Staff on each station had, had specific training for mass casualty incidents and had equipment bags ready to be used. We checked this on inspection and found some supplies at Basingstoke resource centre to be out of date. This was escalated during the inspection and was rectified.
- Equipment was checked daily at the HART unit. There was a process of using stickers on each equipment pouch to indicate the expiry date of equipment stored in the pouch. However, when we checked a sample of the equipment pouches we saw this process was not fully embedded into practices and found that some dressings were out of date. We raised this with HART staff and the HART manager, who took immediate action. Staff replaced out of date dressings and commenced a check of all equipment to ensure expiry date labels were fixed to all pouches. HART operatives had specialist PPE which included powered respirator protective suits (PRPS), to be used in the event of a chemical or biological incident. Staff said and records evidenced these were maintained and checked in line with national guidance.
- The HART base at Winchester did not meet the NARU Capital estate specification for space and facilities. This was because the foot print of the building and grounds

was also used by urgent and emergency services and PTS services. Staff described the impact this had, which included difficulties in parking and a lack of space in the garage for working at height training on site. However, staff said, this did not have an adverse impact of the delivery of safe care to patients.

- The Hampshire and Isle of Wight air ambulance service was based out of a shared hanger and porta cabins at Thruxton airport. Changes had been made to the facilities and equipment used (including night vision goggles) to meet the relevant aviation requirements to support the recently introduced night flying ability. The charity that supported the Hampshire and Isle of Wight air ambulance had invested in a new base for the service. This was in the process of being completed at the time of the inspection and would result in the air ambulance service having its own air hanger with attached office spaces.

Medicines

- Morphine was kept in a safe in the ambulance or rapid response vehicle itself. Access to the safe was by electronic pass card. Only Paramedics should have had access to these controlled medicines. There was a stock check book for the morphine that was signed by the paramedic on starting their shift.
- When the stock level of vials of morphine was five or below a further supply would be requested from the resource centre. Some stations had their own supplies of morphine that could be accessed by team leaders only. This was stored appropriately in a double locked cupboard with restricted access. All stock would be signed in and out when issued to a paramedic.
- We observed one incident where an emergency care assistant was given the electronic access card by the paramedic attending to a patient. The purpose of doing this was for the ECA to go to the vehicle and access the controlled drugs storage and return with morphine for the paramedic to administer to the patient. However, this was against the trust's medicines management policy (July 2014) on access to controlled drugs.
- The disposal of morphine that had been partially used was raised as a concern as not all staff were aware of the trust policy. The trust policy concerning the use of medicines and controlled drugs states that unused morphine should be discarded on paper towel and placed in a clinical waste bin. Staff understanding around this varied and we observed one incident where

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partially used morphine was being disposed of inappropriately. This was raised as a concern during the inspection and information was sent out to staff regarding this policy as a result.

- There was a tagging system in use for ambulance medicines bags. Bags were coded to allow staff to identify a bag that had been opened since it had been dispensed by pharmacy, but that had sufficient medicines within it. A bag that required restocking was sealed with a red tag, this helped ensure that the bag would be swapped for a replenished one. However, some medicines bags that did not contain a supply of red tags. This meant that crews could not always identify when a medicines bag required replacement. This could lead to a crew attending a patient without the expected medication necessary to aid treatment.
- There was a log in each ambulance to record the numbered tag and the medicines bag to which it was attached. However, we found not all tags corresponded with the manual logs. This meant the crews could not be assured that the medicines bags contained the expected levels of medicines. In the resource centres there was an audit trail that recorded medicines bags which had been returned, and the details of the vehicle and member of staff that took the replenished one.
- Controlled drugs registers were appropriately completed. Of the 53 registers were checked, we found two registers at different locations that had not been completed appropriately. The required signatures were missing and stock checks had not been balanced and cross-checked and two ampoules of controlled drugs were not accounted for. This was escalated to the trust during the inspection and an audit was undertaking. The trust identified that there had been poor record keeping but no drugs were missing.
- Staff we spoke with told us that if they found any medicines missing against check sheets this would be reported as an incident.
- Medical gases were stored appropriately on the vehicles we checked, these were found to be in date. The station storage of medical gases was secure and appropriate with segregation between full and empty cylinders. Cylinders were stored securely in racks.
- Paramedics and ambulance technicians recorded medicines they gave to patients including the dosage and the rationale for treatment. Medicines that were administered to patients were documented on the ePR. We observed this being done. There was an additional step on the ePR to ensure that a paramedic was able to sign for medicines they had administered.
- Specialist paramedics were issued with an up to date British National Formulary in order to aid them when giving medicines to patients. We were shown a system of storing and checking medicines, that specialist paramedics were piloting. Medicines were only accessible to trained clinicians and there was a system for logging use by the specialist with a stock check carried out on a monthly basis. We checked the storage of medicines at two bases taking part in the pilot, and found that the stock balanced.
- The trust used green bags on ambulance vehicles to ensure patients own medicines could be taken to hospital. This helped to support medicines reconciliation
- Patients that were not conveyed to hospital but were given medicines by the ambulance service, were given an information card explaining what to do if they felt unwell again and other advice. These cards were written out by the clinician in response to the medicines given.
- We found a number of incidences where medicines were out of date. 1. Medicines within nine anti-nerve agent packs we checked was out of date. The trust were aware and had produced a hot news bulletin in April 2016 raising awareness of these items, and told staff that they were safe to use until more stock could be obtained to replace them. 2. On one team leader car that we checked two out of four bags of intravenous fluid were out of date. We raised this at the time and these were removed and replaced. 3. At one ambulance station we found an ambulance vehicle unattended and unlocked, this gave access to first and second response bags and therefore all the medicines and supplies contained within them. Although we entered and checked the ambulance we were not challenged by staff. This was escalated during the inspection who secured the site. 4. Three medicines used in bags had gone out of date. This meant that disposal of medicines from 200 bags had created a high volume of waste in the make ready medicines room. There was insufficient storage space for this quantity of medicines waiting for removal and destruction by pharmacy.
- Staff were administering medicines to patients with the legal authority to do so. The trust had Patient Group Directions (PGDs) in place to cover the administration of

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a list of authorised medicines. A PGD is a written instruction for the administration of medicines to a group of patients. The trust had no central record of patient group directions or competencies for staff and there was inconsistency with the manual records across the trust.

- Medicines for the HART team were dispensed centrally, in line with trust policy, by the pharmacy team at the Nursling Resource Centre. We saw good processes for checking the medicine module bags to ensure they were complete and in-date.
- Air ambulance paramedics were responsible for replenishing the stock of medicines in the medicine module bags, from the medicine store. A named member of the clinical staff had responsibility for ordering medicines. An innovative practice for monitoring levels had been developed at the air ambulance base in Andover which included the use of QR codes. This meant accurate records of all medicines held on site were accessible to the named clinical staff who ordered appropriate levels of medicines to ensure there was a sufficient stock of medicines at all times.
- Storage of medicines at the air ambulance base in Andover was in a locked cupboard in a locked room. There was a process of storing keys in locked safes to ensure security of the medicines. This process was to be simplified when the service moved into its new base, with access to medicines storage being through staff trust identification cards, in line with the trust's medicine management policy.
- At the beginning of each shift medicines modules were signed out of the storage area and placed in the helicopter in readiness for attending to incidents. During the day, the helicopter was left open so the crew could access it promptly when called to an incident. This meant medicines on the helicopter were accessible to anyone walking through the area. We asked staff how they ensured there was no risk of medicines being accessed by unauthorised personnel. They explained the door to the office was left open so they could see if unauthorised people were in the area. However, the position of the office, the position of the helicopter and the fact the airfield was a public area meant the security of medicines (including controlled medicines) on the helicopter could not be assured at all times. However, there was a planned relocation of the service underway, where the air ambulance was to be moved to a purpose built facility.

- The Make Ready team also handled bags containing medicines, these were sealed with plastic tags with unique identification numbers that were recorded by on-coming crews. The Make Ready team did not have access to controlled drugs.

Records

- Patient records were recorded on an electronic patient record (ePR) and in accordance with Joint Royal Colleges Ambulance Liaison Committee (JRCALC) 2016 guidance. These were secured with passwords. The records used patient pathways to act as prompts for staff.
- This record would also provide staff with special notes if there was important information known about the patient by the emergency control centre. For example, if it was the patients wish not be resuscitated and there was a do not attempt resuscitation order in place.
- When the ePR is not available staff used paper records. This was deposited in a locked box at each ambulance station. Of the 20 resource centres we visited there was one, North Harbour, where the secure box was emptied and scanned into ePR by the make ready team. However the make ready team had not had any training in handling personal identifiable information. The trusts waste management policy states confidential waste was shredded and disposed of by an outside contractor. At the North Harbour resource centre staff told us records had been stored insecurely for two weeks until they were destroyed by the make ready team.
- The patient electronic record is downloaded and printed off by the emergency department administration team when attending reception. Hospital systems do not fully interact with the ambulance trust electronic record so all information needs to be resubmitted by the administrative team.
- At hospitals who did not have the download facility staff could print off a copy of the ePR in the ambulance for the patient record. This could also be done for patients receiving a 'see and treat' service.
- In the emergency department reception, we observed that the ambulance crews liaised closely with the hospital reception staff to ensure that patient records were completed during handover.

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- Patients' clinical records followed a medical model. The format of the patient clinical record form was clearly laid out and followed JRCALC guidance. We reviewed five completed records. The documents were clear and legible, and followed the medical model.
- ECA and paramedics told us they liked ePR as they could quickly see patient records detailing previous interactions with the trust. This enabled them to determine previous concerns, issues, which helped staff plan individual care much more effectively at the scene.
- The trust carried out local reviews of patient records however, there was no process set up for doing this, or the recording of outcomes to feedback as learning to frontline staff.
- Electronic records prompted the recording of triage processes and decision making processes for declaring a major incident.
- HART teams had appropriate documents and tools for recording triage decisions for mass casualty triage decisions. Discussion with staff working on the urgent and emergency ambulances showed they had a good understanding of the processes and tools for triaging at mass casualty events.
- There was appropriate equipment on board ambulance vehicles to provide monitoring and assessment of patients. For example, patients could have a 12 lead electrocardiogram, oxygen saturations, non-invasive blood pressure, temperature and blood sugar recorded on the scene. There was also equipment to measure carbon dioxide in the blood. This allowed the crew to be able to supply the clinical support desk with detailed clinical observations to assist in getting the right urgent treatment for the patient. It also allowed the clinical support desk to liaise this information with the emergency department the patient was being conveyed too.
- Staff were experienced at conveying patients that had a mental health crisis and had received some training. Ambulance crew would ensure that they stayed with the patient at all times during transport to hospital and would talk to reassure them.
- Staff said if there was a concern about their own or anyone else's safety, then they would wait for the police to attend. Staff said police did not routinely attend unless the situation was or potentially could be violent.
- The trust command structure was defined as Gold (strategic), Silver (tactical) and Bronze (operational). Bronze command was the shift team leader and they had their own response vehicle. Bronze command responded to all cardiac arrests and carried an automatic chest compression device.
- A priority system as used by solo responders to identify what transport they required for their patient. We observed this being used and noted that for a priority one (most serious) this arrived in 20 minutes.
- Clinical staff working within the air ambulance and 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. This meant there was appropriately trained staff to assess, identify and treat patients who were deteriorating.
- All front line staff (HART, Urgent and emergency, air ambulance and PTS) had a set of NARU cards that were to be followed in the event of the crew attending a major incident or accident.
- Both air ambulances carried blood products. This was stored appropriately and enabled air ambulance staff to treat critically injured patients quickly.

Assessing and responding to patient risk

- Patients were assessed using a process based on the JRCALC 2016 guidelines. Staff used the National Institute for Health and Clinical Excellence traffic light scale for unwell children.
- Ambulance crews were able to contact the clinical support desk if they required information or advice about a deteriorating patient on the way to hospital or at a scene. The clinical support desk was available 24 hours per day. However, we did hear from some staff that if there was a delay in getting through, we observed this on one occasion. A clinical team leader was contacted as an alternative, however they did not have any additional clinical training to the paramedic.
- The service did not use a standard pre-hospital early warning score however, they provide one to one care on scene and during transit to hospital. Staff use their training and clinical judgement to assess the patient's condition, and they are able to detect and escalate the deterioration of a patient.
- Sepsis prompts were available and used by frontline staff and we viewed this within an issued pocket book. A clinical memo had also been produced and staff were able to refer to this memo.

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- Both the HART and air ambulance services had access to the clinical advisors based at the call centres for specialist advice.

Staffing

- The trust reported having vacancies for paramedic posts that reflected the national shortage of paramedics.
- Staff were structured into teams with a 4-week rota. The fourth week in the rota was a 'relief week', when staff were available to cover shifts that were unfilled in other teams because of staff vacancies, sickness or leave. Staff also worked extra overtime shifts and their hours-worked was monitored by the electronic rostering system. Over 15 week period 28 March to 4 July 2016, staffing hours were above planned levels because of the use of private providers (016% to 114%). The hours filled by SCAS staff alone ranged from 87% to 95%.
- Staff described instances of incorrect scheduling and inappropriate skill mix. This was rectified by a staffing sheet being sent to each ambulance station the previous day so that team leaders could identify errors.
- Clinical mentors reported the scheduling system sometimes omitted to schedule the students.
- The trust was undertaking a rolling paramedic recruitment programme and the service was supporting over 250 students across the trust. In addition, the trust was undertaking international recruitment in order to fill the vacancies. The trust had introduced a band 6 role of Enhanced Paramedic in order to assist with recruitment and retention, although the full scope of the role was not understood by some of the staff we spoke with.
- To mitigate staff shortages and ensure that the service provision was safe, the trust subcontracted work to four independent ambulance services.
- Bank staff were booked and used as part of the standard skill mix, so not normally available to step in to cover short notice absence or shortfall. The trust also used agency staff on a planned basis.
- Community first responders (CFRs) were volunteer staff that had been trained to be the first people on scene at an emergency. CFRs were deployed to support emergency response and were being integrated into front-line teams.
- We spoke with staff who were training to be paramedics but who had been an ECA. Some of these staff also had bank contracts as ECAs. These staff must work two shifts a month minimum and complete all required training for this contract. Managers and staff reported that this system worked well for both the trust and staff.
- All staff reported they often worked overtime as the volume of emergency calls had increased. Staff were sometimes going beyond their finishing time to complete their work with a specific patient. The majority of staff we spoke with estimated that two out of three of their shifts ran over their finishing time, and that this had impacted on their work/life balance. They could claim this additional time as overtime. Staff said if finishing late meant they had less than 11 hours between shifts they had the option to come in late for the next shift.
- Staff told us that they were usually able to take their meal breaks, but many reported that they might not get a meal break for 8 to 9 hours into a 12-hour shift. The staff told us they felt stressed and tired as a result, and this had led to low morale and a number of staff leaving the service.
- Teams had a skill mix of ECAs and clinical staff. A double crew of ECAs could attend red calls, but clinical staff must have provided backup and attended the incident as well. ECAs were unable to discharge patients and could not make the decision not to convey the patient to hospital. When an ECA crew was dispatched they must both have had at least 12 months experience and be signed off by clinical mentor as competent in their role.
- The HART team staff complement was 42 staff and a manager. These staff were broken up into seven teams of six staff. Each team consisted of a team leader, a team educator and four operatives (paramedics). At the time of the inspection the HART service had eight vacancies.
- The NARU's HART interoperability standards state, "The provider must maintain a minimum of six competent HART staff on duty for live deployment at all times." The HART manager and staff told us that, similar to other HART teams in the country, this standard was not always possible to meet. However, the number of HART staff available did not drop below four which meant there was never an occasion when there was not a team available to respond to incidents.
- Usual working practices meant two HART staff were assigned to a rapid response vehicle (RRV) that acted as backup for urgent and emergency crews. The numbers of staff working on the RRVs reduced to one when there

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were only five members of staff on duty, and none when there were only four members of staff on duty. This meant there was always a core team of four HART operatives ready to respond to incidents.

- Trust data for the period 14 June 2015 to 30 January 2016 showed that for 16 out of 460 shifts there were four HART staff on duty. In the same period for 76 shifts, there were five HART staff on duty. This data was submitted to a national database which meant there was national update information about the availability of HART staff.
- HART team members were recruited in accordance with the HART Recruitment and Selection Manual. There was a dedicated Human Resources member of staff, with an understanding of the needs and responsibilities of HART services, who supported the manager with recruitment.
- The air ambulance service had no vacancies. Each helicopter was staffed with a pilot employed by the respective charity, one critically care trained paramedic (CCP) and a pre hospital emergency medicine (PHEM) doctor. At night this increased to two CCPs and a PHEM doctor. When there was no PHEM doctor, two critical care paramedics would crew the air ambulance.
- Each RRV attached to the air ambulance service was staffed with PHEM doctor, PHEM trainee (a qualified doctor) and a CCP.
- Paramedics staffed a Helicopter Emergency Medical Service (HEMS) desk at one of the contact centres. They supported call centre staff to identify calls that indicated the deployment of the HEMS service that would reduce the risk of the patient's condition deteriorating.
- The Trust had an on call rota of a number of different managers with specific responsibilities for command and control during a Major Incident or significant disruption.

Anticipated resource and capacity risks

- The trust used the national indicator resourcing escalatory action plan (REAP). This is an indicator of demand on ambulance services. It is used to trigger specific actions when a trust is operating with significant and sustained levels of increased activity. The levels of REAP range from one (normal service) to six (potential service failure). REAP levels were displayed at ambulance stations, the air ambulance centres and Hazardous Area Response Team (HART) during our inspection.
- There were close working relationships with local hospital emergency departments. Daily telephone

conferences ensured that the ambulance teams were aware of any resource or capacity problems at hospitals. Electronic systems ensured that there was real-time monitoring of ambulances' (and therefore patients') waiting times at hospitals. If there was an increased number of patients and reduced capacity to receive them at emergency departments (ED), the hospital would implement a Hospital Ambulance Liaison Officer (HALO). Bronze command from SCAS or the HALO would then monitor the situation so that the ambulances could be redeployed on the road.

- In South East Hampshire there was a long term problem of extended ambulance handover waits at a local trust. SCAS were working with this trust to mitigate the risks to the ambulance service, such as delayed in responses to emergency calls where vehicles and crews were not able to be released from the ED.
- The area manager and their team at the North Harbour resource centre had undertaken a retrospective audit of patient outcomes, where they compared see and treat rates in two cohorts of 75 patients. The study showed that if ambulance attendance is delayed there was a higher rate of patients that required conveying to hospital. This research was undertaken to demonstrate the risks to the non-urgent patients that were subject to the greatest delays.
- The trust experienced high demand levels January - March 2016, staff experienced shift overruns and meal breaks were disrupted, the trust reported 60-80% compliance with the meal break policy. The trust have worked with unions to agree the policy. The trust was able to monitor staff meal breaks using their operational dashboard which provides up to date information on compliance.
- The trust were aware of shift overruns and developed a 'start and end of shift' policy. This meant that staff only attended priority emergency calls in the last hour of their shift.
- The trust could demonstrate the proactive maintenance of vehicles. To reduce the risk of vehicle breakdowns and time spent off the road. Half of the trust's ambulance fleet was maintained at the Nursling Resource centre, mechanics working from 6.30am-11pm five days a week. On weekends there was cover for 10 hours each day to ensure that urgent repairs could be carried out promptly.
- The trust had an Emergency Preparedness, Resilience and Response Policy (EPRR) in place dated March 2016.

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The policy referred to relevant legislation and guidance. This included the Civil Contingencies Act 2004 and NHS England EPPR documents and supporting materials. The HART team worked in partnership with pre-identified high risk sites in the SCAS region. This included development and monitoring of risk assessments for the sites and joint training with staff 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.

- The trust had a Business Continuity Plan (BCM) dated December 2014, that detailed BCM training was built into training for commanders at all levels (bronze, silver and gold). This was confirmed in discussions with relevant staff members. To ensure appropriate response across the trust to Chemical, Biological, Radiological, Nuclear and Explosives (CBRN-E) incidents 10% of front line staff received additional training and equipment to support the HART team responding to CBRN incidents.
- One hundred and twenty front line staff across the trust were trained and provided with appropriate equipment to support the HART team in response to Marauding Terrorist Firearms Attack (MTFA) incidents. In the event of mass casualty incidents, the trust had service level agreements with local coach companies to support the movement of 'walking wounded' patients as well as using available PTS resources.
- Those vehicles assigned with a dual ECA crew had a clinical appropriateness tool in order to determine that it was dispatched correctly, however we were told by staff and managers that they were sometimes sent to inappropriate calls for their skill mix.
- Reported incidents show seven occurrences of this happening over the last year, including as recently as April 2016. Some staff said that they may not always raise these as an incident and may report them directly to their manager.
- Bronze (operational) command would be stationed in ED at local acute trusts during periods of winter pressures.

Response to major incidents

- The trust had an Emergency Preparedness, Resilience and Response (EPPR) plan that described the emergency response structures and plans for business continuity. This was planned centrally. There was also a major incident policy that described the emergency

response structures and plans in the event of a major incident. Staff were aware of the EPPR and major incident plans. They told us that, in the event of a major incident, staff reported for work and volunteered to help without further prompting.

- In April 2016 a joint training event with HART was held. This was a mock disaster event at an acute trust within the region. This involved the police and fire services, and was organised by the major incident team.
- The trust had ambulances capable of treating multiple patients available for use in a major emergency.
- The trust command structure is defined as Gold (strategic), Silver (tactical) and Bronze (operational). Bronze command cover was provided through a network of Team Leaders.
- Team leaders and clinical mentors reported receiving comprehensive major incident training at the National Chemical Nuclear and Radiological Nuclear training site. This was a national course and was supported by an internal operational commander's course, organised by the trust, and a portfolio where they had to attend a two incidents or exercises per year and reflect on these.
- A SCAS area manager was based at the control centres for the junior doctors' strike as part of plan to minimise admissions to hospital. The trust had a major incident plan that set out the actions to be taken in the event of a major incident and the responsibility of staff. The Major Incident Plan brought together the Major Incident Procedure, CBRN Procedure, Radiological Incident Procedure, Mass Casualty Vehicle Deployment Procedure and the Mutual Aid Procedure to detail the South Central Ambulance Service NHS Foundation Trust's response to a Major Incident. The major incident plan referred to relevant nation guidance and legislation such as Civil Contingencies Act (2004), Multi-Agency National Concept of Operations for CBRN Incidents 2005, Home Office, Strategic National Guidance, The decontamination of people exposed to Chemical, Biological, Radiological or Nuclear (CBRN) substances or material, 2004, Mass Casualties Incidents: A Framework for Planning, DH 2007 and the ambulance service guidance on dealing with radiological incidents and emergencies, March 2010.
- All front line staff (HART, UEC, HEMS and PTS) had a set of cards that acted as guides to follow in the event of attending a major incident or major accident. These were developed from the NARU National Major Incident

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Cards to ensure staff followed current national guidance. Discussions with staff at urgent and emergency resource centres evidenced they had these cards to refer to.

- Front line staff were integrated into the resilience operations. To ensure appropriate response across the trust to Chemical, Biological, Radiological, Nuclear and Explosives (CBRN-E) incidents 10% of front line staff received additional training and equipment to support the HART team responding to CBRN incidents. 120 front line staff across the trust were trained and provided with appropriate equipment to support the HART team in response to Marauding Terrorist Firearms Attack (MTFA) incidents.

Are emergency and urgent care services effective?

(for example, treatment is effective)

Requires improvement



By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Overall, we rated effective as requires improvement:

- The proportion of patients with immediately life-threatening conditions or urgent conditions did not meet the target for 75% of patients to receive an emergency response within 8 minutes.
- The proportion of patients with life threatening or urgent conditions transported to hospital did not meet the target for 95% of patients to be transported within 19 minutes.
- Prolonged delays at some acute hospital emergency departments reduced the capacity of frontline staff to respond to patient's needs.
- The measure of the management of cardiac arrests for the subset of patients where timely and effective emergency care can particularly improve survival was worse than the England average.
- The proportion of heart attack patients having an appropriate care bundle was worse than the England average.

- Proportion of patients potentially eligible for thrombolysis arriving at a hyper acute stroke unit within 60 minutes was below the England average.
- The service clinical audit programme needed to develop further to monitor standards of care.
- Clinical advice to support paramedics was not always available in a timely manner.
- Clinical mentors and team leaders had not received additional training to support their roles; some trainees were not always able to have supervised shifts to assess their competency and development.
- Staff received an annual appraisal and although supervision was available staff did not receive regular supervision. Some required training, for example in dementia awareness and mental capacity, did not meet trust target levels.
- HART team educators did not have a formal qualification and HART staff did not have a formal process for clinical mentorship and supervision to their assess their competency in paramedic skills.
- Paramedics did not always have sufficient time to attend training. Some training was cancelled due to operational pressures. This affected their ability to complete their own paramedic re-registration.

However,

- The service followed National Institute for Health and Care Excellence (NICE) and Joint Royal Colleges Ambulance Liaison Committee (JRCALC) 2016 clinical practice guidelines and had access to a clinical advice team when necessary.
- Staff followed medical care protocols to assess and treat patients.
- The trust monitored national ambulance quality indicators and outcomes for cardiac arrest.
- The number of patients discharged, after treatment at the scene or who had onward referral to an alternative care pathway rather than a hospital (see and treat) was above the England average .
- Patients were given appropriate pain relief. Although this needed to improve for patients who had had a heart attack as part of the national care bundle and where dual crew ambulances had emergency care assistants who could only give gas and air.

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- A response targets for the transport of mental health patients in crises who needed a place of safety (section 136) within 30 minutes was being met for 74% of patients. The trust was above the England average of 62% (range 31% to 90%).
- Patients who had had a stroke and received an appropriate care bundle was comparable to the England average.
- Staff had appropriate induction and preceptorship support and had good access to training
- There was effective coordination of services with other providers and good multidisciplinary working to support seamless care, admission avoidance and alternative care pathways.
- Consent was appropriately obtained from patients prior to treatment. Staff were supported to undertake mental capacity assessments and had received appropriate training to do so.
- The service clinical audit programme, to monitor NICE guidance or prescribing and did not use the NICE tools to audit the implementation of guidelines. The trust planned for specialist paramedics and clinical mentors to lead on audit to monitor outcomes and to also audit patients that had re-contacted the trust within 72 hours.
- The trust participated (with three other ambulance trusts) in the Pre-hospital Assessment of Mechanical Compression Device in Cardiac Arrest (PARAMEDIC), led by Warwick University. This was the first large trial the trust had been involved in and supported clinicians to be part of research. The trial showed that there was no difference in manual and mechanical compression in terms of survival at 30 days. The trust was working to be part of PARAMEDIC 2 which will investigate if adrenaline is an effective treatment for patients suffering cardiac arrest.

Evidence-based care and treatment

- The ambulance service followed both the NICE and the JRCALC clinical practice guidelines. The national guidance was used to inform local practice. The latest 2016 JRCALC guidelines had been rolled out to all staff and staff had been trained in using them. We observed that clinical staff on ambulance vehicles and in attendance at hospital carried the JRCALC guidance and referred to it in their assessment and documentation of patient care. For example, we observed stepwise treatment for a patient that was hypoglycaemic.
- Staff could also access the JRCALC clinical guidance on the ePR system.
- There was guidance available about conveying mental health patients to a place of safety under Section 136 of the Mental Health Act 1983. Most, but not all, staff had had training in its use.
- Clinical updates were sent to clinicians via email. We saw some of these on notice boards in ambulance stations. The Trust was in the process of developing a system of audit to ensure that clinicians read the notice boards and understood the information on them.
- The trust routinely collected and monitored information about people's care and treatment. The clinical audit programme included the national ambulance clinical quality indicators and clinical outcome data for cardiac arrest. There were local audits on long waiting times, infection control, safeguarding and medicines.
- The ambulance staff followed medical protocols in assessing patients and planning their care. Staff also made effective use of other available protocols.
- Guidance was available for staff on considering and assessing the needs of young children. All Staff we spoke with were aware of the key signs of sepsis and the immediate actions to take.
- Staff explained that an increasing number of patients were treated at the scene by ambulance crews ('see and treat') without needing further transport to hospital. However, although figures were above the England average, for the year 2015/2016, the number of see and treat patients was declining from 39% in April 2015 to 35.9% in March 2016.
- Staff were confident with explaining the process for not conveying a patient to hospital and were encouraged to refer patients to alternative care pathways where appropriate. Staff could print a copy of the patient record or send an electronic copy of the patient record to the patient's own doctor if needed.
- Community first responders (CFRs) were deployed to support emergency response and were being integrated into front-line teams. A member of staff was responsible for developing the role of volunteers in the community. This included liaison with police and fire services, and linking responders with ambulance crews. Support networks within the trust were available for responders.
- A 24 hour Decision Support Helpline was available to frontline staff to enable them to access additional

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support whilst attending a patient. This provided support for staff to obtain better patient outcomes without impacting on resources. Some staff reported that it was sometimes difficult to get in contact with them as they were busy. Specialist paramedics could also be contacted via telephone if required.

- There were pathways in place for specialist care centres, including Hyper Acute Stroke Units and Primary Percutaneous Coronary Intervention (pPCI) for treatment of heart attacks in line with national quality standards and staff were aware of these through local bulletins. There were a number of different specialist centres available for specialist urgent treatment of acute conditions. Each service had different operating hours which could be confusing for staff. However, staff could access the pathway via the ePR or guidance would be given by the control centre if requested.
- There was a falls pathway available on the ePR for staff to complete. This system enabled elderly patients at risk of falling to be identified and referred to other services.
- We observed an episode of care with a patient in their supported living accommodation. A paramedic attended in a rapid response vehicle and carried out a comprehensive patient assessment. The paramedic aimed to see and treat the patient at home, however, after further assessment determined that the patient required hospital treatment and called for an ambulance.
- We observed a dual crewed ambulance (paramedic and ECA) arrive and assess a patient in a public setting. An early assessment was made of the situation and the patient was taken into the ambulance as soon as was safely possible. Assessment of the patient continued throughout and, following further details obtained from the patient, the paramedic revised the initial decision to discharge patient and conveyed the patient to hospital.
- Operational staff for HART and air ambulance described their use of a trauma bypass tool. The tool allowed them to bypass the nearest acute hospital emergency department. Data entered about the patient's condition, identified the most appropriate acute hospital for the patient to be treated at rather than the nearest one. For example, patients with acute head injuries would be taken to the nearest neurological unit and patients with an acute cardiac event would be taken to a hospital that could treat their condition promptly.

Response times

- Category A (Red 1) incidents are patients presenting conditions, which may be immediately life threatening and should receive an emergency response within 8 minutes irrespective of location in 75% of cases. For the period April 2015 to March 2016 the trust only reached the national target of 75% in two months, April and May 2015 for Red 1 calls. The lowest response rate was 69% which occurred in July and September 2015 and March 2016.
- Category A (Red 2) incidents are patients presenting conditions, which may be life threatening but less time-critical and should receive an emergency response within 8 minutes irrespective of location in 75% of cases. The trust had not met the 75% target in five of the 12 months in the period April 2015 to March 2016. Performance against this target had been deteriorating month on month for the period January to March 2016. In March 2016 the trust recorded its lowest response rate of 68% against the target of 75%.
- Category A (Red 1 and Red 2 referred to as Red19) are incidents of patients presenting conditions, which may be immediately life threatening and should receive an ambulance response at the scene within 19 minutes irrespective of location in 95% of cases. If Red 1 or Red 2 calls were initially attended by a single clinician in a Rapid Response Vehicle (RRV) and onward conveyancing of the patient was required by a double crewed ambulance (DCA). For SCAS, the standard was only met during four months of the year for the period April 2015 to March 2016. In the trust recorded its lowest response rate of 92.8% and 93.8% in February and March 2016 respectively. The trust was above the England average during this time period.
- A response targets for the transport of mental health patients in crises who needed a place of safety (section 136) within 30 minutes was being met for 74% of patients. The trust was above the England average of 62% (range 31% to 90%).
- The trust had contract performance notices issued to them by the clinical commissioning groups in response to not meeting the target for red response times. An improvement plan was in place that the trust are working towards.

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- We observed noticeboards in ambulance stations that displayed Red 1 and Red 2 response time current levels against targets. All staff we spoke with were aware of the expectations of them in regard to these times and the reasons that it was important for performance.
- Local managers used an online system to monitor individuals performance around key areas. In particular the mobilisation time (the time that the crew receive an incident to the ambulance being mobile) and the handover to clear time after conveyance. This allowed local managers to positively impact on trust targets by operationally managing their resources.
- The NHS HART interoperability standard 2015/16 published by NARU February 2015 detailed the response times required by HART teams to attend incidents. The location of the SCAS HART team meant they were able to meet the requirement to place HART staff on scene at strategic sites of interest, as identified by the Home Office, within 45 minutes. The practice of only releasing HART staff to work on the RRVs when numbers of staff on duty were over four meant the provider met the requirement that four HART staff must be available to respond locally to any incident identified as potentially requiring HART capabilities within 15 minutes.
- However, on the occasions when staffing numbers were below six, the trust would not be able to meet the requirement that if HART capability was confirmed as being required that six HART staff are available to respond to the scene within 15 minutes of that confirmation, (the six included the four already mobilised).
- Response times for the HEMS services was incorporated into the urgent and emergency response times.
- We observed staff asking patients about their pain using these tools when assessing patients. Some staff told us they needed further training, and this was due to be done at a team training day.
- When pain relief medicines were given to a patient, we observed staff checking with the patient that this had been effective and updated the pain score. Staff recorded the medicines they had given the patient on the ePR.
- Hospital staff reported that patients were usually administered pain relief proportionate to their pain, and this was usually handed over. Children were administered analgesia by a specific protocol that staff had access too. Dual crewed ambulances with emergency care assistant (ECA) only had Entonox as an option for pain relief. Hospital staff reported to us that this meant some patients would be transported without sufficient pain relief.

Patient outcomes

- The number of patients treated at the scene that did not need to be conveyed to hospitals was above the England average. For the period April 2015 to March 2016 the number of 'see and treat' patients averaged 36% of patients. The rate had declined from 39% in April 2015 to 35.9% in March 2016. The rate was above the England average.
- At the time of inspection the proportion of patients who re-contacted the service following treatment and discharge at the scene, within 24 hours, was 5% which was the same as the England average of 5%.
- Following a cardiac arrest, the Return of Spontaneous Circulation (ROSC) (for example, signs of breathing, coughing, or movement and a palpable pulse or a measurable blood pressure) is a main objective for all out-of-hospital cardiac arrests, and can be achieved through immediate and effective treatment at the scene. Percentage of patients with ROSC at time of arrival at hospital was better than England average. The overall rate measures the overall effectiveness of the urgent and emergency care system in managing care for all out-of-hospital cardiac arrests. The overall survival rate for patients surviving to discharge post cardiac arrest was better than England average (April 2014-October 2015).
- The rate for the 'Utstein comparator group' provides a more comparable and specific measure of the management of cardiac arrests for the subset of

Pain relief

- 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 give pain relief medicines (with the exception of morphine).
- The trust used three pain tools for assessment of patient's pain levels. There was a tool for adults, another for children, and one for patients with a learning disability or who did not speak English.
- Records demonstrated staff asked patients a pain score as part of their initial observations. Staff were checking patient's pain as a priority, and administered pain relief quickly. Staff checked the effectiveness of pain relief.

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patients where timely and effective emergency care can particularly improve survival. For example, 999 calls where the arrest was not witnessed, and the patient may have gone into arrest several hours before the 999 call are included in the figures for all patients, but are excluded from the Utstein comparator group figure. For the Utstein Comparator Group the percentage of patients with ROSC at time of arrival at hospital was worse than England average. For this group the percentage surviving to discharge was variable above and below England average, but was consistently worse from June 2015 (April 2014 – October 2015).

- Heart attack or ST segment elevation myocardial infarction, (STEMI) is caused by a prolonged period of blocked blood supply. It is therefore vital that blood flow is quickly restored through clinical interventions such as thrombolytic ("clot-busting") treatment or primary percutaneous coronary intervention. In addition to these primary treatments, however, patients with STEMI need to be managed in the correct way, including the administration of an appropriate care bundle: that is, a package of clinical interventions that are known to benefit the health outcomes of patients. For example, patients should be administered pain relief medicines to help alleviate their ongoing discomfort. The proportion of patients receiving primary angioplasty within 150 minutes was comparable to the England average. The proportion of patients with ST-elevation myocardial infarction who received an appropriate care bundle is worse than the England average for all months in the reporting period. (April 2014 – October 2015). The trust was implementing an action plan to improve this.
- As set out in the NICE national quality standard, the health outcomes of patients can be improved by recognising the symptoms of a stroke or transient ischaemic attack (TIA), making a diagnosis quickly, and early transport of a patient to a stroke centre capable of conducting further definitive care including brain scans and thrombolysis. The proportion of stroke patients potentially eligible to receive thrombolysis at a stroke unit within 60 minutes was below the England average. The proportion of suspected stroke patients assessed face to face who received an appropriate care bundle was in line with the England average (April 2014 – October 2015)
- For the month of March 2016 the following care bundles were also reported against national targets. The use of

care bundles for patients with Hypoglycaemia was 100% against a target of 98%; asthma 74% against a target of 82%; limb fractures 50% against a target of 46% and febrile convulsion of 94% against a target of 87.5%.

- Staff had access to direct phone numbers for specialist centres which treated acute conditions such as stroke and heart conditions. This meant that they were able to discuss the patient directly with the receiving hospital to gain authorisation to take them straight to the unit where they would be treated. We observed this being done for a patient that required direct admission to a cardiac centre.

Competent staff

- The frontline staff were split into teams led by a clinical mentor and a team leader. Neither of these roles had received any additional clinical training and staff told us that this could be challenging when they were acting as clinical lead. However, to mitigate this they did use specialist paramedics and other health care professionals when required to deliver training or provide specialist advice to their teams.
- Staff informed us of a thorough induction process and new staff reported the induction and training gave them confidence and knowledge in starting work with the trust. Paramedics received a comprehensive induction programme that included emergency driving for an RRV. Emergency care assistants (ECAs) completed a 12-week induction course before taking on clinical duties. Staff told us that they felt confident and supported.
- Staff who had transferred from another service had a week of corporate induction, one day clinical training and supervised third person shifts.
- Preceptorship was used to provide support for newly qualified clinical staff during their first six months of employment by the trust. A newly qualified paramedic told us they were on a six month preceptorship. This included five shifts as an additional person, eight shifts with a clinical mentor and an additional seven shifts with a clinical mentor spread out over the first six months.
- Staff we spoke with, particularly trainees, reported , it was difficult to get shifts rostered with clinical mentors. For some trainee staff this meant that they were not able to fulfil their requirement for 15 mentored shifts in six months. Therefore they would be unable to get the requirement elements of their training signed as completed.

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- All staff reported that team training days were valuable. These were organised by team leaders, with agenda's and content designed around the training needs of the staff at that time.
- There was an in-house training program for Emergency Medical Technicians (EMTs) to study towards paramedic registration in conjunction with Oxford Brookes University. We spoke with one paramedic who had recently completed this training route and they reported that it had worked well with good support from the trust.
- All teams received protected time for team based training. This was two hours every six weeks however, this was often accrued so that a whole day could be used for training. Examples of team training were updates from midwives, talks on major trauma, mental health and from specialist paramedics.
- Staff had the option to attend other training in their own time. An example included using tools for managing patients which encouraged staff to involve GPs to help make triage decisions and a neuro assessment refresher consisting of cranial nerve assessment to aid in diagnosing or ruling out critical indicators of serious injury.
- Paramedics are required to re-register with the Health and Care Professions Council (HCPC) every two years. As part of the process, they are required to undertake continuous professional development (CPD) and receive clinical supervision. The majority of paramedics we spoke with across all divisions told us there was insufficient time given to support this process, and training sessions, (including mandatory training), had been cancelled.
- The service employed specialist paramedics who were trained in primary care and could attend patients with minor illnesses and injuries and treat them at home, in order that they could avoid admission to hospital.
- All front line staff in urgent and emergency services completed training about resilience and major incidents. Staff we spoke with at resource centres had a good understanding about the role of the HART and HEMS team and were confident in requesting their support when required.
- Staff had undertaken training in dementia. Some staff reported that the training had been helpful in raising awareness. However the uptake was variable and overall was low at 49%. The trust target was 95%.
- Car shifts (in an RRV) were included on the rota for paramedics. However these were not rostered until the paramedic had been qualified a year and they had completed an additional driving course.
- Staff reported that the appraisal process was positive, with most having received an appraisal from their named team leader in the last year. Data provided by the trust demonstrated that at April 2016 the appraisal completion rate for frontline staff was between 33% to 93% against a trust target of 95%. Overall 22% of staff were overdue their appraisal.
- Staff did not have regular supervision. Supervision was undertaken by team leaders and clinical mentors at a minimum of once every year.
- The NHS HART Interoperability Standards require each member of staff to have 37.5 hours protected training every seven weeks. To facilitate this staff team was divided into seven teams of six staff. Every seven weeks they had a training week where they were not rostered for operational duty. The team educator facilitated the training programme for the team, ensuring that over a 12 month period the plan encompassed all the training required to meet the national training standards for HART.
- HART training records incorporated an annual planner that fed into weekly plans. This provided assurance that training plans were delivering the required training. Individual staff records evidenced they were completing the required training.
- At the time of the inspection HART team educators told us not all of them had had the opportunity to obtain a formal teaching qualification suitable to the role they carried out. This issue had been recognised by the trust and team educators were being provided the opportunity to acquire formal teaching qualifications. Team educators facilitated the on-going training and education of the team either through delivery of the education or collaborative work with internal or external subject matter experts. There was protected time for training every seven weeks. HART training and education incorporates the specialised components of HART skill sets as specified by National Ambulance Resilience Unit (NARU) as well as generic paramedic skills and competencies. The trust informed us, informal peer group mentoring and supervision occurred when

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HART teams attended incidents. They also said it was common practice to have a hot debrief after incidents where there was an opportunity to discuss clinical interventions as well as HART specific procedures.

- All air ambulance paramedics completed critical care training to become specialised critical care paramedics. All air ambulance medical staff employed by the air ambulance charity were required to have completed the pre hospital emergency medicine (PHEM) course as specified by the Royal College of Anaesthetists. Both air ambulance paramedic and medical staff completed training specific to air safety to equip them with the skills to support the pilot and promote the safety of patients carried in the aircraft.

Coordination with other providers

- Ambulance staff told us that they had good working relationships with the other emergency services. This included the fire and rescue services, police, coastguard, the Royal National Lifeboat Institution and the local acute hospitals.
- Hospital emergency departments worked with ambulance staff in most areas to ensure the ambulances could be released quickly. For example, in Southampton there had been work to ensure that there was good liaison between the services to allow emerging pressures to be discussed.
- The trust had implemented an 'immediate handover policy' across the service to address issues of ambulance queues. This has not needed to be used in all cases, however, it provided a framework of clarity between the service and the hospital when required. The policy had not been agreed across the Portsmouth system. The trust had attended risks summits to agree urgent action because of long queues and delays in ambulance handover. The trust had recently agreed May 2016 an escalation policy in Portsmouth.
- There were shown a number of agreed care pathways that had been set up with local services.
- The trust had put a lot of effort into hospital admission avoidance, and staff had a list of alternative care options to try and assist with what to do to help. This included contacting district nurse teams, GPs and specialist paramedics for advice.
- The ePR system used by ambulance staff triggered certain pathways for patients. For example local pathways included access to multi-disciplinary beds and a Rapid Assessment Community Clinic.
- Ambulance staff were provided with documentation showing alternative care providers and referral pathways for SCAS staff and independent providers to use to try to avert hospital admissions.
- The trust were reviewing their high intensity users (those people that have called 999 10 times and more in the last 12 months). The trust has developed a scheme to reduce ambulance journeys. The emergency operations centre (EOC) had information on these users, and call takers follow agreed care plan for a particular patient and recommended an alternative referral route. The trust currently had plans in place for approximately 100 such patients.
- The UK Ambulance Services National Memorandum of Understanding Concerning the Provision of Mutual Aid sets out the agreement between emergency responders in the UK, within the same sector or across sectors, and across boundaries to provide assistance with additional resources during an emergency. These resources may go beyond that of an individual service. We observed the HART team acting in accordance with this memorandum during the inspection when they responded to the request for support in an incident from a neighbouring ambulance trust.
- Records from reviews and action plans of major incidents and exercises attended evidenced a multi-provider response to incidents, including neighbouring ambulance providers, police and fire and rescue services and acute hospitals. Detail in action plans we reviewed showed that all agencies were involved in developing them and took responsibility for relevant actions, and ensured that learning from incidents was shared across all agencies.
- Hampshire and Isle of Wight air ambulance served the population of the Isle of Wight. The Isle of Wight had its own ambulance service, but relied on the Hampshire and Isle of Wight air ambulance service to provide rapid transfer of patients to the mainland for time critical treatment. In the event of an incident requiring HART expertise, the air ambulance service was tasked with transporting HART equipment and personnel to the Isle of Wight.
- The trust had a care pathway agreed in Buckinghamshire commissioners for the care of Stroke patients in the hyper acute stroke unit. The site was at Wycombe General Hospital which did not have an emergency department. The trust identified difficulties ensuring Stroke patient could be transferred and treated

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within the national standard of 60 minutes, if they went to a hospital with an emergency department prior to the diagnosis of stroke. Transfer protocols currently did not identify how to ensure stroke patients would receive treatment within appropriate timescales.

Multidisciplinary working

- Emergency department (ED) staff across the south central area reported that handovers of patients from SCAS ambulance crews were appropriate and detailed. They spoke positively about caring, hands on, and professional delivery of care to patients by ambulance staff. We observed patient handovers between ambulance staff and ED staff at hospitals across the south central region. There was an initial verbal handover for triage then the SCAS crew would download the patient records from their tablet computer to the hospital patient information system or provide a paper copy, where required.
- ED staff reported good working relationships between them and ambulance staff. For example, an ED consultant group in Oxfordshire worked across two hospital sites. They were therefore able to bring shared learning to both emergency departments and work in a co-ordinated way with ambulance crews.
- Hospital staff across the south central area reported they saw the ambulance staff as part of the emergency team. We observed handovers from crews using the acronym ATMIST (A – age and other patient details, T – time of incident, M – mechanism, I – injuries sustained, S – signs, T – treatment and trends) which ensured that they were thorough and consistent. Staff at one ED reported how they had worked with SCAS to change how priority calls were structured such that the ED staff would lead the call requesting information from the ambulance crew. ED staff reported this had resulted in priority calls being more efficient and effective when transferring priority information regarding the patient and took pressure off the SCAS crew dealing with the incident.
- The trust attend multi-agency meetings at hospitals for those patients experiencing a mental health crisis. In addition ambulance crews could contact mental health team using a mobile directory of service system for advice for particular patients and to discuss the most appropriate course of action for that particular patient.
- Ambulance staff reported good working relationships with other areas of the trust. We observed good

communication between the call centres and ambulance crews. Ambulance crews could contact the clinical support desk if they had any queries about a patient's condition or treatment and needed advice or support

- Ambulance staff completed a falls referral when a patient aged 65 years or over has fallen but was not conveyed to hospital. This is sent to the patient's own GP.
- Staff, including EOC staff, received training about the Joint Emergency Interoperability Programme (JESIP) principles, which included multiagency working and structured processes for conveying information about major incidents.

Access to information

- A variety of information was available to all emergency and urgent care ambulance staff. Policies and procedures were available on the trust's intranet system. Some were available on ambulance station notice boards. However, staff informed us they did not always have time to look at them. Clinical updates or changes in procedures were generally emailed to staff but there were no systems in place to ensure staff had read and understood the information they were sent. Staff could access the trust's intranet from home via a secure log-in through the public website. The Trust was in the process of developing an audit system at the time of the inspection.
- The electronic patient record was used across all the services in the trust. If there was information held about an address at the control centre for example, where threat of violence had been recorded, there would be a special note displayed to make crews aware of this. On some occasions the ambulance would not attend unless co-responded by police.
- Where the patient was subject to a do not attempt cardio-pulmonary resuscitation (DNACPR) this information would also be available to ambulance crews. However, sometimes this information had not been accurately communicated with the control centre. Crews were required to see the original DNACPR form in order to attend the scene but not resuscitate a collapsed patient.
- Hospital staff reported that normally anyone with a DNACPR would have a form with them from their previous place of care and SCAS ensured this was handed over to the hospital staff.

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- The electronic patient record system also contained patient pathways, these helped guide staff to collect the correct information to monitor for signs of deterioration. The system also led staff to relevant parts of the JRCALC guidelines.
- Staff were able to access the directory of services and alternative pathways for patients using their hand held tablet. Alternatively they could contact a team in the control room for advice of the tablet was not able to access the internet.
- All staff including ambulance, HART and air ambulance staff said they could access policies, procedures and other clinical guidance via the trust's intranet and paper documents held at ambulance stations or air ambulance and HART bases.
- Access to medical advice and information was available through the clinical advisors team based at the emergency operations centres. Staff spoke positively about the availability and information provided by the clinical advisors.
- We saw both the HART team and the HEMS teams had robust systems to ensure staff were informed about relevant patient safety alerts, and any changes in practices in response to safety alerts.
- Staff reported that they had received training related to the Mental Capacity Act (MCA) 2005. Data from the trust confirmed that at the time of inspection 81% of staff had received MCA training, against the trust target of 95%.
- We observed ambulance staff using a form on the ePR in order to guide them in the assessment of a patient's mental capacity. We spoke with a mental health nurse who had been involved in a recent transfer of a patient experiencing a mental health crisis and she gave positive feedback about the ambulance crew.
- Emergency department staff confirmed that ambulance crews would highlight vulnerable patients upon arrival at the department. Where appropriate, crews would inform ED staff prior to offloading patients from the ambulance. This enabled the ED staff to advise the crew on the most appropriate place for the patient to be accommodated within the department.
- All HART and air ambulance staff we spoke with demonstrated a good working knowledge of their responsibilities in relation to the Mental Capacity Act 2005. Staff confirmed, where possible they would always seek verbal consent before providing treatment to patients.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Crews were aware of their responsibilities for obtaining consent from patients. We observed crews asking patients for their permission to undertake observations and examinations.
- We observed staff seeking patients consent before they used seatbelts or straps to restrain them safely for the journey.
- Data from the trust showed that, at the time of inspection, 78% of staff had received training in conflict resolution against a trust target of 95%.
- Ambulance crews, including clinical mentors and paramedic staff, had a good understanding of consent and the Mental Capacity Act (MCA) 2005. They were aware of knowledge of the Act and how the ambulance service interacted with other agencies in implementing its requirements. Information was displayed in resource centres about mental capacity and consent. For example, the mental capacity assessment flowchart for staff to use as a reminder.

Are emergency and urgent care services caring?

Good



By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Overall, we rated caring as 'good':

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

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- Patients, their relatives and other people important to them received emotional and practical support from ambulance crews.

However,

- We observed two incidents where ambulance crews were not talking to patients or checking on their welfare while they waited to handover patients.

Compassionate care

- During our observations of care by front-line SCAS staff in all divisions, we observed compassionate care to patients in ambulances, patients' homes and in the emergency departments of hospitals.
- Patients and relatives across all the divisions in SCAS told us they were very happy with the treatment and care they received from ambulance crews.
- The majority of patients we observed were treated with respect by ambulance staff. Patients conveyed to hospital were covered in a blanket to maintain their modesty and keep them warm whilst on a stretcher or in a wheelchair. Ambulance doors were shut after loading patients to ensure they were kept warm or cool and their privacy and dignity maintained. Ambulance crews maintained the dignity of patients when transferring them from a stretcher to a hospital trolley or bed.
- A patient's relative told us that ambulance staff were 'lovely' and 'excellent'. They showed respect towards them and the patient with learning disability. The patient was unable to communicate and staff were understanding and patient with them. The relative had called the ambulance frequently since Christmas and she found staff consistently professional and kind.
- We observed staff demonstrating empathy and a caring approach with their patients. The staff we saw introduced themselves to patients and made sure that they were thoroughly informed of the treatment that was needed, and what was going to happen next.
- Staff at one hospital told us that ambulance staff often asked after patients that had been admitted.
- We observed the assessment of a patient in the lounge of a nursing home where other residents were present. The staff considered moving the patient but stayed in this area as the patient was calm and comfortable. They considered the patient's privacy during the assessment and discussion they then carried out.

- We observed staff speaking with relatives in a caring and respectful way, informing them of choices of transportation, such as travelling with the patient in the ambulance or directing them if they wished to travel in a car.
- Where a patient did not have capacity, we observed the ambulance crew discussing the treatment options with the relatives.
- We observed an ambulance crew reassure a relative whose father was unconscious. They gave the relative clear information and told them what treatment they would be carrying out. They did this in a calm and compassionate manner.
- Friends and family tests results for April 2015 to March 2016, showed the majority of patients would recommend the service to friends and family. The average was 74% (range 63% to 92%), other than for November 2015 (42%). However, the response rate was very low, and therefore results were variable, the average was 0.1%.
- Hospital handovers were conducted as privately as possible and staff tried to ensure that confidential information was not overheard and curtains were drawn in the receiving bays.
- Relatives were treated with courtesy and respect and staff engaged with them appropriately, and provided information and support.
- We only observed two incidents where ambulance crews were waiting to handover patients to a hospital. The crews were not talking to or checking on their welfare but were talking amongst themselves. At one point the crews were talking over a patient.

Understanding and involvement of patients and those close to them

- We observed patients being involved in decisions about their care and treatment throughout our inspection. Ambulance crews gave clear explanation of what they were going to do with patients and the reasons for it. Staff checked with patients to ensure they understood and agreed to the treatment offered.
- Patients we spoke with told us that the reason for the care and treatment they were given was fully explained to them. Relatives we spoke with said staff always explained what they were going to do, and that they could travel with the patient to hospital. They were grateful for the support of the ambulance staff.

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- We observed staff adjusting the way they communicated with different patients in order to explain treatment and gain their consent. They listened to the patient's wishes and offered options for care that suited the patient's individual situation and circumstances.
- We observed a patient being given a choice of options available for care and treatment at a minor injury centre or by a specialist paramedic. Staff listened to the patient's preferences and helped them to decide what care and treatment most suited them.

Emotional support

- Ambulance staff were observed giving emotional support to patients. We saw staff holding the hand of an elderly frail woman while the patient was being dropped off at ED. Another example was where a relative came to give staff a thank you card, they told us how their grandmother was helped and supported by a staff as she was being taken to hospital. They described the emotional support provided to them and to their grandmother.
- We observed ambulance crews being very calm and supportive to distressed patients and their relatives. Hospital staff we spoke with said that the ambulance crews had a gentle approach to those patients experiencing a mental health crisis.
- We saw an ambulance crew offering reassurance and support to a patient who had suffered a fall this was seen to have reduced the patient's anxiety.
- We observed good interaction between a crew and the mother of a sick child, the mother was supported by ensuring they understood and agreed the treatment plan.

Supporting people to manage their own health

- The service had introduced demand practitioners to work with high intensity users (patients who call 999 frequently). The demand practitioner organised multidisciplinary team meetings with the patient's own doctor and other organisations, as well as involving the patient themselves to devise a specific care plan for the patient.
- Frequent and high volume callers were identified by the operation centre staff and ambulance crews would be

informed before they attended the address. Staff told us they always relied on clinical assessment when they attended that ensured patients received appropriate care.

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

Good



By responsive, we mean that services are organised so that they meet people's needs.

Overall, we rated responsive as good:

- The emergency service was being planned around the needs of local people, and urban and rural issues were being taken into consideration.
- The trust was dealing with an increasing number of emergency calls and was developing alternative pathways to transport to hospital. The trust was above the national average for treating people at the scene without the need to take them to hospital.
- The trust developing services to reduce long waiting times and was increasing its use of community first responders, identifying further resources for GP ambulance calls, and employing specialist paramedics to who could treat patients at home in order to avoid hospital admission.
- There was a demand practitioner was in post who was working with acute trusts and care homes with the aim of reducing the number of inappropriate calls and frequent callers to the service.
- The air ambulance services could respond to calls within their region within 15 minutes. In addition, night flying had commenced (until 2am) to meet the demand of the service.
- There was support for vulnerable patients, for example, people with a mental health condition, a learning disability and those living with dementia. Staff told us they had more awareness of meeting the needs of vulnerable patients.
- Staff had access to translation and interpreter services for people whose First language was not English.

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- Staff understood how to deal with complaints and concerns and received feedback from the investigation of complaints; learning was shared and performance was managed appropriately.
- Specialist equipment was available for bariatric patients.

However,

- Prolonged delays at some acute hospital's emergency departments reduced the capacity of front line staff to respond to patient's needs. The number of long waits for an ambulance had steadily increased.
- Complaints were not being responded to within the trust target time of 25 days.

Service planning and delivery to meet the needs of local people

- The nationally recognised Resource Escalation and Action Plan (REAP) is used by the trust in order to quantify pressure on ambulance services. There are six levels starting a REAP Level 1 (normal service) to REAP Level 6 (potential service failure). The service has been at REAP Level 3 (pressure) since 10 July 2015. The service was changing to a different system (Black, Red, Amber, and Green) so that it was easier to communicate the service pressures to outside organisations such as hospitals.
- The area manager attended meetings with the local clinical commissioning groups (CCGs) and the System Resilience Group (CRG) where they provided updates about ambulance service capacity issues. The area manager gave an example where they had added paramedic shortages to the SRG group's risk register.
- The trust had developed the 'hear and treat' and 'see and treat' service. This was where the clinical team assessed and triaged patients that required medical help without sending an ambulance by sign posting them to other healthcare options, for example a local pharmacist, walk-in centre or GP. If an ambulance was required to be sent then they would attempt to treat in their home without the need for them to be taken to hospital. However, the patient would always be conveyed to hospital if that was appropriate.
- From December 2015, the trust had employed demand practitioners to focus on nursing/care homes and high intensity users to reduce or control demand for ambulance services. In the South East area the demand practitioner was working with teams from the acute and

community trust to ensure that nursing homes were educated in managing patients in care homes. The demand practitioners worked with other providers to develop alternative patient pathways (other than hospital) and educate staff and the public in when to appropriately use the ambulance service.

- There were a number of different specialist clinical services designed to meet the needs of the local population. For example the emergency and community first responder schemes to respond to life threatening emergencies in rural areas where ambulances might take longer to get to a patient.
- In some city areas, the trust provided temporary first-aid facilities in the vicinity of clubs and pubs. This was meant to assist in accommodating the peaks in demand and offered treatment for minor injuries and reducing the need for people to attend emergency department.
- A smartphone triage app had been produced in conjunction with the Wessex Trauma Network. This meant clinicians could use the triage tool to identify if their patient needed to bypass a local hospital and be conveyed directly to the closest major trauma centre.
- During our inspection we visited a number of stand-by point locations. However, we found some of these stand-by points had not been used for up to two years, despite them being listed on the trusts own data. The trust had plans to review stand-by points using past demand data to ensure that they were optimally placed.
- The trust was working towards increasing the effective use of Co-responders. For example community first responders (CFRs) were deployed to support emergency response and were being integrated into front-line teams. Also, a member of staff was responsible for developing the role of volunteers in the community. This included liaison with police and fire services, and linking co-responders with ambulance crews. Support networks within the trust were available for co-responders.
- The location of the HART service meant the team got to the scene of strategic sites of high risk, as identified by the Home Office, within 45 minutes. The HART team worked in partnership with pre identified high risk sites in the trusts' region. This included development and monitoring of risk assessments for the sites and joint training with staff 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.

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- HART operatives were used to support normal operations. Unless there were only four HART operatives on duty, one or two HART operatives were assigned to an RRV to support the urgent and emergency services. The NHS Service Specification 2015/16 detailed that these HART staff must be relieved in order to respond to incidents that required HART services. The HART manager and staff confirmed that staff assigned to RRV duties were always relieved within the required time scale.
- Air ambulance services could respond to a call within their region within 15 minutes, ensuring patients could receive effective emergency care and attend to a life threatening situation.
- Air ambulance services used their blue light rapid response vehicle that was equipped and manned as the air ambulance to respond to emergencies when the air ambulance was unable to fly such as in adverse weather conditions.
- The air ambulance service commenced night flying until 2am in April 2016 to meet demand for the service at night. Staff told us the service would be reviewed after six months to identify whether the demand for the service is sufficient or whether there is a need to increase the service to 24 hours.
- The air ambulance service held joint clinical governance meetings. To facilitate no interruption to service provision, the meetings were held at venues that had outside areas large enough to accommodate both helicopters. This meant both helicopters could respond to incidents within the normal time scales.
- The trust had met with representatives of CCGs and GP practices in February 2016 following concerns about time taken to respond calls from GPs for an ambulance. The trust presented the changes they had implemented to alleviate the problem for example putting in place a separate resource to respond to calls from GPs. This was to be reviewed in September 2016 by the trust, CCGs and GPs.
- The trust had received a contract performance notice in October 2015 for stroke patient care from North and West Reading CCG. An action plan was in place to support this improvement.
- The trust had effective coordination with acute care pathways. Hospital staff reported that care pathways were followed appropriately for emergency calls. They

identified that the trust prioritised calls effectively and patients had timely arrivals in emergency departments. Care pathways for maternity admissions were always followed.

Meeting people's individual needs

- The service employed specialist paramedics who were trained in primary care and could attend patients with minor illnesses and injuries and treat them at home, in order that they could avoid admission to hospital. These specialist paramedics had received education and training in patient assessment and treatment. Ambulance staff were able to use these specialist paramedics as clinical advisors.
- The trust had a mental health and learning disability lead. There were staff that acted as champions for certain patient groups. For example, there were staff champions for end of life care, learning disability, black and minority ethnic groups and care for patients living with dementia. Staff had access to dementia awareness training but the uptake was low, 49%, compared to the trust target of 95%. Most staff identified a greater awareness of dementia issues.
- Emergency services managers (ESMs) we spoke with knew nearest place of safety for patients with mental health issues. Staff reported receiving significant training in Mental Health and the Mental Capacity Act. Staff had access to a directory of services that they can use to look up local services, by type, location and opening hours. This enabled staff to direct crews to best alternative and available services for patient. Most staff identified their knowledge to support patients with a mental health condition was improving.
- A dedicated telephone helpline was available for local mental health teams in Berkshire to access an ambulance, and the target was a one hour response. A mental health liaison nurse that we spoke with said that it could sometimes take three or four hours for an ambulance to arrive once a call had been placed and that this was a concern.
- Staff had received training in conflict resolution that included management of violent or aggressive patients. Ambulance crews said they had good support from the police and currently they attended whenever needed. For example, for the safety of the patient or staff.

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- Staff had access to interpreting services through language line and ambulances carried communication cards for people who were not able to speak English or that had communication difficulties.
- There was a variety of equipment available to meet the needs of people and included appropriate bariatric chairs and trolleys. There were ambulances available in each division (north, south and central) that were equipped for ease of access for bariatric patients.
- SCAS was promoting the 'Message in a bottle' scheme so that staff could access care plans held within the patients' home. Community geriatricians could be contacted directly and they provided advice to support the staff.
- The air ambulance teams told us that where possible they would transport a patient with an injured or unwell child.

Access and flow

- The trust had seen a steady increase in the number of emergency calls during 2015/16. From approximately 40,000 calls (April 2015) to 48,000 by March 2016. The proportion of patients that they could see and treat had declined over the same period from 39% to 36%. This is the proportion of patients discharged, after treatment at the scene or had onward referral to an alternative care pathway. However, this was above the England average.
- The trust was monitoring long waits for ambulances. The reasons for a longer than target response time had been identified because of changes in call category (the symptoms described by a patient), peaks in demand for services and ambulances being held at hospitals, staff shortages and distances to scene. The proportion of long waits for emergency life threatening and urgent calls response within 8 minutes was 0.8% of emergency calls in March 2016. This had increased from 0.5% in April and had peaked at 1.1% in February 2016. The proportion of long waits for emergency life threatening and urgent calls transport within 8 minutes was 1.7% of all calls in March 2016. This had increased from 1% in April and had peaked at 2.1% in February 2016. Waiting times were higher in the south of the county than the north.
- There were also long waiting times for green (non-life threatening) calls. Which are calls that require ambulance transport but which do not fall into the emergency and urgent care category. These may be calls requested by the public or by GPs or other healthcare professionals. The proportion of long waits for emergency life threatening and urgent calls transport within 8 minutes was 1.7% of all calls in March 2016. This had steadily increased from 7% in April 2015 to 26.7% in March 2016.
- The trust had introduced escalation plans to ensure higher-priority calls took precedence, that clinical advisors supported people with welfare checks, staffing rotas had changed to match peaks in demand and there were stand-by points in rural areas which included facilities for staff. Community first responders were also being used. However, shortage of ambulance crews was a limiting factor in the responsiveness of the service. Overtime was offered to front line staff prepared to work, in order to increase the number of staff available. Staff were also encouraged to join the staff bank to be able to work additional hours when they wanted to. The trust was developing arrangements to improve on the long waiting times that GPs and healthcare professional currently experienced.
- Data from the trust showed the number of hospital handover delays varied between the north and south of the south central region. The data showed the number of handover delays in the three month period January to March 2016 was 1,112 in the north and 4,496 in the south. The trust reported the handover pressure at one particular acute trust in the Portsmouth area as being a major cause of the variance. Problem within the Portsmouth system had been identified for some time. There had been risk summits in December 2015 and January 2016. There had been intransigence and across the system for various reasons. During our inspection we identified that patients had to have an 'immediate handover' to the acute trust but this had not been agreed. Following this, SCAS and the acute trust agreed an escalation policy in May 2016.
- Area managers had daily conferences with acute hospital site managers for regarding hospital capacity status. These relationships allowed the trust and hospitals to liaise, discuss and prevent issues developing. Ambulance crews pre-alerted hospitals prior to the arrival of a seriously ill patient. Emergency departments in acute hospitals had handover screens where they were able to see which ambulances were en route to their hospital.

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- The trust had systems for monitoring the timeliness of handovers using terminals at hospital emergency departments. Staff were clear that they prioritised patient safety before logging on and completing their sign off. Where appropriate, the trust received daily reports from local acute trusts (8am and 2pm) on ED delays and used this information to prioritise and plan routes
- During our inspection we tracked patients that were taken to the emergency department of a local NHS trust. One patient who had previously suffered a cardiac arrest was taken straight into the department. Five other vehicles queued between eight and 10 minutes
- The service employed specialist paramedics who were trained in primary care and could attend patients with minor illnesses and injuries and treat them at home, in order that they could avoid admission to hospital. These specialist paramedics provided 24 hour cover across each area. However, they could also be sent to provide cover for red calls which, reduced their capability to be dispatched to the most appropriate calls for them. Staff told us that appropriate dispatch of these specialists could be challenging as the Clinical Coordination Desk were often too busy to identify appropriate cases. The best method was for the specialist themselves to use an online 'net viewer' tool to self-select incidents that they could attend.
- There was a rolling programme to recruit paramedics to this pathway, although it was dependent on provision of funding. There was also a difficulty retaining these staff as they were recruited by other providers. There was ongoing work with the local CCGs to arrange rotation of the specialist paramedics into local emergency departments and a Walk in Centre, to provide learning and experience for them, and offer more variety of clinical experience.
- The trust had introduced a monitoring system to minimise the time overlap of a responding RRV with a double crewed ambulance. The trust's aim is to make the RRV available as soon as safely possible once the ambulance crew has attended the scene. Staff were aware of the system and adhere to it as much as they are able.
- The trust had a 15 minute handover time standard when a patient was conveyed to hospital. The trust's aim was to make the ambulance available as soon as possible after conveying the patient to hospital. This was broadly successful however some crews reported that they did not always meet the target as they also had to clean the ambulance and equipment within this time. Crews were able to contact control and make themselves unavailable, if cleaning would take longer.
- The proportion of patients who re-contacted the service, by telephone, after being discharged at the scene of their care within 24 hours was in line with the England average. Year to date figures for the trust, at February 2016, showed a re-contact rate of 5% against a national average of 5%.
- The proportion of calls from patients for whom a locally agreed frequent caller procedure was in place. This had been consistently higher than the England average for the whole of the reporting period from January 2015-2016. An action plan had been developed to address this.
- Call handlers at the EOC completed triage processes to assess whether the incident required HART or air ambulance services to ensure patients received treatment in a timely manner in relation to their suspected condition.
- Front line staff told us they requested the support of HART or air ambulance services if their assessment of the incident and patient's condition indicated support was needed to provide timely or specialised treatment to the patient.

Learning from complaints and concerns

- Information on how to make a complaint was on the trust's website. Staff were aware of how to advise patients that wished to raise a complaint.
- During the period February 2015 to January 2016 there were 186 complaints regarding the 999 service. Of these, 48 were upheld and 47 were partially upheld. The majority of complaints were about long waits and staff attitude.
- Staff were able to describe the difference between a complaint and a concern. Concerns (an example given was one that was received by someone saying that the sirens were too loud) usually received a telephone response from a local manager. Complaints received a formal response letter. Managers identified whether complaints were logged as concerns or complaints.
- Some staff reported that they would contact the duty team leader if they had a patient that wished to make a complaint. A member of staff identified where this had

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been done and the team leader made contact with the patient and gave details of the service's complaint team to the patient. The team leader also gave details for direct contact for the patient.

- Staff would normally try to resolve concerns locally and if they were unable to deal with a patient's concerns satisfactorily, the patient would be directed to the Patient Advice and Liaison Service (PALS). PALS provided an immediate acknowledgement and responded to a complaint within five working days. If the person still had concerns, they would be advised how to make a formal complaint.
- The trust procedure was to respond to complaints within 25 days. However the trust was not achieving this target and the timescales were reported as difficult to achieve because the investigations included a formal audits of calls, location of vehicles at the specific time of the incident and this was requiring more time .
- Performance management was undertaken for staff members in some cases where complaints were made. Performance of the staff members was then monitored to ensure improvement had been made.
- HART staff told us they received very few complaints about the service. Records provided by the trust showed they had received one complaint between February 2015 and January 2016. The record showed the complaint was investigated and was not upheld.
- Staff at the Andover air ambulance base said they had only received one complaint about the service since the service commenced operation. The complaint was not about the service provision, but about the effect the helicopter had on any nearby animals.

Are emergency and urgent care services well-led?

Requires improvement



By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Overall, we rated well-led as requires improvement:

- Staff reported dissatisfaction with the scheduling and planning of rotas, this was affecting their work life

balance and morale. All staff reported working more hours than scheduled and cited time unallocated for vehicle checks and handover. Some staff reported being frustrated and tired. The trust had recently surveyed staff to ask about ideas for improvement. Risk registers were held at divisional level and local teams reported limited knowledge of the progress made or actions taken to mitigate them.

- Governance issues did not always effectively identify areas of inconsistent practice. There were safety issues that had not been identified appropriately through monitoring arrangements.
- Staff did not always have time to report incidents and this was starting to affect the culture of reporting incidents
- Staff did not always receive feedback on governance issues, for example following incidents, audit or safeguarding issues.
- Team leaders had time scheduled for team management, however this was sometimes eroded due to daily operational pressures.
- Given the nature of the shift pattern for this service, staff could not always attend regular team meetings. The trust was developing a system to improve the governance surrounding the distribution and recording of guidance and policies around the organisation.
- The trauma risk management practitioners did not always receive consistent supervision or counselling. Some staff reported that the quality of trauma risk management support could vary
- There were still areas that the trust needed to improve following the last inspection.

However,

- The trust was revising its strategy and operational response to the increasing demand for emergency services. Most staff were engaged with the vision and strategy of the organisation and all staff displayed the values of the trust through their own working practices.
- Risk and performance were monitored at divisional level.
- There were effective governance systems in the resilience and special operations teams.
- Staff received regular communications and a daily cascade of operational issues. There was an action plan to improve performance targets.

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- Staff were very positive about their local leadership and team leaders were being supported to develop their skills. There was a good framework to support the health and wellbeing of staff and various initiatives to acknowledge and reward the contribution of staff.
- The trust had a trauma risk management team to follow up staff regarding safeguarding concerns and to provide support following traumatic incidents. The majority of staff were positive about trauma risk management support.
- Staff reported engagement and communication was improving, for example, on retaining staff and responding to staff survey actions. Staff were hoping for positive changes to staff rotas.
- The trust could demonstrate some improvements to the service following the last inspection in September 2014.
- Patient and public engagement was developed through a variety of channels, such as social media and community liaison work
- The trust could demonstrate areas of innovation in practice.

Vision and strategy for this service

- The trust describe their five year strategy as being designed to respond to the challenge raised by their commissioners and health partners, of avoiding conveying people to emergency departments unless appropriate for their needs.
- The majority of staff we spoke with had an awareness of the trust's strategy. They also described the trust's vision as working 'Towards Excellence' and 'saving lives and enabling patients to get the care they needed'. The strategy, which had been written in 2014, had predicted a decrease in emergency calls. However, the trust understood that demand patterns were changing, and this was impacting on its service profiles and patient acuity. The trust had recently developed a new clinical strategy and were currently reviewing operational deployment models.
- Staff were not aware of the trust's new clinical strategy and how services were changing to cope with demand. Some staff were aware of the further operational priorities to increase clinical recruitment and recognised their role in supporting new staff.
- Frontline staff were aware of the trust's values, 'Teamwork, Innovation, Professionalism and Caring' and in some instances they could quote them all. Through

discussion and observation of the service the staff showed a commitment to saving lives and displayed the individual values and behaviours that aligned with the trust's values.

- All of the staff we spoke with demonstrated a high level of commitment to providing a good quality and safe service. Although they were frustrated by not being able to always achieve national target times for responses to emergency calls.

Governance, risk management and quality measurement

- Performance in attaining national targets for ambulance response times was monitored and reported to the divisional performance review meetings each quarter. This meeting was chaired by the chief executive and the board had a good overview of how performance was being managed in each division. Performance was not meeting national response time targets in May 2016 and the trust had an action plan to improve the performance across the region.
- There were no risk registers held locally. All risk registers were held by a central risk department, some local managers had no knowledge about these. This meant that resource centres did not always have an accessible method of managing and escalating their own local risks. Ambulance staff we spoke with were not always aware of the risk register and also how to raise and record concerns. An area manager informed us that they were able to inform the main operational risk register, and that they were also able to add local risks to the local area System Resilience Group, for example staff vacancies had been added to this risk register.
- There was evidence that monitoring arrangements did not identify inconsistent practice. We had identified during inspection examples of inconsistent practice, such as an unmanned and unlocked ambulance station, CD registers not completed appropriately, inconsistent infection control, insecure storage of paper records at a resource centre, resuscitation bags that required repair and major incident vehicles unable to support immediate action. These had not been identified appropriately through monitoring arrangements.
- Emergency service managers attended fortnightly meetings and monthly meetings with area managers to

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identify issues of concern and share good practice.

Information from patient experience, serious incidents, clinical review and patient safety were discussed at this meeting.

- There were team training meetings for frontline staff. However, staff across the whole service reported that they could not always attend meetings regularly due to shift patterns and being constantly out on the road. The trust created a clinical review group who checked clinical risks for example through reviewing incidents or through patient safety alerts (issued via CAS). The group then sent alerts to staff by a variety of methods including email, SCAScade and HOT news. This gave the trust a level of assurance that staff had access to important data to help them in their day-to-day work. However, there were no systems in place to record if staff had read communications from senior managers.
- There was a daily cascade of information through conference calls via the trust command structure (silver and gold command) to discuss key performance indicators (KPIs) which included using a daily performance dashboard, giving data on calls attended and times, and a shift report showing lost hours. Information was passed to staff face to face by team leaders at the start of the shift and by email. Notice boards and displays at stations were also used to pass on information. However, staff were not routinely informed of trust performance against their KPIs unless there were problems identified, for example, long handover times at hospitals.
- Staff had identified that they did not routinely receive feedback or information on safeguarding, feedback from incidents and the learning from complaints.
- The staff had identified that they sometimes did not have time to report incidents and the lack of feedback was feeding a disincentive to report incidents.
- Staff had identified there was no protected time to complete mandatory training. Time was not set aside in team training days and staff were required to do this at the between calls on shift, at the end of a shift or in their own time at home. Staff reported difficulties with remote IT access at home.
- The HART team made use of the national PROCLUS tool (an Incident management & team development software for the emergency services) to monitor and evaluate its performance. The tool enabled HART teams to learn from incidents that other HART teams had attended.
- The air ambulance manager discussed had identified that there were no processes in place to record and demonstrate the effectiveness of the air ambulance service. In response, a specialised business analyst had been appointed and tasked to find measures to demonstrate the effectiveness of the service. This included whether the service was being sent to appropriate incidents, how the service was contributing to performance targets, and whether the bases were appropriately located.
- Resilience and Special Operations held their own risk register. There were 11 risks detailed on this. These included risks specific to the HART service and risks to resilience and business continuity for the whole of SCAS, this included the EOC and frontline services. The risk register detailed the actions taken to mitigate identified risks. However, in comparison to the trust wide risk register, there was no detail of the dates when risks were identified, or that the risks were regularly reviewed and updated. However, records from Resilience & Specialist Operations Team meetings showed risks and the associated action to reduce the level of risk, were routinely reviewed.
- The Helicopter Emergency Medical Service (HEMS) air ambulance team at Andover shared a risk register with the funding charity. Staff described some risks on the register, that included difficulties recruiting medical staff and risks to the service due to grounded air craft. Records from air ambulance clinical governance days showed risks and action to mitigate risks was reviewed.
- There were regular meetings with independent providers to discuss performance and review quality.
- The trust could demonstrate improvements following the wave 1 pilot CQC comprehensive inspection in September 2014. There had been improvements in working with partners, infection control, recruitment, incident report, mental health training and leadership. The trust still needed to improve mandatory and safeguarding training, pain relief following heart attack, and feedback on reporting incidents.

Leadership of service

- Team leaders were the first line managers and were responsible for around 15 staff. Team leaders reported to Emergency Service Managers (ESMs) who reported to area manager. Each area managers had one or two ESMs as a direct report.

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- All staff we spoke with reported that they regularly saw their team leaders, clinical mentors and ESMs. They said they could always contact them if required. Agency staff reported that they were also supported by a team leader when required.
 - Staff reported excellent support at a local level from team leaders. Newly qualified staff felt able to call on team leaders for advice and guidance either during a job or afterwards.
 - Team leaders were supported to develop their leadership skills with a programme of training that included bronze commander course, the NARU team leader development course, SCAS team leader development course, Institution of Occupational Safety and Health safety and risk assessment course and participation in the silver commander training.
 - The team leader was based in the ambulance station, they had a vehicle that they would use to respond to calls with. They would communicate with staff at the beginning of shifts where possible or contact them by phone if required. They were able to plan their shifts so that they could support staff when needed.
 - Team leaders had some protected management time for their roles (2 days a week) included in their shift pattern. However most team leaders reported this can be lost at times of high alert.
 - Frontline teams followed the same type of shifts across an eight week pattern, meaning that there was regular contact with their manager during this period.
 - Frontline teams received protected team time of two hours every six weeks which could be accrued to be used as a team day where updates and training could be given.
 - All staff we spoke with in the HEMS and HART teams spoke positively about leadership and support provided from their immediate line managers.
 - Records of meetings and conversations with the RSO manager, HART manager and air ambulance manager evidenced a commitment to promoting the RSO services to all staff of SCAS as an important part of their leadership roles.
- Culture within the service**
- Staff were positive and proud about the care that they provided to patients and relatives and we observed that staff showed dedication to their job. We saw that staff were committed to ensuring patients received a good service and their behaviours reflected the values of the organisation.
 - We observed a friendly and supportive culture at the ambulance stations. Most ambulance staff told us they felt they got appropriate communication and felt involved in what was happening across the organisation.
 - We spoke with two newly appointed Polish staff that highlighted very positive engagement with trust and their new team leader. The new staff were made to feel very much part of the community and they were quickly integrated into the team. Team leaders and clinical mentors gave support and the new staff contributed to the team day.
 - Agency staff we spoke with were positive about the support they received from the trust. They were included in team communication and training.
 - The trust had a trauma risk management team in place to follow up staff regarding safeguarding concerns and any post-incident personal support needs. Trauma risk management was also available to agency staff if required.
 - The majority of staff who told us about their experiences of using trauma risk management were very positive and reported having received excellent support. For example, staff were assessed three days after a traumatic event and again after 28 days. Trauma risk management sessions were attended by the crew (that attended the patient), as well as team leader and also call takers and despatcher where required (could be up to six staff) and had the opportunity to have a 'hot debrief'.
 - The staff that we spoke to were not aware if this service had been evaluated since it had been started. Most staff who had used the service said it was very helpful. However, we were also told it was possible to 'slip through the gaps' with some staff reporting that the process was little more than a tick box exercise. Trauma risk management support was often provided by team leaders and clinical mentor. However those providing support had not received regular support and supervision themselves as counsellors.
 - There was concern about the supervision arrangements for the trauma risk management practitioners. During

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our inspection we saw an example of a practitioner about to provide support when they were not in a fit state to do. This was escalated to the trust during the inspection and senior managers intervened.

- Staff also had access to the 'employees support' which was a confidential counselling service. MIND is a mental health charity which delivers the Blue Light programme. This programme provides mental health support for emergency services staff and volunteers. The trust are supporting managers by enrolling them on a MIND Line Managers training course, which focuses on managing mental health for staff in the emergency services.
- Managers also praised their staff and said that they would be happy for friends and family to be treated by them.
- The service had identified various ways to recognise the contribution of staff. We saw a noticeboard at one ambulance station that had thank you cards displayed from members of the public and also notes praising staff from their colleagues. At another ambulance station there was an 'over and above' book where staff could notify the management team of any incidents for recognition. From this, an employee of the month was chosen. One ambulance station reported that the chief executive had attended two recent retirement parties for long serving members of staff.
- Staff reported good access to welfare checks where required. Staff were happy to approach team leaders, ESMs and control for support if needed. A member of told us of an outstanding episode of employee care. Following the dismissal of a failing staff member, welfare checks had continued even though the employee no longer was employed by the trust.
- Support is provided for sickness and absence. All managers can refer online to Occupational Health and inform the Human Resources team. There is an option for managers to attend the first meeting with the team member to support them. Staff told us that sickness absence was now managed more proactively and data provided by the trust indicated a slight downward trend in sickness rates between the period March 2015 to February 2016.
- During the period February 2015 to January 2016 sickness levels had remained constant (February 2015 7.14%, January 2016 7.86%) with good support systems reported by staff. For example regular welfare calls were

made every three days by team leaders, trauma and risk management practitioners support staff and were trained in spotting signs of stress and post traumatic stress disorder (PTSD).

- The service had a new and expectant mother's policy and we spoke to a paramedic who was expecting a baby. She told us how this was being followed as she had been removed from operational duties. Regular risk assessments took place to ensure her personal wellbeing and that of her unborn child.
- Air ambulance and HART staff described working within a positive and caring culture.
- Following major or traumatic incidents there were structured debriefing sessions, at which staff could express their feelings. Air ambulance and HART staff said there was a strong culture of peer support for their colleagues.
- Air ambulance and HART staff spoke positively about the trauma risk management service and the support provided by the trauma risk management practitioners. However, they described incidents when the service failed because the trust's occupational services did not deliver the support the trauma risk management practitioners had advised.

Staff engagement

- Staff morale was low. Staff reported dissatisfaction with the trusts planning and scheduling, especially the way it scheduled relief work. Staff reported difficulty getting specific requests for annual leave confirmed and therefore were unable to plan ahead. This impacted on work-life balance for example with childcare provision, weekend working and family holidays. The scheduling department was undergoing a re-structure so it was hoped that this would improve the issues. For smaller staff groups, such as specialist paramedics and team leaders, it was often more difficult for them to take leave as they were included in the weekly allocation.
- The trust were working to introduce new rotas to improve the work life balance of staff, whilst continuing to meet the challenge of rising demand. The current shift profile had been in place for two years and was based on historic demand levels and forecasting by the planning team. Local adaptation to these shift profiles had been put in place to reflect local geography and

Emergency and urgent care services

requirements in order to reduce the risk of overruns. This had been broadly successful in responding to demand but had resulted in inconsistency of shift patterns across the trust.

- Staffing levels were a concern and staff were working under pressure. Staff reported that they did not have regular meal breaks or meal breaks could only be taken much later towards the end of their shift. The trust had been changing rotas and identified that 80% of frontline staff now had regular meal breaks, although these may not always be at the scheduled time.
- Staff were dedicated and without exception, every member of staff we spoke with reported regularly working more hours than their shift allocation which was having a detrimental effect on their work-life balance and they were frustrated and tired.
- Crews reported restrictive time limits for vehicle and equipment checks at the start of a shift and challenging handover targets when handing over a patient from a single crew to dual crew or at a hospital. The trust had not reviewed allocation and scheduling time to alleviate the problem.
- Staff reported that they had completed an online survey regarding their thoughts and views on new shift rotas and patterns. Staff were aware that the intention was to address their concerns with rotas. It had taken a long time for the trust to respond to issues but communication had improved. At the time of inspection the survey had not been analysed and no data was available.
- The ability to manage sickness absence, and to recruit and retain staff was on the trust risk register. In 2015/16, paramedic staff attrition rates remained constant at 14% although emergency care attrition rates had reduced to 9%. Sickness absence rate varied throughout the year and averaged at approximately 6.5% (ranged from 6.3 to 7.2%).
- We saw notice boards in crew rooms that had the dates of regular station meetings. These contained information regarding staff matters, operational bulletins, "Impact" newsletter that gave information on educational development and opportunities, and "Hot News".
- Local managers had commenced 'stay interviews' with staff, as well as routinely carrying out 'exit interviews'. This enabled managers to better understand the needs of their staff and to address issues before staff left the trust.

- Staff survey results were displayed on notice boards. Staff at all resource centres that we visited told us how the local management team had reviewed the results of the most recent staff survey and compared it to last year. They had now generated some action plans for the areas identified where improvements were needed.
- Staff told us how they had highlighted areas for improvement, for example with electronic patient record team. These were reviewed and changes were implemented. Staff reported that their views were listened to and acted upon.

Public Engagement

- Two recruitment open days had been held in January 2016 to improve recruitment. The trust noted 100 people had applied for roles within the trust and 61 had registered their interest to become community first responders
- The trust participated in the 'Safe drive, stay alive' campaigns in partnership with other emergency services such as the fire and police and local councils. The events aimed to reduce the number of casualties and deaths on the road for young adults between 17 - 24 years old
- The trust was introducing real time feedback from patients to elicit their views on using the ambulance services. This would include the friends and family test methodology. The survey would take place in hospitals and minor injury units and would be called WIGFY (Was it good for you?).
- Social media was used to further develop public engagement and keep the public up to date with information. The trust website included information and initiatives about 999 services, the HART team and the Helicopter Emergency Medical Service .
- The Hampshire and Isle of Wight and Thames Valley air ambulances had their own individual websites which gave the public information about the work they did and how the service was funded.
- Both HART and Thames Valley Air Ambulance had twitter accounts that public could use to follow the work of the service. The air ambulances attended local events to promote and educate the public about the service.

Emergency and urgent care services

Innovation, improvement and sustainability

- The emergency and urgent care service was continually looking for ways to develop, improve and sustain the service. Achievements over the past few years were recognised by the trust in the 'What does SCAS do well' book.
- The introduction of local demand practitioners had meant that local plans could be made for high intensity users of the service and support patients with specific needs.
- The availability for the telephone application that the Wessex Trauma Network has developed is a useful aid to frontline clinicians in assessing where a patient should be transported directly to a major trauma centre.
- Placing solar panels on the rapid response vehicles means that the engine does not need to be constantly run to ensure that equipment maintains on charge.
- Specialist paramedics were trained to deal with urethral catheterisation, wound closure, antibiotics, minor injury assessment, x-ray referrals and to refer patients directly to other services.
- The trust was piloting a handover leaflet for maternity cases (called PANDORA). This was being piloted in North Hampshire and Northern Buckinghamshire.
- An innovative practice for monitoring levels of medicines had been developed that included the use of QR codes. This meant accurate records of all medicines held on site were accessible to the named clinical staff who ordered appropriate levels of medicines to ensure there was a sufficient stock of medicines at all times. There were plans to increase the stock of single use, disposable items used on ambulances held at key resource centres, so that this could be used for crews to replenish vehicles instead of having to return to base.
- During our inspection we saw a local gym instructor had been invited into resource centre in Oxford. This was a local initiative set up to provide information and guidance on health and well-being for ambulance staff.
- The trust was working with a community trust in Berkshire as part of a three month trial (February – April 2016) for patients treated for hypoglycaemia. Patients from participating GP practices who were treated and discharged at the scene were referred to a new pathway. They were provided with information and referred to a specialist nurse for further management and advice. Information was shared with GPs for ongoing care.
- Following discussions with staff, the trust had produced a resuscitation pocket guide to give clear guidance in the event of a cardiac respiratory arrest. The guide, which was to be introduced shortly would cover when to resuscitate, advance care plans, advanced decisions to refuse treatment and do not attempt cardiopulmonary resuscitation (DNACPR)

Patient transport services (PTS)

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

Information about the service

South Central Ambulance Service (SCAS) provides patient transport services (PTS) for people who meet the eligibility criteria within the populations of Oxfordshire, Buckinghamshire, Berkshire and Hampshire.

The trust has seven patient transport contracts with Thames Valley Consortium (from April 2016), Care UK Hampshire (October 2015), Hampshire Clinical Commissioning Groups (CCGs) (October 2014), Milton Keynes CCG (April 2015), Northants CCG (rolling contract), Oxford Health (April 2015), and Royal Surrey (rolling contract).

The trust provides PTS over an area of 3,554 square miles and serves a population of over four million. In the last financial year, 2015/16, the PTS provided 528,139 patient journeys. The service has 242 vehicles which include 226 PTS ambulances and 16 cars. Eight of the ambulances were equipped for transporting bariatric patients; these were shared across all areas of SCAS. Approximately 390 staff work in the PTS service, 350 were operational staff and 46 in the contact centre. The trust had contracts with 12 private ambulance services to provide PTS journeys on an ad hoc basis, 10 taxi companies and 143 volunteer car drivers, who undertook 15% of all patient journeys.

During our inspection, we visited both contact centres based in Bicester and Otterbourne, 15 resource centres (ambulance stations), five in Berkshire, two in Oxfordshire, two in Buckinghamshire and six in Hampshire. We also

visited 11 local hospitals to speak with staff and patients using the PTS service, particularly patients attending on a regular basis for treatments such as dialysis and radiotherapy.

We spoke with 44 patients and observed care being provided to patients by accompanying crews on seven PTS vehicle journeys. We spoke with 88 staff, including ambulance care assistants, call handlers, planners, dispatchers, team leaders, hospital liaison officers and staff in management positions including business and operations managers and the assistant director. We also spoke with 18 staff working at local hospitals to seek their views on the service. We reviewed 21 vehicles and also analysed data provided by the trust both before and after the inspection.

Patient transport services (PTS)

Summary of findings

We rated patient transport services (PTS) as good overall. We found the service to be outstanding for caring, good for effective, responsive and well-led and requires improvement for safe

All feedback from patients and hospital staff was positive about the care patient transport services (PTS) staff provided to patients. Patients told us staff treated them with kindness, were caring and went above and beyond to meet their needs. Staff treated patients with dignity and respect, encouraging patients to be involved with their care. Staff understood the importance of supporting patients' emotional needs and patients valued the personal approach of staff.

The service was able to meet the individual needs of patients and was accessible to all patients who met the eligibility criteria by commissioners and national criteria for renal dialysis patients. There was good use of risk assessments to keep patients and staff safe, with information stored electronically so it was easily accessible. Staff though did not always feel confident to meet the needs of patients with mental health problems.

Services were planned to meet the needs of local people. New contracts had extended the operating hours of the service. Staff felt involved with PTS and able to make suggestions on how the service could be improved and developed. PTS had introduced a number of innovative changes, to improve the quality of the service but also to consider the future sustainability.

Staff working for PTS told us they enjoyed working for the trust, as they provided a good standard of care to patients. They felt well supported by the team they worked with and their manager. We observed good multidisciplinary working and co-ordination with other providers to deliver good quality care to patients.

Senior managers understood the importance of the commercial aspect of the service and the current competitive market for PTS. Key performance indicators (KPIs) were used effectively to monitor compliance with contracts but patient care remained the overall focus.

However:

We found that staff did not always report incidents as sometimes they did not receive feedback or learning was not shared at team meetings. Senior staff took appropriate action to respond to and investigate complaints. However, the learning from the investigations were not always shared with staff at a local team level.

Practices to keep staff and patients safe were not always identified or concerns acted upon. This included lack of clarity for staff around the administration of oxygen to patients, concerns around requesting emergency assistance when working in rural areas due to variable connectivity, Some vehicles were also not appropriately maintained and staff did not follow best practice guidance for infection prevention and control.

In PTS, some staff groups were below the trust target for compliance with mandatory training and appraisals.

The service struggled to meet some of the performance indicators set in the commissioner contracts as part of the quality monitoring of the service. In particular telephone calls were not being answered quickly enough and there were delays in patients being collected before and after their appointment.

The introduction of new contracts had been a challenging time for staff and had extended working hours. In some areas there remained issues with recruitment of staff, particularly frontline staff, in the Thames Valley area. Private providers were being used to cover vacant shifts.

Patient transport services (PTS)

Are patient transport services safe?

Requires improvement



By safe, we mean people are protected from abuse and avoidable harm.

Overall, we rated safe as “requires improvement” because :

- There was no assurance that staff always reported safety concerns or they were acted upon. Staff across the PTS did not report all incidents that occurred. Where they had, they did not always receive feedback nor was learning shared. This imposed a risk to staff and patients’ safety as improvements could not be made when things had gone wrong.
- There were inconsistencies between the trust’s ‘Medicines management’ policy and the standard operating procedure for ‘Transporting patients on oxygen therapy’. This meant even though staff were trained to administer oxygen, they were unable to do so unless they were Band 3. This led to situations where staff potentially were unable to support patients requiring oxygen.
- In Hampshire, vehicles did not have a radio and staff relied on the personal digital assistant to request help. The connection was not maintained in all rural areas and presented a potential risk to staff and patient safety. This was because in an emergency or threatening situation in these areas, staff would only be able to request help using 999 on a mobile phone
- The trust used volunteers and independent providers to ensure they were able to provide cover for the service as trust staffing levels were below planned levels with high vacancy levels in some areas.

However,

- There were effective systems in place to assess new and ongoing risks to patients. Staff carried out regular risk assessments and this information was accessible. Staff used the trust escalation processes to raise any concerns if a patient became unwell. There were systems in place to manage anticipated resource and capacity risk, with involvement of the PTS in any major incidents.

- Staff across the PTS knew where to access information on raising a concern and were able to access specific safeguarding information via the patients’ electronic record
- Resource centres and vehicles were in general well maintained, clean and tidy. They were also locked and secure. The systems for maintaining vehicle safety, such as inspections and servicing were generally up-to-date, however, staff did not always have time to complete the daily vehicle safety checks. This was due to the number of checks to complete in the time allocated.
- The ‘make ready’ team worked hard to maintain cleanliness on vehicles including regular deep cleans. There were processes in place to monitor the quality of their work.

Incidents

- Data provided by the trust showed between August 2015-January 2016, PTS staff had reported 321 incidents and the investigations for 221 were complete and approved. The remainder were under investigation or waiting for an investigation. There was no record on the data of the level of harm caused to identify those incidents rated as serious or never events. There were no never events in the PTS over the same period. Never events are serious, largely preventable patient safety incidents, which should not occur if the available preventative measures have been implemented.
- The three top categories of incidents were manual handling difficulties (59), often due to inappropriate risk assessment by health care professionals, slips trips and falls (40) and vehicle problems (44). Staff in management positions felt competent to investigate incidents and had completed additional training.
- Staff felt competent to use the electronic reporting system and understood their responsibility to raise concerns. However, staff described incidents they had not reported as when they had previously raised concerns they had not always received feedback and learning had not been shared. Two staff told us not all PTS staff had login access to be able them to receive feedback, they had to ask their manager. Sometimes staff had reported the same incident (the same problem in the same location) over a number of times but no action had been taken to address the issue. Staff felt discouraged from using the system. In Berkshire, staff told us they were discouraged from reporting incidents. There was no assurance across the PTS that staff always

Patient transport services (PTS)

reported safety concerns or they were acted upon. We reviewed 10 sets of minutes from team and managers meetings, also forum meetings for crews and contact centre staff, and found there was no record of discussions on learning from recent incidents.

- The trust produced two bulletins called 'SCAScade' and 'Hot News' to specifically distribute key learning from incidents and clinical information to staff. These were circulated to all stations. We observed these on display at stations but the staff we spoke with did not mention these as being relevant to PTS and as a way to share learning.
- 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. The trust's policy on 'Being open and duty of candour' reflected the Duty of Candour legislation.
- A manager in Hampshire described and we saw the completed root cause analysis for an incident where the trust had applied Duty of Candour and followed the correct process, keeping the patient informed. An action plan had been completed following the investigation.
- Hospital staff were able to access the secure trust electronic reporting system to log any incidents involving the PTS. The trust hospital liaison officer normally investigated and reported on these incidents.

Mandatory training

- Staff we spoke with told us they had completed their mandatory and statutory training as part of their induction. They felt this system worked well but not all staff had completed the required updates to their training. The trust told us they allocated staff two days every year to complete their mandatory training.
- Mandatory training for staff included information governance, manual handling and conflict resolution. Training modules were a mix of online e-learning or practical sessions.
- Some staff found the training was to a good standard and that they had flexibility on when to complete the training. Whereas other staff were disappointed and felt it was not tailored towards their role and lacked the opportunity to discuss or ask questions such as the equality and diversity training.
- Data on compliance with mandatory training as of May 2016 showed 88% of frontline staff were compliant, 88%

of staff working at Bicester contact centre and 87% of staff working at Otterbourne contact centre were compliant, against the trust target of 95%. Staff told us they sometimes found it difficult to keep up to date with their mandatory training.

- The trust had recognised the safety risks associated with poor compliance with training and included this on their directorate risk register. Training time was to be incorporated into staff rotas. However, the risk register did not identify any progress or review of this action to address the immediate risk.
- Some staff we spoke with were uncertain how often they needed to update their training. Information was available to staff on training. For example, we saw information displayed at Adderbury resource centre advising staff how often they needed to complete the different training modules.

Safeguarding

- There were trust wide safeguarding children and adults policies. Staff in all the areas we visited knew how to access these policies and the process they should follow if they needed to raise a safeguarding concern.
- Staff felt confident to make a referral and described situations where they had done so. This was sometimes when returning a patient to their home and they had concerns. The trust and social services were developing additional training to support staff where patients' social circumstances may not be ideal but there was no safeguarding concern.
- Safeguarding concerns about patients were recorded in the electronic record held about each patient. Frontline staff could access this information through their personal digital assistant (PDA) they told us this system worked well. The trust had acquired six electronic patient record tablets to be used by staff across the trust. However this was not for the use in PTS and private sub-contractor services and paper referrals would still be made to the local authority.
- PTS frontline and contact centre staff completed safeguarding adults and children training to level 2, as part of their mandatory training. As of May 2016 overall compliance with safeguarding training was 93% for PTS against the trust target of 95%. Compliance for frontline staff ranged from 78% to 100% and for contact centre staff was 88%. Compliance for frontline staff overall was

Patient transport services (PTS)

85%. The areas of lowest compliance for both safeguarding children and adults level 1, was Bicester contact centre (64%), for safeguarding adult and children level 2, Otterbourne contact centre (56%).

Cleanliness, infection control and hygiene

- All the resource centres we visited and vehicles we inspected were visibly clean and tidy.
- Cleaning audits were completed for resource centres and vehicles. The trust submitted data to show these had taken place and a log kept of the number of actions remaining for each area. It was not possible to ascertain the compliance level from the audit information provided.
- Frontline staff were responsible for keeping their vehicle clean on a daily basis and recording this check on their personal digital assistant (PDA). Staff told us the change in rotas meant they generally used the same vehicle each shift, which was a positive. They took a sense of pride in the cleanliness of their vehicle.
- A contractor performed six weekly deep clean of vehicles. Team leaders told us the deep clean system worked well. The work was completed to a high standard and the company audited the standard of their work. Team leaders also undertook spot checks on vehicles to monitor the standard of cleanliness and kept written records of this.
- Deep cleans normally took place outside the standard operating hours of the service to limit the impact on patients, through vehicles being off the road. If a vehicle became significantly contaminated, the crew returned to base for vehicle cleaning and the team leader allocated them a spare vehicle. If no vehicles were available, the contact centre would reallocate journeys across other crews.
- Staff had access to personal protective equipment (PPE) such as gloves and aprons on their vehicles to reduce the risk of the spread of infection between staff and patients. Crews carried a spills kit on their vehicle to manage any small spillages and manage the infection and hygiene risk to other patients. However, one vehicle we checked did not have any PPE. On another the PPE, linen, spills kit and sick bowls were stored in a cardboard box. This was a new vehicle and staff raised concerns there was no storage space for this equipment

as there was on older vehicles. This imposed a safety risk staff could not wipe the box and items were not easily reached and the box was not stored securely in the vehicle.

- Staff told us they were responsible for cleaning their own uniforms. Staff kept a spare set of uniform at their base, should it become dirty. Trust policy required staff to dispose of heavily contaminated uniform.
- Frontline staff transporting patients did not all clean their hands between each patient contact, to minimise the spread of infection. This was not in line with the trust's 'Infection prevention, control and decontamination policy and procedures' and part of the National Institute for Health and Care Excellence quality standard 61- Prevention and control of healthcare-associated infections.
- The service was not inconsistent with checking staff compliance with infection control procedures. Minutes from the January 2016 patient safety group, identified only five observational infection control audits had been completed across the PTS since April 2015. The trust required all staff having direct patient contact to be observed once a year. However, the trust reported as of May 2016, 93% of PTS staff had been observed. Information on patients with specific infection and hygiene risks was recorded as part of the booking process. Frontline staff could then access this information on their PDA, prior to collecting a patient.

Environment and equipment

- The majority of vehicles we reviewed were in a good condition and the resource centres we visited were well maintained and secure.
- We inspected 21 vehicles, three vehicles in Berkshire had a groove in the foot well, this had the potential to impact on the safe driving of the vehicle. Staff told us this was a regular problem across the current fleet of vehicles. On two vehicles, staff had not logged this in the vehicle book as per trust guidance. We brought the fault to the attention of the team leader and the vehicles were taken out of service and repaired. We saw two vehicles where staff had reported the groove, with it being repaired with a reinforced plate.
- Team leaders had systems in place to monitor the date for servicing and MOT of the vehicles at their resource centre. There was a central log kept of vehicles MOT dates but the PTS held servicing information locally. The trust leased all vehicles from an external provider

Patient transport services (PTS)

normally for a period of five years. The PTS performed vehicle inspections every eight weeks for PTS ambulances and every 12 weeks for PTS cars so staff were aware of any faults and the action they needed to take. Servicing was as per manufacturers' recommendations. Tail lift inspections took place every 24 weeks.

- Team leaders raised concerns that vehicles sometimes were off the road for up to three weeks when due an MOT. The fleet maintenance company were busy and did not always have time to collect or return vehicles. Team leaders sometimes dropped off and collected vehicles themselves to ensure they had enough vehicles to meet the needs of their area. Team leaders were also responsible for entering the current mileage onto the trust central database, to help them plan the servicing date.
- Keys for vehicles were stored securely in a locked safe. All resource centres we visited had keypads on external doors to restrict unauthorised access. We did not find any unattended unlocked vehicles. If a vehicle was off the road, the keys were stored in a separate area of the safe.
- Daily vehicle checks were required as part of the standard operating procedure 'Operational protocols for ambulance care assistants'. Staff in Oxfordshire and Buckinghamshire told us they did not always have time to complete these in full, as it took longer than the allocated 15 minutes. Minutes from the ambulance care assistants forum September 2015, reported a new shorter 10 point vehicle check was to be introduced. However, on reviewing the breakdown of the list, staff had to check 59 components. Staff told us they came in early to complete the checks or did key safety aspects each day and a complete check every couple of days. Staff were required to record the daily checks they had completed on their PDA. The trust did not provide information on how they managed the safety risk should all the checks not have been done.
- Staff knew the process to follow if their vehicle broke down or was involved in an accident, addressing the immediate needs of any patients first and then liaising with their team leader and dispatch for a replacement vehicle.
- Managers monitored driving standards and the trust used CCTV on vehicles to help with any insurance claims made against the trust. The trust issued a safety bulletin every six to eight weeks that included advice on driving standards and improvements to practice.
- In Hampshire, staff were not issued with radios, communication was via the PDA system. The trust reported that there was 99% coverage for this device, although staff raised concerns about connectivity in the rural areas of Hampshire. In an emergency, the trust handbook clearly indicated that staff should call the emergency services, which could be completed without a signal on a mobile phone, in those area where the PDA did not work.
- In addition we found the emergency call function on some of the PDAs in Hampshire was not working during our inspection. This posed a risk to patients, as the crew were unable to summon for help in an emergency. We fed back our concerns during the inspection and were told the designated 'lone worker phone' at the control centre was found to have a low battery and a replacement was on order.
- We observed, and staff told us, it was difficult for them to remove the trust patient wheelchair stored in the front of vehicles. It was heavy and they had to lift it from the vehicle at a height. Managers told us there was a plan to reconfigure the layout on some vehicles, although staff were not aware of this.
- Patients could travel in their own wheelchair if it was safety crash tested and had a safety test sticker in place. This information was communicated to patients via the trust website and also asked at the point of booking. If there was no sticker, staff transferred patients to the trust wheelchair or moved them by another means, such as on a stretcher. We observed staff making patients secure using safety belts or safety straps to keep them safe during their journey.
- Staff could access child seats or appropriate restraints at allocated resource centres so children were transported safely. Vehicles to transport bariatric patients were available across the service and contact centre staff requested at the time a booking was made to ensure suitable equipment was available for the safe moving and transportation of the patient.
- On some vehicles, the step for patients to climb in and out was narrow. Podiatry patients found this a particular

Patient transport services (PTS)

problem, as their boots did not fit fully on the step, causing a potential safety risk. We observed staff using safe moving and handling practices when loading patients on and off a vehicle.

- Staff did not routinely have to manage clinical waste, however, on all but two of the vehicles we saw clinical waste bins provided to ensure clinical waste was disposed of in line with trust guidance. On one vehicle, there was a loose black bag, secured around a headrest and no clinical waste bag. Some vehicles had sharps bins which were secured safely and in date. The vehicle check list did not identify what clinical waste products should be on each vehicle, to ensure consistency for staff and patient safety.
- The correct coloured mop heads and buckets were used to clean vehicles, staff knew to throw away any mop heads used to clean clinical waste or spillages.
- Staff visited the nearest resource centre if they needed to restock on any items, such as gloves and wipes.
- Resource centres we visited were tidy, with appropriate use of storage areas. Electrical equipment had been safety tested at all centres within the last year and a written record was kept. This did not show which items were faulty, just how many had been tested. There were no health and safety risk assessments completed at the resource centres to ensure premises were safe for staff to work from.
- Volunteer care drivers had to submit evidence of their insurance and vehicle MOT on a yearly basis or when they changed their car, to confirm they were eligible to transport patients.

Medicines

- PTS frontline staff were trained to administer oxygen, nitrous oxide, dextrose and aspirin. Only oxygen was stored on vehicles, although we found two vehicles with no oxygen available. An appropriate health care professional had to prescribe the oxygen so staff could administer it or the patient had to have a home oxygen order form in place.
- Staff told us only Band 3 ambulance care assistants (ACAs) could administer oxygen to patients, although they had all received training. There had been occasions where no band 3 member had been present or a double crew contained two band 2 staff. Also, staff were generally now recruited as a band 2. A couple of staff

told us they were given temporary permission by the contact centre to administer oxygen to patients for a journey. Staff found the situation confusing and a risk to patients and themselves.

- The trust policies on the administration of oxygen for PTS were contradictory. The trust 'Medicines management' policy (July 2014), did not state the grade of PTS staff who could administer oxygen, only that they had to be trained. The trust standard operating procedure for 'Transporting patients on oxygen therapy' (July 2015), stated band 2 ACAs could not administer oxygen and were to be the driver for the journey. There was further confusion, as a band 2 member of staff working as a single crew could transport patients who administered their own oxygen but the crew member could not support the patient and had to seek assistance if they had concerns. In emergency situations, staff had to call clinicians on the clinical support desk for advice before administering oxygen to a patient.
- Replacement oxygen cylinders were stored at resource centres and secured with a collar system to prevent them falling over.
- Patients traveling on PTS vehicles were responsible for their own medicines, including controlled drugs.

Records

- All patient records were electronic, with secure access; staff had to login to their personal digital assistant (PDA) with their access code.
- Information on whether a patient had a do not attempt cardiopulmonary resuscitation order in place (DNACPR) or end of life care planning notes were recorded on the patient notes section of the electronic record. Staff could access this information via their personal digital assistant (PDA), including voluntary car drivers and private contractors. If their PDA was not working, staff could call the contact centre to obtain the information.
- There were also sections for staff to complete journey notes or private notes, this information however was not accessible to staff using their PDA. We observed a situation where a dispatcher had to search through the journey notes to find a key piece of mobility information. This was time consuming and a potential safety risk. They moved the relevant information to the patient notes section for ease of access next time.

Patient transport services (PTS)

- Patients travelling with their medical records carried them in an envelope to ensure confidentiality. PTS staff handed these directly to health or care staff on arrival at an appointment.

Assessing and responding to patient risk

- There were appropriate systems and processes in place to assess and respond to patients who were at risk. Either a reoccurring risk that required the service to put a risk assessment in place or a sudden change to a patient's health that staff needed to escalate promptly.
- Call handlers followed a script so relevant questions were asked at the time of booking about a patient's mobility or additional needs. If concerns were identified a risk assessment was requested, as per the trust 'Contact centre risk assessment process' standard operating procedure. The risk assessment was carried out by experienced frontline staff, who were allocated the work during their shift, or a team leader. Staff used a standardised form and the information uploaded on the patient dispatch system. This meant it was accessible to relevant staff within PTS.
- Staff told us in general, contact centre staff allocated journeys to them appropriately, for example, they allocated a double crew to patients needing a stretcher lift. We observed the contact centre and frontline crews all working together to co-ordinate the safe movement of a patient who needed a multi-crew lift. A risk assessment had been completed for the patient. However, they did raise concerns that inappropriate online booking by hospital or GP practice staff meant they could not always transport the patient as they did not have the correct number of staff or equipment to move the patient.
- The process for staff to follow if they arrived at a location and could not locate the patient was included in the vehicle handbook. The contact centre attempted to contact the patient or a family member if the patient could not be located. Staff were confident how to escalate any concerns, for example, if they observed through a window that the patient had collapsed.
- If a patient became unwell during a journey, staff stopped their vehicle when safe to do so and then assessed the severity of the situation. Staff told us if the patient deteriorated or suffered a cardiac arrest, they called 999 and requested support from their colleagues.

Staff completed basic life support training and some staff had completed first person on the scene training. Information on the escalation processes was included in the vehicle handbook for ease of reference.

- Volunteer care drives had the following checks prior to working for the trust. A mandatory CRB check, an informal driving assessment together with brief overview of the car, a check on all driving documentation and an informal interview. We spoke with three voluntary drivers who confirmed these checks had happened.

Staffing

- The PTS service had developed contracts to respond to the move to seven-day services. In all areas, the new contracts had extended the working day, previously shifts finished around 7pm but some services now ran until 10pm. There was greater provision at weekends and bank holidays. The majority of contracts required at least one ambulance to be allocated for same day patient discharges.
- ACAs and contact centre staff, across all areas, frequently raised concerns with us about staffing. The new contracts had created additional work and increased pressure on staff due to difficulties recruiting and retaining current staff. Volunteer car drivers felt they could do more work to support the service. The trust was using their contracts with independent ambulance services to ensure shifts were covered.
- Senior staff noticed an increase in the number of incidents reported about staffing following the introduction of the new contracts. A review took place to look at the time of day and which areas were affected the most. This identified problems in all areas in the afternoon and evening. Rotas were reviewed to allocate more staff to these shifts or to use private providers.
- Planning staff told us if they could not allocate all journeys with the current resources, they contacted the private provider lead, who would review the rotas and authorise the use of a private provider.
- The vacancy rate for operational staff in PTS was 18% in December 2015. This was highest in Oxford (43%), followed by 19% in Thames Valley, 7% in SHIP and 2% in the Milton Keynes areas. Data for December 2015 showed a vacancy rate of 43% for frontline staff for the mental health contract. The vacancy rate was impacting on the ability to cover shifts.

Patient transport services (PTS)

- Over a three month period between April to June 2016, staffing hours did were not filled against planned levels. The hours filled were 91% in April, 89% in May and 85% in June.
- Vacancy data for May 2016 showed there were 52.5 whole time equivalent frontline vacancies across the Thames Valley area, the trust did not provide a breakdown by county.
- Staff working in Berkshire had seen an increase to 15 lines of work on one rota and 18 on another. They told us there were not enough staff to complete all their work even prior to the changes being made. Rotas provided by the trust for Berkshire PTS, covering 25 April- 15 May 2016, when the new contract was introduced showed 52 vacant shifts in the Slough cluster and 193 in the Reading cluster. The trust told us they used contracted taxi services to cover some journeys and enable ambulances to be used for patients with greater need.
- The majority of frontline staff told us they did not get regular meal breaks, they were either not allocated a break or there was not the time to take them. They were concerned about their wellbeing and the impact on patient safety. Staff shifts varied in length from eight to 12 hours. Senior managers told us the trust had told staff to take their meal break. Minutes from the ACA forum January 2016, identified the need for union representation and for input from leads working in both contact centres around the issue of meal breaks. Management were aware of staff concerns and they were reconsidering the trust meal break policy for PTS, along with discussions with relevant staff.
- Rotas we reviewed during our inspection showed in general breaks had been allocated to frontline staff but the timing was not always appropriate, for example, staff started their shift at 8am and were required to take their break between 9am -11am. Staff took their break in an allocated time window and contacted staff in dispatch to inform them they were on their break. However, we found no evidence of monitoring or recording of whether staff had taken their meal break.
- Vacancy data for the contact centre in May 2016, showed there were 4.6 (%) whole time equivalent dispatcher vacancies; one post in the north and three in the south. The trust had advertised all posts. There were no vacant team leader posts.
- At Bicester contact centre,. We were told the planned staffing for the team was two team leaders, four

dispatchers and two radio controllers. There was currently one team leader, three dispatchers and one radio controller. Bank staff covered four half-day shifts per week. Staff received additional support from dispatchers in Otterbourne but they did not know the geography of the local area that made it more difficult for them to allocate journeys.

- There was an on-call process in place both for the contact centres and for frontline crews. Staff we spoke with knew how to escalate concerns when working out of hours.

Anticipated resource and capacity risks

- Business and operations managers considered the impact of different resource and capacity risks and could describe the action they would take. There had been a phased implementation of the new contracts so that staff could adjust to the new rotas, areas covered and different key performance indicators (KPIs). This also enabled managers to address any immediate concerns in a manageable way.
- One manager described how planned down time for the patient scheduling system was managed, with journeys dispatched manually, recorded on paper and retrospectively uploaded. An incident occurred with complete IT failure at both contact centres. This had identified although the fall back process had worked, the back-up of the IT system was not complete. The issue was resolved that day and the system backed up every three minutes. During the down time, crews allocated for outward journeys were sent to hospitals and day hospitals. Hospital liaison officers made hospital staff aware of the current situation and kept them updated. During this time no patients were missed.
- The radio controller reallocated journeys if staff made them aware of potential concerns or risks, such as a single crew allocated to a journey but the patient had limited mobility or staff became stuck in traffic and were unable to make all their planned journeys.
- Frontline staff raised concerns that in poor weather, such as snow, journeys took longer to complete due to the impact on patients' mobility and also the speed they could travel. They were not given extra time to complete the journeys.
- There was an adverse weather policy in place giving guidance for PTS, such as attending their nearest rather than normal work base to help keep staff safe.

Patient transport services (PTS)

Response to major incidents

- Staff were aware of the trust's major incident policy and the role of the PTS, although staff we spoke with had not been involved in a major incident response. Managers provided examples where the service had responded such as during a gas leak in Portsmouth and during flooding in Oxfordshire.
- Hospital liaison officers acted as a point of contact between the control team and the receiving hospital. Also, PTS staff were required to transport low risk patients from the scene.

Are patient transport services effective?

Good



By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

We rated effective as "good":

- Care and treatment for patients was planned taking account of current evidence based guidance, standards and best practice.
- Multidisciplinary working was a strength of the patient transport service (PTS) with teams working well together within the trust and with other external providers to co-ordinate care for patients. The role of the hospital liaison officer had developed and improved working relationships between the PTS and local hospitals.
- Staff had access to the information they needed to enable them to provide suitable care for patients. This included care plans for patients with long-term or complex conditions. Staff could access risk assessments and considered patients overall wellbeing during the journey.
- Staff across all team were positive about the induction process and the initial training they had received. There was good use of competency based assessments, particularly for call handlers and the driver training course. Although some staff groups were below the trust target for compliance with appraisals.
- Transport times for renal patients in general met national standard times and had significantly improved from the previous financial year.

However:

- Patients reported delays in collection after their appointment or following discharge from hospital. Data provided by the trust supported this, with only three out of six commissioner contract performance indicator targets being met for the collection of patients before their appointment and one out of six meeting the performance indicator on patient collection after their appointment.
- Staff told us they had not received adequate training to support patients with a mental health condition. Although staff were aware of the principles of the Mental Capacity Act (2005) and obtaining patient consent Staff were also concerned about lack of regular supervision and opportunities for further development were limited for certain staff groups.

Evidence-based care and treatment

- The patient transport service (PTS) provided transport to patients according to guidelines in the Department of Health 'Eligibility criteria for patient transport services' document.
- Call handlers assessed patients' eligibility for the service at the time of booking by asking set questions. If patients did not meet the criteria, staff gave advice on other services they could use.
- To enhance the delivery of care the service had introduced an online booking system for health care professionals so they could book and track journeys in a more timely way.
- Staff working for the Milton Keynes contract also followed National Institute for Health and Care excellence (NICE) quality standard 15 (Patient experience in adult NHS services) as part of the contract agreement.
- The PTS followed guidance in NICE quality standard 72- Renal replacement therapy services for adults, which stated patients should be collected no earlier than 30 minutes prior to their appointment time, and collected within 30 minutes of their treatment finishing. Performance to this standard was measured as part of the key performance indicators.
- The trust had a specific standard operating procedure for the transportation of children. Additional information, such as the child's height was recorded at

Patient transport services (PTS)

the time of booking, to ensure national policies were followed around the type of restraint needed. The trust used only their own equipment when transporting children.

- We saw in minutes that updates to NICE guidance were discussed at the monthly contract review meetings

Assessment and planning of care

- A risk assessment was completed for all eligible new patients to ensure the service could provide suitable care for them during their journey. This information was stored on the patient's electronic record.
- Staff accessed care plans for patients on the computer aided dispatch system and personal digital assistant (PDA) as part of the patient's record. GPs and other healthcare professionals submitted plans for patients, including those with long-term conditions or those who had an end of life care plan in place.
- Information on whether a patient had a mental health problem was recorded at the time of booking and accessible for trust staff in the patient's electronic record. Frontline staff accessed this information as needed.
- We saw frontline staff asking patients if they were in any pain prior to starting their journey. Staff made patients as comfortable as possible. Although staff had completed training to administer aspirin, no pain relieving medication was stored on vehicles. Patients could use any pain medications they could self-administer.
- We saw two patients at different hospitals, who had long-term conditions that caused pain, the PTS was delayed collecting them after their appointment. Dispatchers told us there was no way to show on the patient transport list, who was a priority for collection due to their needs. They could only find this information by looking at the detailed patient record.

Nutrition and hydration

- The PTS did not routinely provide food or drink for patients during their journey.
- Staff told us they reminded patients to eat and drink before travelling or to bring some food with them for the journey, particularly for patients who were diabetic.
- Regular users of the service told us they brought their own snacks and drinks with them.

- At the Portsmouth resource centre, we saw bottles of water kept in vehicles, should patients or staff need them, such as on a warm day or if a journey became delayed.

Patient outcomes

- There were key performance indicators (KPIs) set by commissioners for the PTS based on national guidance. KPIs are a set of quantifiable measures used to measure or compare performance in terms of meeting agreed levels of service provision.
- There were different KPIs in place across the PTS, due to commissioners setting different performance indicators in different areas, these were mainly around collection times before and after appointments. KPIs for renal patients were set nationally and were the same in all areas, although the agreed thresholds varied by contract. Senior managers told us it had not been possible to negotiate the same KPIs in each area. Staff we spoke with, particularly in the contact centre had a good knowledge of the different KPIs and allocated journeys to help meet the KPIs. There was a clear commitment to meet KPIs to ensure good outcomes for patients.
- Patients were generally positive about being collected in time for their appointment. All contracts had a KPI on patient arrival time. Hospital staff in the Thames Valley area told us response times had improved with the introduction of the new contract and staff in Hampshire told us the service had improved since the trust had started to provide the service.
- Renal patients told us there had been occasions when their treatment had started late and therefore finished late due to delays in them being collected for their appointment .. We saw staff in one renal department keeping patients updated about any collection delays.
- The National Institute for Health and Care Excellence (NICE) quality standard 15: Patient Transport (March 2011) stated that patients with chronic kidney disease receiving haemodialysis or training for home therapies should have transport within 30 minutes of their clinical treatment. This KPI for arrival time prior to appointment and collection of renal patients was set nationally. The trust reported on this data for two contracts. Data for 2015/16 showed in Hampshire the threshold of 90 % was partly achieved, the trust achieving 85% for arrival and 96% for collection from April to September 2015.. However, the trust told us the commissioners reviewed

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and changed the threshold to 85% for the remainder of the financial year. They achieved this other than for arrival time in November 2015. In Berkshire, the arrival time threshold was 85% and the trust achieved 77%; for collection the threshold was 75% with the trust exceeding this and achieving 91%. This was, an improvement compared to 2014/15 when trust data indicated that fewer than 20% of patients were transported within 30 minutes.

- A consistent complaint from patients and staff at local hospitals were the delays in patients being collected after their appointment or treatment. Hospital staff told us patients regularly had to wait up to two to three hours for the PTS to collect them. In general pre-planned patients were to be collected no more than 45 minutes after their agreed collection time or once the patient had been booked as ready by hospital staff. Bookings made on the day had longer collection times, ranging from three to four hours.
- Trust data on patient collection times for 2015/16 was available for six contracts. Patients arrived within the agreed time frame for their appointment for three out of six contracts. Patients were collected within the agreed time frame for only one of the six contracts, this was with a mental health trust. Patients spent more than the locally defined time on vehicles for two of the five contracts, which recorded this as a KPI. Three contracts had KPIs for collection times for on the day bookings, the trust met these for two of the contracts. Overall performance was worse for the contract in the Hampshire area, with all KPIs described above being missed by 20-40%.
- Hospital staff stayed late with patients until they were collected and described patients becoming anxious. Patients, although frustrated by the delays were grateful for being able to access the service and did not have any concerns around the quality of their care
- An audit of the 4925 aborted journeys in October 2015, found the PTS were responsible for 15%, the patient 33%, local hospitals 38% and shared responsibility 14%. An aborted journey is where the PTS arrived for the patient but did not convey them. The service had devised an action plan to address their areas of concern and planned to repeat the audit once they had embedded the changes. They shared the results and action plan at the patient experience review group.

- Minutes from the monthly contract meetings across all areas showed, that demand in excess of contracted levels was discussed and suggested actions to improve performance considered.

Competent staff

- Staff across all roles told us they had received a well-structured induction programme and felt competent to start in their new role. They did though have concerns about access to refresher training or opportunities to develop in their role. This was of particular concern for ambulance care assistants (ACAs), although some ACAs in Hampshire had recently started a new training course.
- ACAs completed a three-week competency based induction programme. Staff had to achieve all aspects before a trainer signed them off. Action plans were developed to support staff who had failed any of their competencies. The training department provided detailed workbooks for staff.
- ACAs also had to complete a one-week driver training course, which included daily competency assessments. Prior to this staff had to complete their C1 training, if they did not have this category on their driving licence. The driving standards used an internal points system to monitor staff driving. A reassessment was required if staff accrued too many points. Patients told us they felt safe when travelling on vehicles.
- years. Trust appraisal data as of May 2016, showed 100% of service managers 91% of Buckinghamshire staff 75% of Bicester contact centre staff 90% of Hampshire frontline staff 75% of Otterbourne contact centre staff 95% of Oxfordshire frontline staff and 72% of Berkshire frontline had received an appraisal, against the trust target of 95%.
- Frontline crews in particular felt they encountered situations that they had not received training for but managed due to their experience in their role. They did not feel confident when supporting patients with mental health problems. They felt the allocation of a single crew to transport a number of patients with mental health problems was not appropriate. They could not provide support to patients and drive safely.
- Managers and team leaders had completed additional relevant training for their role such as conduct and capability, and leadership. They told us their manager was supportive and the service gave them time to complete the training.

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- The PTS had recently introduced a new competency based assessment for call handlers to improve the consistency and quality of the service. Team leaders provided support for staff who failed any assessments. Managers routinely listened in on any calls lasting more than 10 minutes, to see if staff needed any help. The service planned to provide a mentoring course for staff in the contact centres who supported staff during their induction.
- Volunteer car drivers had a structured induction programme that included a driver assessment and some elements of the trust mandatory training programme, relevant for their role, such as safeguarding children and vulnerable adults.

Coordination with other providers

- We saw and staff told us that there was effective co-ordination between different providers to coordinate patients' transport around their care and treatment and discharge.
- The trust had hospital liaison officers (HLOs) in major hospitals across the region where staff were the public face of the PTS. They dealt with booking queries, any problems that occurred on the day (such as late arrivals, changes in patients' appointments) and, most importantly, ensured that every patient was conveyed so that they received the treatment they needed. HLOs also worked with occupational therapists and physiotherapists to complete risk assessments for patients due for discharge. This meant teams considered any access requirements for the PTS at the patient's home
- Hospital liaison officers attended bed meetings or operational meetings at local hospitals, to help in the co-ordination of patient discharge or to prioritise patients for transport if demand for beds on a ward increased. PTS and hospital staff told us this role had improved working relationships.
- Hospital staff commented on the good rapport PTS crews had with their patients and were always pleasant to staff working on the wards or various departments.
- The service held weekly meetings with local renal teams to discuss the impact of any transport delays. Again, staff told us these had improved engagement and co-ordination between the different teams.
- Dispatchers attempted to contact departments to let them know if patients were going to be late for their appointment. Hospital staff said they were being told if

patients were going to be arriving late, or when they would be collected. However, this sometimes did not happen and they were unable to contact the operation centres because their calls were not always answered.

- The driving standards team held monthly meetings with the police to discuss any concerns relating to staff driving ability.

Multidisciplinary working

- We observed good team working across the different staff groups within the PTS service and external organisations. Staff were committed to providing good care to patients.
- There was a variable level of knowledge about the HLOs within hospitals. Some HLOs had been in post longer than others, and in these areas hospital staff were more aware of the role. However, feedback from hospital staff was positive overall. The trust continued to promote the HLO role, through emails and information updates via the online booking system.
- A hospital liaison officer (HLO) in Buckinghamshire provided a list to outpatient clinics of any patients attending on a stretcher so the hospital could allocate a suitable room for the patient's appointment for ease of access and patient privacy.
- The service had recently introduced observational sessions for frontline staff in the contact centre and vice versa, to help staff understand the different challenges of each role and the impact on patient care.
- The patient dispatch system included information from other providers on whether a patient had an advanced care plan, advanced decision to refuse treatment or do not attempt cardiopulmonary resuscitation (DNACPR) order in place. Staff knew also to check for these in a patient's home through the 'message in a bottle' scheme. This national scheme encourages people to keep their personal and medical details in a bottle in their fridge. This ensured staff delivered care in keeping with the patients' wishes.

Access to information

- Staff felt they had access to sufficient information for the patients they cared for. If they needed additional information or had any concerns, they spoke with their team leader or staff working in dispatch.
- Volunteer car drivers and independent ambulance providers could access the same information as PTS staff.

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- Staff had access to relevant patient information as provided on their PDA, including patients' individual needs such as a sight or hearing impairment or epilepsy. This enabled them to give additional care to patients when needed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Frontline and contact centre staff told us although they were required to complete Mental Capacity Act (2005) and dementia awareness training as part of their mandatory training, they were not up-to-date with their training.
- data provided by the trust for May 2016 showed overall compliance of 93% for PTS staff for dementia awareness and Mental Capacity Act training against the trust target of 95%. Compliance for frontline staff ranged from 78% to 100% and for contact centre staff was 88%. Data for January to December 2015, showed 66% of frontline staff, 62% of contact centre staff at Bicester and 56% of staff at Otterbourne contact centre had completed Mental Capacity Act training against the trust target of 95%.
- Staff in Hampshire, showed awareness and understanding of the Mental Capacity Act (2005) code of practice and consent processes. They described how they would support and talk with patients if they initially refused care or transport.
- We observed staff seeking patients consent before they used seatbelts or straps to restrain them safely for the journey.

Are patient transport services caring?

Outstanding



By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

We rated caring as "outstanding":

- All feedback from patients and hospital staff was consistently positive about the care patient transport services (PTS) staff provided to patients. Patients described situations where frontline staff had gone the

extra mile and the care received had exceeded their expectations. Staff were diligent in checking patients' welfare and emotional needs were met, not just their clinical needs.

- Staff developed supportive and caring relationships with patients, particularly regular users, such as renal dialysis and mental health patients. Staff clearly valued these relationships and leaders recognised the importance of keeping regular patients with same crew.
- Patients appreciated this personal approach and the respect shown by staff for their social and emotional needs. Staff were conscious about maintaining a patient's privacy and dignity.
- Staff focused on making sure patients were active partners in their care, encouraging independence and seeking the patients' opinion. Staff told us they came to work every day because of the patients they cared for.

Compassionate care

- The majority of patients we spoke with were happy with the quality of care they received. Patient transport service (PTS) staff spoke to them in a kind manner and treated them with dignity and respect.
- Patients told us staff were caring, supportive and professional. For example, one patient told us 'I was looked after by the crew'. Another commented, "The crew staff do a wonderful job, and they are always polite, caring and cheerful". Other patients told us staff were courteous, and helpful. Patients commented that staff apologised when they were running late.
- Staff and patients described situations where we felt they had gone above and beyond because of their care and empathy for their patients, particularly regular users of the service. For example, staff checked on patients who had become unwell and visited them on the ward. A dialysis patient described how the crew would make them a cup of tea if they were too weak after their treatment. A patient described how staff always walked them to the door of their house and ensured they were settled before leaving. A regular user of the service described how staff always made sure a fellow patient travelled facing forward, as the patient suffered from travel sickness.
- Feedback from all the hospital staff we spoke with at various hospitals was also positive about the care they

Patient transport services (PTS)

saw PTS staff providing for patients. They commented on their professional but friendly approach and consideration of the total needs of the patient, not just their medical needs.

- We observed care provided to patients during their journey to or from the hospital. Staff asked patients their preferred name and ensured patients were comfortable. They maintained patients' privacy and dignity by closing blinds, keeping doors closed between unloading and loading other patients.
- We saw PTS staff using blankets to keep patients warm during their journey. PTS staff told us they had spare blankets on each vehicle; these were especially useful during the winter period.
- Staff knew the needs of regular users of the PTS, such as patients receiving dialysis. Patients told us they valued having the same crews or volunteer car driver for their journeys and the regular contact with staff made the trips to hospital more manageable.
- We observed an instance where two patients had a dispute. PTS staff managed the situation appropriately. Staff completed conflict resolution training as part of their mandatory training. For any reoccurring issues, planners reallocated patients to separate journeys.
- Friends and family tests data was collected for April 2015-March 2016, however the response rate was very low and therefore meaningful conclusions could not be drawn from the data.

Understanding and involvement of patients and those close to them

- Patients described having confidence in the staff providing their care and patients were involved as much as possible when planning their journey to the hospital.
- Staff working in the contact centre were polite and clear in their explanations to patients and health care professionals when explaining the criteria to access the service. They phrased questions in a different way if a caller did not understand. This ensured staff captured the correct information about the patient and the contact centre arranged appropriate transport for them.
- We observed a family member travelling with a patient to support them during their journey. Where possible escorts were booked onto journeys but there were strict eligibility criteria due to the limited space and demand for the PTS.
- Staff provided clear information to patients about their journey and informed them of any delays.

- Staff accompanied all patients to their destination and assisted with booking-in at reception when attending for an outpatient appointment.

Emotional support

- Patients enjoyed being able to talk to staff about 'every day things' rather than focusing on their clinical condition. Staff told us they 'loved talking with patients', this was one of the positives about their job and why they continued to work for the service.
- Staff told patients when they were on annual leave, so they knew a different crew would be collecting them. They understood the value patients placed on having the same crew collect them, who knew their individual needs and preferences.
- In Berkshire, staff completed a 'rest in peace' book so colleagues were aware if a regular patient had passed away. Staff were given time to attend the funeral if appropriate.
- A number of staff described how they had built positive relationships with mental health patients they transported. Patients would come and talk to them if they saw them at the hospital. One member of staff described how they had provided support to patients who had a mental health crisis whilst on their vehicle. The patients had remained safe until further help arrived. One patient told us the crew staff were always empathic and provided them with emotional support when going through a difficult period.
- PTS staff did not routinely transport patients who were end of life or had passed away. However, staff were aware of the need to support family or other patients should a patient suffer a cardiac arrest or die during a journey. Staff could access welfare support afterwards.

Supporting people to manage their own health

- Patients were encouraged where possible to use their own mobility aids to walk to and from the vehicle. We observed staff supporting patients and encouraging patients to walk where possible, even if they were running late.
- Patients had to meet set eligibility criteria to use the service. PTS staff directed patients to alternative patient transport services if their health had improved and who no longer needed to use the PTS. Commissioners provided and updated this information. Patients could also access this information themselves on the trust website.

Patient transport services (PTS)

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

Good



By responsive, we mean that services are organised so that they meet people's needs.

We rated responsive as “good”:

- The PTS planned and delivered their service to meet the need of the local population. New contracts had extended the operating hours of the service, to support the development of a seven-day NHS. The service had also used feedback from staff and patients to provide services which responded to specific local needs.
- Systems were in place to establish, record and respond to the individual needs of patients, including the allocation of a suitable vehicle, staffed appropriately. The service was accessible to all eligible patients irrespective of any additional needs. Staff responded to individual needs well.
- The service had a constant list of patients who needed transport. Staff were using their knowledge and patients notes to identify patients who needed prompt transport, for example, if they had significant pain, a chronic illness or were to receive a home care package.
- Changes had been introduced in the PTS to try and ensure better management of the resource, such as the ‘book ready’ system to prevent vehicles being sent when a patient was not ready for collection.
- The service monitored its performance on a daily basis and responded to areas of concern.
- The online booking system allowed hospital staff to see the estimated time of arrival. Patients could access this information through the ‘my booking’ section of the trust website

However:

- Only two-thirds of staff had attended dementia awareness training. This was an improvement but was still below trust targets.
- Despite the introduction of the PTS online booking system, patients and staff still experienced delays when calling the contact centres. The trust had not met

response times for calls in the last year (2015/16). Hospital staff could not always contact the service to identify delays in transport arrangements or to inform about changes in patient circumstances.

- The electronic systems did not identify patients as a priority for collection to ensure this happened in a systematic way.
- There was limited sharing of learning from complaints with staff, although thorough investigations were completed by team leaders and managers. The trust did not always respond to complaints within the agreed timeframe.
- Patients who had transport by a taxi service did not always get the appropriate escort service.

Service planning and delivery to meet the needs of local people

- Patient transport services (PTS) provided non-emergency transport for patients who were unable to use public or other transport due to their medical condition. This included those attending hospital, outpatient clinics, being discharged from hospital wards or requiring treatment such as chemotherapy or renal dialysis.
- Management staff had over the last year worked with local stakeholders, which included clinical commissioning groups, local NHS trusts and an independent healthcare provider to retain all their contracts and secure a new contract in Hampshire.
- The PTS service had developed new contracts to respond to the move to seven-day services. In all areas, the new contracts had extended the working day, previously shifts finished around 7pm but some services now ran until 10pm. There was greater provision at weekends and bank holidays. The majority of contracts required at least one ambulance to be allocated for same day patient discharges. The trust used their contracts with independent ambulance services to ensure shifts were covered.
- In Berkshire, a pilot project had improved the PTS for patients attending for dialysis. Changes were making planning for these patients a priority, with dedicated PTS crews who only transported renal patients to enable greater compliance with key performance indicators (KPI's). Liaison work had taken place with the matron at the local hospital to understand the needs of this patient group. The trust planned to introduce the approach into Oxfordshire and Buckinghamshire.

Patient transport services (PTS)

- In response to feedback from staff at a local community trust in Berkshire, a dedicated service was being trialled for patients attending rehabilitation. Patients previously tended to be late and missed some aspects of their rehabilitation session.
- Staff at local hospitals valued the role of the hospital liaison officers. They worked closely with staff to co-ordinate discharges, preventing delays. They also spent time explaining the new contracts to staff so they understood the benefits for patients. This role was
- Planners and management staff described how they responded to the differing demands of the service depending on the time of day and location. Crews were sometimes required to work in different areas, if there were more journeys in these areas needing completion.

Meeting people's individual needs

- The PTS service had robust systems in place to enable them to meet the individual needs of patients.
- At the time of booking a journey, call handlers asked relevant questions to obtain information on the patient's mobility, additional needs such as hearing or sight impairment and if the patient needed an escort, for example if they were living with dementia or had a learning disability. Staff also recorded whether a patient was bariatric.
- This detailed recording enabled the planners to allocate the appropriate crew to the journey. In some situations, a double crew was used to better support patients' individual needs.
- A phrase book, containing key questions in 41 different languages should have been available on all vehicles, for staff to use should they not have access to an interpreter. This also contained a short section on sign language. Seven of the 21 vehicles we checked did not have a phrase book. Also, the daily vehicle check list did contain this item to prompt staff to check it was available.
- In Hampshire, staff told us they would use an online translation system should they not have access to a phrase book and a non-English speaking patient needed transport.
- Some staff described situations where they had used their dementia awareness or mental health training to support patients, as described above in the caring section. Approximately 64% of staff had had dementia

awareness training (figures from December 2015), this was an improvement from the previous inspection in September 2014 when staff told us they did not have any training available on dementia awareness.

- Patients with a hearing or speech impairment calling the contact centre, could use a text phone and the support of a nationally provided specialist operator, when making a call.
- Hospital staff at a Hampshire dialysis unit described how the PTS had continued to provide transport for a patient who moved outside the catchment area, so they could continue to attend their regular unit for treatment.

Access and flow

- There were different ways for patients to make a booking depending on where they lived. Patients in Oxfordshire, Buckinghamshire and Berkshire could book their own journeys through the patient eligibility line or a health care professional (HCP) could arrange the journey for them. For patients living in all other areas, a health care professional had to arrange their journey. They could do this through the dedicated HCP phone line or via the website. All patients could manage their booking through the online system on the hospital's website.
- Two contracts monitored use of the on-line booking system as part of the key performance indicators (KPIs). The target was for 80% of eligible bookings to be made on-line. For 2015/16 around 50% of bookings had been made using this system.
- In both contact centres, screens were used to display up-to-date performance data for each contract, such as calls answered within 60 seconds, length of time the longest call been waiting and overall performance for the day. Areas were highlighted red, amber or green to show the level of performance. This meant team leaders could take timely action for areas of poor performance.
- Data for 2015/16, showed at year-end, the trust had not met KPIs on call-answering times. The KPI target varied depending on the contract, requiring call-handlers to answer between 90-96% of calls in either 25 seconds or 60 seconds, the trust achieved around 75%. There were additional KPIs in some contracts for the percentage of calls that went to answerphone and the time to respond to those calls. These KPIs were not met either.
- Other than in Hampshire patients were not auto allocated a return journey until hospital staff or the

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patient contacted to say they were ready for collection. This helped to reduce wasted journeys when the patient was not ready and a crew had to be sent again. On the day of our unannounced inspection, the trust had reverted to manual planning of inward and outbound journeys in Oxfordshire and Buckinghamshire as the auto allocate system had resulted in some KPIs being missed. Staff in these areas told us the system would allocate them a journey but they may not be the nearest vehicle to the location. By the time they reached the location, another closer vehicle had become free. This caused additional mileage, affected staff finish times and the overall efficiency of the service.

- Senior PTS managers had twice-daily teleconference to discuss performance from the previous day and to address any key concerns identified during the current day. We observed dispatchers planning on the day bookings and if crews became delayed reallocating patient journeys. They kept crews informed by telephone and updated information on their PDA. Where possible they called the relevant outpatient department if a patient was going to be late for their appointment.
- Hospital staff told us it was difficult to get through on the estimated time of arrival (ETA) phone line or the dedicated health care professional line, particularly in the afternoon. We observed at both contact centres there were sometimes delays in answering calls, during our observation the delay was up to five minutes. However, minutes from the Hampshire area contract meeting for January stated an example of a patient waiting 45 minutes for contact centre to answer their call. Data for 2015/16, showed at year-end, the trust did not meet the KPI on response times to calls to the healthcare professional line. Three contracts required this data to be collected. The KPI target was for the contact centre to answer calls within 25 seconds or 60 seconds depending on the contract, with a target of 90%. Compliance with the KPI ranged from 75-80%. We requested data on the ETA line, this was not available.
- The online booking system allowed hospital staff to see the estimated time of arrival. Patients could access this information through the 'my booking' section of the trust website. Hospital liaison officers (HLOs) had worked hard to promote the online system to hospital

staff, prior to its launch in April 2016 as an alternative to the using the ETA line. The PTS had provided training and HLOs acted as a point of contact for any difficulties using the system.

- Community hospital staff in Berkshire raised concerns that patients' needs sometimes changed and the patient needed a two person crew or access to a stretcher. They could not always get through to make the service aware of the change.
- Dispatchers managed a constant 'list' of patients needing transport. The electronic system did not show patients who were a priority for collection, such as those in significant pain, or needing prompt return home, for example, if they had diabetes or received a care package at home at a set time. This information was available on the detailed notes for the patient. Dispatchers and planners told us they remembered regular users with significant needs and used this knowledge to help plan their journeys.
- Staff at one hospital in the south told us the trust was frequently relying on taxi companies to deliver transport services. The PTS did not always make patients aware of this arrangement before they were collected. Patients fed back that they did not feel comfortable or cared for in this arrangement. For example, two patients told us drivers would often leave them in the car park and not escort them to the entrance of the unit. The trust standard operating procedure for 'Private providers working for SCAS PTS' requires staff to escort the patient to the location of their appointment.

Learning from complaints and concerns

- Staff described the process they followed to support a patient who wished to make a complaint, including contacting a team leader when appropriate. However, frontline staff told us team leaders did not routinely share feedback and learning from complaints.
- We reviewed four sets of minutes from local and area meetings, there were no discussions about complaints. Senior staff did though discuss the numbers and reasons for complaints at the monthly contract review meetings and as part of the trust board meetings.
- Between February 2015 to January 2016, there were 551 complaints to the trust, 187 of these were about the PTS. The majority of complaints were about delays. Managers or the customer care lead investigated complaints and sent a written response to the

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complainant. The trust policy required a response to the complainant within 25 days, the trust acknowledged they did not consistently meet this target and work was taking place to improve the response time.

- Two managers confirmed they had completed additional training to investigate complaints. Team leaders usually spoke with the complainant to try and resolve the complaint before it became a formal complaint. The trust had completed a patient satisfaction survey in 2015 and the majority of complainants were happy with how the trust had managed and responded to their complaint.
- Patients we spoke with wrote to the trust or looked for information on the trust website to help them make a complaint or raise a concern. Information on how to make a complaint was on some but not all PTS vehicles.

Are patient transport services well-led?

Good



By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation and promotes an open and fair culture.

We rated well-led as “good”:

- The patient transport service (PTS) had a clear vision and strategy with effective governance processes in place to support the implementation of the strategy. The service was continuously looking for ways to develop and used innovative ideas to improve the quality of the service for patients.
- There was regular monitoring of quality and performance through the key performance indicators set by commissioners. The service itself had process for the validation and monitoring of the standards of care for the independent providers used.
- Staff were positive about the leadership of the teams they worked in. They had confidence in their manager and felt well supported by them. They described a positive culture and enjoyed working for the PTS. Team leaders and managers had the relevant skills for their role and felt well supported to complete additional training.

- The size, geography and shift patterns of the service made regular team meetings difficult but staff felt communication with them was effective and they were kept informed.
- Staff felt able to contribute ideas to develop and improve the service and gave examples of changes the service had made in response to staff feedback. Although, the service struggled to get high levels of feedback from patients.
- The trust could demonstrate some improvements to the service following the last inspection in September 2014.

However:

- Morale was low amongst frontline staff in some areas, particularly Berkshire. Across all areas, staff were affected by changes in working hours following the introduction of new contracts, issues with recruitment and retention and lack of regular meal breaks.
- Internal audits did not happen in a timely way.
- There was not a consistent standard for the recording of meeting minutes. In some areas these lacked detail and key information such as the date and location were missing. It was not always possible to see how teams had reached decisions, although action plans were included.
- There were still areas that the trust needed to improve following the last inspection.

Vision and strategy for this service

- The vision for the patient transport service (PTS) was to grow and enhance the service.
- The trust was inspected in 2014, following this inspection a transformation programme was introduced across the patient transport service (PTS), which was incorporated into the trust's five year strategic plan. The introduction of the same patient transport scheduling system at both contact centres was part of this plan. Future plans included providing a more efficient service and ensuring resources could meet the demands of the service.
- Frontline staff we spoke with were generally unaware of the trust's vision and strategy for the PTS, although we did see this information displayed at a resource centre in Buckinghamshire.
- Staff felt the service had kept them informed about the changes following the introduction of the new contracts, this included those staff who worked at smaller resource centres. The contracts had been in place for just four

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weeks, staff were focused on the impact of these changes, meeting the new key performance indicators (KPIs) and continuing to provide a high quality service to patients.

- Managers had a good understanding of the commercial aspect of the PTS, ensuring they remained competitive, this demonstrated this by retaining all their current contracts and securing a further contract.

Governance, risk management and quality measurement

- There were effective governance systems in place to monitor the quality and risks of the service to support the delivery of good quality care.
- The service had a clinical governance lead who was supporting staff training, incident reporting, complaints and patient surveys and risk management.
- All staff contributed to these processes but with differing levels of responsibility. Staff knew those areas they were responsible for and understood the importance of reporting things correctly, such as entering collection time data on their personal digital assistant (PDA).
- The service used KPIs extensively to monitor performance. The trust analytical team were valued for their work compiling all the data for the monthly contract meetings due to seven different contracts being in place. Senior managers held monthly contract review meetings with commissioners to discuss current performance. Areas of poor performance were acknowledged and action plans agreed. KPI data was shared with staff through team meetings and posters in staff rest rooms. Staff overall felt there was the correct balance between meeting the KPIs and making sure patients received safe care and treatment. Team leaders told us they looked at their local data and provided feedback to senior managers on why they had not met KPIs.
- Staff recorded on their PDA, the time they arrived to collect a patient, their departure time, arrival time at the destination and time when they left the patient. The analytical team used this information for the KPIs. Senior staff told us they could assess the accuracy of this information through the satellite tracking of vehicles. They sometimes amended data submitted as part of the KPIs as staff had been delayed entering the information.
- The PTS had a validation system in place before agreeing to subcontract and use an independent ambulance provider. There were checks in place, for example, DBS checks, vehicle checks. They held performance meetings with these services, as their performance contributed to the overall performance of the PTS, they also undertook unannounced visits to monitor the standards of care. There was also a validation process in place before contracts were setup with local taxi companies.
- Volunteer drivers had appropriate checks prior to working for the trust. The trust had introduced a new checklist to review insurance, DBS checks, driving licence and vehicle checks. We had not however, received any monitoring data from the trust.
- Senior staff had devised a PTS workforce plan for 2016/17. This detailed spreadsheet contained their forecasted recruitment, attrition, vacancies for the PTS overall and broken down by contract. Actual figures were to be entered on a monthly basis to enable senior managers to monitor areas of risk and take action.
- There was a directorate risk register in place, which overall mirrored concerns raised by staff and managers. However, the directorate risk register identified the need for improved compliance with statutory and mandatory training and appraisals but there was no evidence of action to improve numbers of staff receiving training and appraisals.
- Business managers presented information at trust board meetings on future potential contracts, the income from these and risks related to providing the service. The main risks were recruitment and retention of staff, both in the contact centres and on the frontline and loss of income if the service did not retain current contracts.
- Some senior managers we spoke with within the PTS could not describe the current risks and performance concerns for the area they managed. They tended to delegate and rely on staff in their teams managing these areas. They did not demonstrate an overall awareness of key concerns.
- Standard operating procedures were in use across the service to ensure consistency and safe practice.
- The trust had a standard operating procedure for PTS who were lone workers. This required the use of the personal digital assistant (PDA) to raise the alarm. Two incidents occurred during the inspection where this process did not work due to the designated 'lone worker phone' having a low battery. We raised this immediate concern with the trust. The trust told they had raised

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this as an incident and ordered a replacement phone. In Hampshire, staff in addition felt at risk as they did not have radios, to enable them to raise the alarm should there be no signal for their PDA or mobile.

- Internal audits were used to monitor compliance with areas such as cleanliness and infection control but these were not completed at regular intervals as advised by trust policy. There was potential risk to staff and patient safety, through lack of observation and monitoring of performance. Team leaders were responsible for monitoring and achieving any actions.
- All meetings held were minuted but the standard of these was not consistent. We reviewed minutes from team, ACA forum and operational performance meetings. Minutes did not all record the date, location, time or attendees. In addition, minutes were not in sufficient depth to enable non-attendees to see how decisions had been reached. The language used was not always appropriate for a formal record. Although, actions were always noted and assigned. In Hampshire, team meeting minutes used a standard template and format.
- The service issued all frontline staff with a fuel card. The provider for this service monitored use of the card and they reported any discrepancies to team leaders for them to investigate.
- The trust could demonstrate some improvements following the wave 1 pilot CQC comprehensive inspection in September 2014. There had been improvements in reducing IT vulnerability, oversight of third party providers, contract arrangements, working with partners, transport times for renal patients, dementia awareness training, and leadership within the service. The trust could not demonstrate similar improvements in mandatory training including safeguarding training, incident reporting, complaints handling, supervision of staff, call handing times and transport response times. Though action had been taken in these areas.

Leadership of service

- Staff spoke positively about their team leaders. They had confidence in their ability to lead their team, felt able to raise any concerns with them and found them easy to contact
- Staff felt their team leaders had a good understanding of the current concerns that affected their team and where possible addressed these concerns or escalated them to

their manager. However, staff working in the contact centre in Bicester felt management staff did not fully understand the issues affecting them, as they were predominantly based in Otterbourne. They had though recognised the need for greater support for the dispatch team and staff appreciated this.

- Team leaders and managers told us they had received additional training for their role, such as incident investigation and performance management. They felt supported to access this training both financially and for time to attend.
- Two team leaders raised concerns about sufficient time to complete all their responsibilities. The change in contracts meant more time was spent looking at team performance through the KPIs, whilst they still needed to complete work on safety and maintenance work of their vehicles. Although team rotas were planned centrally, team leaders had to make local adjustments due to staff sickness or local knowledge about the area.
- Business and operations managers attended local station meetings, which team leaders organised as drop in sessions for PTS staff, as it was not possible to for all staff to be off the road at the same time. Frontline staff could raise any concerns with senior management at these meeting. We saw an invite for staff working in north Oxfordshire to meet the new chief operating officer, who was attending their local resource centre.
- Staff gave mixed feedback on the visibility of the executive team and the chief executive, particularly for those staff working at more remote resource centres. However, staff acknowledged the team might have visited on a day they were not working.

Culture within the service

- The majority of staff were proud to work for the trust and the PTS. They wanted to make a difference to patients and were passionate about performing their role to a high standard.
- PTS staff worked well together to ensure that patient journeys were achieved, endeavouring to meet KPIs. The service had recently introduced observation sessions for contact centre and crews so they could see and understand the challenges faced by each role. Also, this helped with accurate planning and dispatch of crews for patients. We observed there was a tendency for teams to work in silos and communication across teams needed to improve.

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- Morale was low amongst ambulance care assistants (ACA) working in Berkshire. The main reasons were the impact of the changes in contracts, particularly problems covering all shifts. Staff felt stretched and over worked. They did not feel supported by higher management, particularly around their well-being.
- Across the trust, ACAs raised concerns around the inconsistencies for the banding of their role, in some areas they were Band 2, in others Band 3. They did not always feel valued and combined with the high cost of living in the areas covered by SCAS affected their ability to stay with the trust long-term. Those staff who had worked for the organisation for a long time did so because the caring aspect of the role was important to them. The lack of planning of breaks for ACAs also affected their morale. Staff did not always call in to request a break, as they were concerned about the numbers of patients waiting to be transported. The trust was reviewing the meal break policy in consultation with PTS staff and union representatives.
- In some resource centres, such as Bletchley and Adderbury, PTS, urgent and emergency care and the make- ready teams all integrated together. In Bletchley, a weekly meeting was organised for all these teams to meet together. We observed morale to be better in these areas. The trust had recognised the staff morale as a risk and included this on the directorate and trust risk register, particularly the difficulties recruiting staff and the impact this had on current staff.
- Data for December 2015, showed for the commercial services directorate, which included PTS, the vacancy rate was 16%, staff turnover 18% and staff sickness 6%. Data broken down by management, contact centre and operational staff did not show a significant difference in the turnover rate. Long-term staff sickness by contract area was consistently higher in Milton Keynes than other areas over the same time period. Vacancy figures for May 2016 for PTS, showed 85.7 (20%) whole time equivalent vacancies. Fourteen of these were in the contact centres (26% vacancy rate) and 71.7% in frontline operations (18% vacancy rate).
- Staff told us and we saw minutes from meetings showing consultations, regular updates and information sessions had taken place, prior to the introduction of the new contracts. Staff although disappointed by changes to their working hours, felt informed and able to raise concerns.

Public engagement

- The PTS provided eligibility information for the public on its website to identify who could access and use the service. Demand was high and therefore staff were keen the service was used by patients appropriately.
- Patient feedback was encouraged through access to forms on vehicles, the forms had recently been updated to provide relevant questions for patients who were regular users. There was also the option for patients or family members to complete a survey, available in paper and online. The trust collected Friends and family data but response rates were very low, less than 1% so the data although generally positive did not represent a large enough sample of users.
- The service was reviewing the quarterly surveys undertaken within the PTS to ensure this provided better data on patient experience.

Staff engagement

- The majority of staff told us they felt able to concerns and senior staff sought their views were sought on how the PTS could be improved.
- Team leaders in Oxford had recently changed some of the shifts for the new rota after feedback from staff, to benefit both patients and staff.
- Staff feedback and difficulties in recruitment for ambulance care assistants had changed the requirement for staff to have the C1 component of their driving licence when applying for a job. The trust covered the cost of this training with staff applying for and paying for their provisional licence. Staff were required to stay with the trust for a year in recognition of the trust providing this training for them.
- In the most recent staff survey (2015) the trust performed better than the national average for 13 out of 33 questions, including for team work, immediate manager support and contribution towards improvements. It was similar for 11 questions and worse than the national average for nine questions, including staff motivation, suffering from work related stress and quality of work. In response to the 2015 staff survey the PTS had devised four action points, which they called pledges, which were based around performance information, management visibility, training and reflecting on progress. Not all staff were aware of these action points, although we did see them displayed at

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some of the resource centres we visited. Individual actions had been allocated to a senior member of staff but the trust did not send us an action plan to show that performance to key dates would be monitored.

- Staff told us and we saw posters at resource centres for station meetings. It was difficult for whole teams to meet together due to the different shifts staff worked. Staff working in the contact centres told us team meetings with colleagues were difficult due to the distance between the two centres, meetings were sometimes held as conference calls. ACAs in Berkshire told us they did not have regular team meetings. This made it more difficult to share information and integrate as a team.
- Communication to staff was also through emails and weekly newsletters which we saw displayed in resource centres. The most recent edition had covered pain relief and an update for staff on the new contracts. Urgent written updates for that working day were placed by the PDAs so staff read them as they collected their PDA.
- In Berkshire, staff were encouraged to nominate a staff member of the month. We saw thank you cards displayed on staff notice boards. Two staff had been nominated for national awards for the work they had done to improve the service provided to patients.
- Volunteer car drivers told us they did not feel as integrated as other staff members within the PTS. Also, although they had their own meetings, not all volunteers received the minutes from these meetings. Sometimes communication was not effective and volunteers were unclear when the service had made changes that affected them.

Innovation, improvement and sustainability

- The PTS was continually looking for ways to develop, improve and sustain the service. Achievements over the

past few years were recognised by the trust in the 'What does SCAS do well' book. This included the introduction of porters at the main acute hospitals in Hampshire to improve turnaround time of vehicles and reduce the amount of time patients spent on vehicles, whilst it was at the hospital.

- Senior managers considered the sustainability of the service during contract negotiations, extending the operating hours of the service meet the needs of patients better. The service planned to provide a tablet for hospital liaison officers so they could access 'live' information from the patient booking system when visiting areas such as wards or outpatients rather than having to come back to their office or base. This would enable them to address issues more quickly and give accurate information to staff and patients on arrival time or delays.
- The PTS was proud of achieving ISO:9001 status. This demonstrated the services ability to consistently provide products and services that meet the needs of the patients and the stakeholders they worked with, through the use of quality monitoring systems.
- Health care professionals could book non-complex journeys through the on-line booking system introduced during 2015, to reduce the delays experienced calling the contact centres. The target was for health care professionals to book 70% of these journeys online.
- Eleven cost improvement programmes were in place during 2015/16. Two of these had been achieved; the remainder were behind plan, five by 25% or £25,000. Difficulties recruiting to vacant posts had affected costs savings which the service could make, through using private providers less frequently.

Emergency operations centre

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

Information about the service

South Central Ambulance Service (SCAS) NHS Foundation Trust serves a population of over 4 million across Berkshire, Buckinghamshire, Hampshire and Oxfordshire covering approximately 3,554 square miles. SCAS provides services for 14 Clinical Commissioning Groups (CCGs).

The trust has two EOCs; northern house, based at the trust's headquarters in Bicester Oxfordshire, and southern house located in Otterbourne, Hampshire. The trust has a single virtual emergency operations centre across their two call centres meaning all calls are routed to the next available operator. The EOC is formed of three core areas emergency call takers (ECTs), emergency dispatchers (EDs) and a clinical support desk (CSD). There is also an air ambulance dispatch team and a special incident desk. Approximately 267 staff work in the EOCs.

Staff at the emergency operations centres (EOCs) handle around 500,000 emergency and urgent calls each year, approximately 1,400 calls a day. Staff receive and triage 999 calls from members of the public and other emergency services. They provide advice and dispatch ambulances to the scene as appropriate. The EOC staff provide assessment and treatment advice to callers who do not need an ambulance response, a service known as 'hear and treat'. Callers may receive advice on how to care for themselves, be advised to make an appointment with their GP or be directed to other services that may be of assistance. The EOC staff also manage requests by health care professionals, to convey people either between hospitals or from the community into hospital, sometimes these are urgent transport requests

Within 2015 the trust received 540,387 emergency 999 calls; 342,342 (76.8%) of calls resulted in a patient service that was either listening and treating the patient ('hear and treat'), seeing and treating the patient ('see and treat'), referring the patient to their GP, or treating the patient at the scene and taking them to hospital. There were slightly more calls, 192,045 (56.1%), in the northern region.

During our inspection, we visited both EOCs in Bicester and in Otterbourne. We spoke with approximately 61 staff, including emergency call takers, clinicians, emergency dispatchers, emergency dispatchers' assistants, clinical auditors and non-clinical auditors, team leaders, duty managers and senior managers. We listened to 55 emergency calls and observed how patients were treated and responded to over the phone. We also analysed data provided by the trust both before and after the inspection.

Emergency operations centre

Summary of findings

Overall, we rated the emergency operations centre (EOC) as “good”. We found the service to be good for safe, effective, caring, responsive and well led.

Staff used evidence-based systems to provide care, advice and treatment to patients. Clinicians worked to national guidance and standards when providing advice over the phone. Calls were monitored for consistency and to ensure advice was in line with clinical protocols.

Emergency operations centre services were delivered by caring and compassionate staff. We observed good examples of staff treating patients and callers with dignity and respect.

Staff had good awareness of how to ensure vulnerable patients including children were safeguarded and there was a dedicated team who ensured safeguarding referrals were appropriately made. However, there was not a direct referral route to local authority safeguarding teams outside of normal working hours, although when urgent the police would be informed.

The service had an escalation plan for when calls exceeded capacity and action was taken to shorten calls if safe to do so. There was organisational and individual learning from incidents and complaints, staff told us they received learning through feedback from managers.

Staffing levels were a concern and staff worked long hours, often with delayed or missed breaks. There were a number of staff vacancies and staff were working under pressure.

The average time to respond to emergency calls was worse than the England average and the trust had some of the longest call waiting times. The trust was performing better than the England average for the proportion of emergency calls resolved by telephone advice and support (hear and treat). The proportion of the calls abandoned before being answered had decreased and was now better than the England average. The trust participated in the ambulance quality indicators, which enabled it to monitor performance.

There were delays in sending emergency response vehicles to emergencies. This frequently happened due to excessive hospital handover times when ambulances were being held because hospital emergency departments did not have sufficient capacity.

The trust were not routinely responding to complaints in a timely manner. They were not always meeting their own target of investigating and responding to complaints within 25 days.

There were clear governance processes in place, risk registers were regularly reviewed, and managers were able to describe the current risks to the emergency operations centre. The service managed risk appropriately and performance was measured through monthly staff audits, management meetings, and reports to the board. There was a long-term strategy for the EOC and staff were aware of the trust’s vision and strategy.

We saw that staff received appropriate induction and training. Staff were trained in the NHS pathways, (the process for assessing the calls received into the call centres) so that patients could be triaged appropriately. Staff were supported to identify good and poor practice and learn about how to handle emotional calls in a sensitive and caring manner.

Emergency operations centre

Is emergency operations centre safe?

Good



By safe, we mean that people are protected from abuse and avoidable harm.

Overall, we rated safe as “good”:

- All staff we spoke with understood how to report incidents and told us that they received feedback and learning from incidents that was helpful to them.
- Staff were aware of safeguarding and how to recognise and report abuse. They were able to explain the different types of concerns that would result in a safeguarding alert being raised.
- Staff prioritised and assessed emergency calls allocating suitable resources to respond to incidents and the trust had procedures in place to manage calls when demand was high.
- The environment at the emergency operations centre was visibly clean and staff could identify potential infection control risks.
- Records were stored appropriately on an electronic system and special notes were available for patients who had specific individual requirements.
- Staff were mentored and supported during difficult calls by quality assurance coaches.

However,

- There was a high number of emergency call taker vacancies. Despite the use of bank and agency staff, planned staffing levels were not always met. Staff were working under pressure to ensure performance targets were made. There was an increased risk of delays to dispatch and mistakes.
- Statutory and mandatory training varied across both emergency operations and not all staff were not up to date with all aspects of training.
- Local authority teams were not made aware of safeguarding concerns out of hours although urgent concerns were notified to the police.
- Some care plans were informally generated and shared because of incompatible IT issues.
- Noise levels in the emergency call centres were high and distracting. Staff could over hear other calls whilst they

were on a call. There was the potential for patient information to be missed or miss-heard. Double head sets were available for staff and ordered individually if required, to minimise background noise.

Incidents

- There were 302 incidents between March 2015 and February 2016 recorded for the EOC. Of these, there had been 13 serious incidents reported, two were due to suspension of services and seven of these were delays in dispatching ambulance crews. The number of serious incidents in the EOC had increased. In 2013/14 there had been two and there were 13 in 2015/16. There were no never events in the service over the same period. Never events are serious, largely preventable patient safety incidents, which should not occur if the available preventative measures have been implemented
- Staff in both EOCs were able to describe the processes for reporting an incident via the electronic reporting system. They were able to provide examples of incidents they had reported.
- The dispatch team and helicopter emergency medical support (HEMS) staff felt confident to report an incident using the electronic reporting system and staff were encouraged by management to report incidents. Emergency call takers (ECTs) said they would escalate any incident to their managers for them to report. The HEMS staff described receiving feedback from their manager about incidents they had reported.
- ECT staff told us they did not report and record abuse of staff as an incident in line with trust abusive caller’ standard operating procedure. Most staff said they saw taking abuse as part of their job.
- Learning arising from incidents was disseminated to all staff via email, including via the staff bulletin “Hot News”. This was issued regularly and all staff we spoke with had read this bulletin.
- SCAScade was a clinical learning tool based on real scenarios from serious incidents. The educational department produced SCAScade and the learning was shared with staff via the trust’s intranet. SCAScade included a reflective tool for learning from incidents. All staff were encouraged to complete the reflective activity as part of their ongoing learning; however, some teams within the EOCs were unaware this training was available.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of

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health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. The trust monitored duty of candour through their online incident reporting system. Serious and moderate incident investigations showed the trust informed and involved patients when things went wrong. Managers understood the need to be open and transparent with patients.

Mandatory training

- The trust provided statutory and mandatory training by eLearning and face-to-face training. Staff and managers received an electronic reminder when their training was due. The eLearning training could also be accessed from home.
- Mandatory training covered a range of topics including fire safety, health and safety, basic life support, safeguarding, manual handling, hand hygiene, conflict resolution, consent and information governance training.
- Dispatchers and emergency call takers did not have any training time built into their rota. Time was allocated for training within their shift if patient demand was low. The staff told us this time usually occurred during the night shift.
- Clinical support desk (CSD) staff had 54 hours a year rostered for training which included statutory and mandatory training. This included in house training, reflection, study days, road shifts and anything they felt pertinent as an individual.
- Data provided by the trust for May 2016 showed that compliance with mandatory training covered aspects such as conflict resolution, dementia awareness, fire safety and information governance, varied across the two EOCs. The percentage of staff that had completed their training in northern house ranged from 61% to 100% and in the southern house it varied between 72% and 100%. The trust target across all aspects was 95%.

Safeguarding

- The trust had a designated safeguarding lead who staff could contact by phone during office hours. Out of hours contact was by email only.
- Staff did not know who the named safeguarding lead was, although they all described how they would raise any safeguarding issues to their line manager.

- Staff were encouraged to make safeguarding referrals and they had a good understanding of what safeguarding concerns might be for children and vulnerable adults. We observed staff making safeguarding referrals using paper forms and following the safeguarding policy.
- There was a standard safeguarding referral form to report safeguarding concerns. These would be completed and sent through the internal post where it would be reviewed by a member of the trust's safeguarding team and then manually sent to the local authority. However, the trust safeguarding team were only available during office hours and staff in both EOCs did not have a direct referral route to local authority safeguarding teams. There could be a delay in a local authority receiving safeguarding referrals, particularly during out of hours and at weekends. However, the staff told us if the referral was urgent they would pass the information to the police. This remained an informal arrangement.
- Staff told us they had received training in safeguarding vulnerable adults and children and were aware of the trust's safeguarding policy. As of March 2016 northern house training figures for safeguarding adults' was 92% Level 1, 61% Level 2; safeguarding children 92% level 1 and 75% level 2. In southern house, compliance was at 100% for adults and children at 92% level 1 and 92% level 2 training. The trusts target was 95% for all levels.
- ECTs told us if a caller contacted the EOC to cancel an ambulance for a child, this call was transferred to the CSD and a clinician made the decision if it was safe to do so.

Cleanliness, infection control and hygiene

- The EOCs were not clinical areas. However, both Emergency Control Centres (EOCs) appeared visibly clean at the time of inspection. We observed hand sanitiser gel was available outside the entrance of the EOCs and other office spaces. There were notices and information in the toilets, kitchen and the EOC bulletin providing guidance on infection prevention, control and hand hygiene.
- We observed staff cleaned their desk space before they went home; drinks were allowed at desks with lids only; snacks were allowed but not meals.
- All EOC staff received infection prevention and control training as part of their induction programme. Infection prevention and control training was repeated every

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three years. Training included hand hygiene, sourcing infection control information, return to work after illness and use of food and drink. If EOC staff needed further information about infection prevention and control, they could contact the infection prevention and control team.

- The service had processes for identifying patients who were an infection control risk. We observed ECTs asking callers if they knew of any known infections or contagious diseases affecting the patient. Staff recorded this information on the patient's electronic record. The information was then visible to the dispatch officer who would pass it to the ambulance staff attending the scene.
- Eighty two percent of, northern house staff were up to date with their infection prevention and control training. In southern house 78% of non-clinical staff and 92% of clinical staff had completed their infection prevention and control training. This was below the trusts target of 95%.

Environment and equipment

- The emergency operating centre (EOC) premises were secure and all areas identification was required to gain access.
- Staff at both EOCs complained that noise levels were an issue and could be distracting. A 'green card' system had been introduced in northern house to reduce noise levels. If an emergency call taker (ECT) had any difficulties handling a call they would raise a green card that notified the senior emergency call taker (SECT) that there was an issue. We observed the green card system to be effective in reducing noise levels however if the SECT was on a call the ECT may be holding the green card for a long time before help arrived.
- However, our inspection team found both EOCs to be quite crowded and noisy. The headsets used by some staff only had one earpiece. Staff told us while they were taking calls the background noise was quite distracting. This meant that there was a risk of mishearing important information provided by callers. There were no reported incidents or near misses in relation to this.
- Staff completed a display screen equipment self-assessment questionnaire on induction. Staff could request a display screen equipment assessment post-induction and the risk and security team would

assess them. This was in line with their Display Screen Equipment Policy, January 2016. We saw specially adapted chairs, screens and footstools for staff that required them.

- In the event of equipment and software failure, there were systems and processes to ensure the service could continue to operate. If the computer aided dispatch (iCAD) system failed, crews would still receive information via telephone and radio. Arrangements were to use paper forms, which contained all the necessary information required for each call.
- In northern house we witnessed computers temporarily freeze during emergency calls. However, this did not affect the calls observed as ECTs knew what question would follow and could continue communicating with the caller until the computer unfroze. Managers were aware of the IT issues and had escalated their concerns.
- A radio check between dispatchers and the ambulance crew was completed at the beginning of each shift.
- Both EOC centres had access to a "time-out" room and a kitchen, which was located on the same level. A quiet space was important when staff had been dealing with particularly distressing calls.

Medicines

- We observed call handlers asking patients whether they were taking any medicines or pain control medication and providing advice accordingly. Call handlers obtained advice from the clinical staff working on the CSDs.
- The CSD clinicians used a national poisons information service and British National Formulary guidelines for medicines advice. Clinical staff told us they would never give medicines advice about medication prescribed by the patient's GP, as there was a risk of it adversely affecting the patient's health.
- The CSD team gave self-medication advice as recommended by the clinical decision support software used (NHS Pathways). The software supported staff to give the correct advice because the IT system regularly updated in line with clinical pathways.

Records

- All patient records were stored electronically on the NHS Pathways system and access to computers was password protected.
- The service used a computer aided dispatch (iCAD) system to record details about patients who used the

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service. Staff created a record at the beginning of every 999 call. The ECTs asked a set of questions as guided by NHS Pathways. All answers were recorded and staff updated records as more information became available. All callers were advised of their reference number if they needed to call back.

- Records were colour-coded purple, red, orange or green to indicate priority and response. All records were visible to CSD clinicians and emergency dispatch (ED) staff and they were able to update them as more information became available.
- The trust used “special notes” to share with ambulance crews. These notes were electronically attached to a patient’s record and contained detailed clinical needs or risk information if there was a safety concern. Special notes assisted emergency dispatchers or the CSD clinicians in their decision-making for the caller or patient. Special notes included the code for a key pad to gain entry to a patient’s home or complex care instructions, such as care pathways for someone with a known and recurring mental health problem. However, because special notes were electronic it meant that they were not available in the event of a system failure.
- Care plans were attached to patient records by patient NHS number, or patient location. In northern house, some care plans were developed informally and placed on a shared drive and shared electronically between CSD clinicians. This happened because the information received from 111 was not compatible with the IT systems used in northern house. This was a local arrangement to maintain patient safety but the information governance issues had not been identified.
- All calls were voice recorded which meant calls could be audited later if further information was needed about a call, for example for a complaint or incident investigation.

Assessing and responding to patient risk

- Emergency operating centre staff used NHS Pathways to assess and prioritise emergency calls. NHS Pathways guided the call takers through specific questions, which varied according to the symptoms discussed by the callers. They were prompted to ask the caller about patient alertness and breathing, physical temperature, mobility, pain and other symptoms, which resulted in an accurate assessment of patient symptoms. The result was dispatch of an appropriate response vehicle or treatment advice from the clinicians.

- We observed the clinical support desk (CSD) clinicians change the code and priority of calls appropriately after re-assessing the risk to patients. This meant the service had procedures to re-assess risk and ensure an appropriate response to keep the patient safe.
- The CSD clinicians undertook a welfare check by telephoning a patient if there was a delay in the ambulance crew responding to them in accordance with the assigned category. This also led to a call being upgraded or downgraded depending on whether there had been an improvement or deterioration in the patient’s symptoms. We observed CSD clinicians make follow-up calls to patients for welfare checks, to assess them while they were waiting for an ambulance or following up on the advice given. Green (non-life threatening) calls were classified as less urgent emergencies and may present greater risk if allowed to deteriorate. We were informed that patients were called back after approximately one hour for a green call.
- The emergency call takers (ECTs) would carry out patient welfare checks when a healthcare professional (HCP) requested an emergency ambulance to transport the patient from home to hospital. We observed staff immediately telephoning patients once they had taken the call from a HCP.
- Dispatchers could see the skill set of each member of frontline operational staff. This meant staff with the appropriate skills were deployed to the patient. The nearest rapid response vehicle (RRV) was dispatched and ambulances were dispatched to provide appropriate conveyance for emergency calls.

Staffing

- The trust used the national Resource Escalation Action Plan (REAP) in order to plan for additional resources in the event of operational pressure being experienced. Such as an increase in demand, seasonal or weather changes, or disruption to staffing levels. Six REAP levels were identified nationally with level 1 being considered as functioning as normal and level 6 classified as potential services failure. Mitigating actions were made depending on the REAP score. At the time of our inspection, the trust was operating at REAP level 3.
- The turnover rate for staff at both EOCs between April 2015- April 2016 was 22.3%. At the time of our visit, staffing levels for emergency call takers in southern house were 18% below their establishment and in northern house 21.7% below.

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- There was a small number of bank staff who managers contacted to ask if they could work a shift at short notice. Managers contacted bank staff by text to see if they were available to work an additional shift at short notice, to fill vacant slots in the rota. Over a 15 week period between 28 April 2016 and 4 July 2016, staffing hours were filled against planned levels (average 99% of hours filled). However, the hours filled varied across the weeks, the lowest was 82% and the highest 108%. There were six weeks where staffing hours were not being met by the rota
- The head of EOC in northern house informed us they used agency and bank staff to increase staff numbers. Data provided by the trust showed agency staff were used an average of 301 shifts a month between April 2015 and March 2016, across both EOCs. All agency staff were required to hold a current NHS Pathways licence and undertake a three day training and induction course with the education and development team.
- Staff told us it was stressful when they were short of staff on a shift, and there was an increased risk of human error mistakes. Calls also took longer to answer and would 'stack' in a queue and incidents had demonstrated dispatch delays for emergency calls. The risk register included the risk of 'failure to respond within disposition timeframe due to lack of operational resources resulting in a long wait or delay for red and green calls'. The trust had included mitigation measures which covered clinical welfare checking of calls awaiting a response and for the EOC to advise patients to take their own transport if appropriate.
- Senior staff in EOC discussed resource and capacity risks on a daily basis. There were two daily conference calls daily as well as an additional morning EOC handover. The handover discussed capacity, skill mix of crews, staffing levels and potential service risks.
- New emergency call takers were placed on relief rotas, meaning they were allocated shifts five weeks in advance and they were not part of a team. They would be placed in a team if a member of staff left. We were informed that they would be allocated mostly night shifts and this had caused staff to leave
- The senior emergency call taker (SECT) role was split into two in order to ensure the workload was managed effectively. As a SECT began their shift, they became the duty SECT, overseeing all emergency call taker (ECT) calls. The previous duty SECT would then become the administrative SECT for the last two hours of their shift, completing administration tasks such as appraisals. We observed this overlap to work effectively, ensuring all SECT tasks were completed.
- The emergency dispatch team worked 12-hour shifts with an allocated break of only 30 minutes. ECTs also had a 30-minute break and worked between eight to ten hours each shift. Although staff were allowed short comfort breaks throughout their shift, staff told us that they often found it difficult to leave their desk when it was busy. We observed several members of staff postponing their breaks to answer emergency calls.
- Emergency dispatchers (EDs) allocated breaks for the road crew during their 'break window'. There was a meal break policy in place that described the conditions of when a meal break could be disrupted. If the road crew did not receive their break within the 'break window' or if their break was interrupted, they were allowed to claim payment from the trust. There was therefore a financial incentive for EDs to allocate breaks in a timely manner. Each ED had a copy of the policy at their workspace for reference and we observed it being used multiple times.
- Emergency call taker (ECT) shifts were staggered to provide a 24-hour service and meet workload. ECTs worked two early shifts, two afternoon shifts and two nights shift before receiving four days off. The ECT rota was not popular with staff and many staff said that they favoured the ED rota.
- EDs and emergency dispatcher assistants (EDAs) rotated between dispatch desks (North, South, East, and West). South and east were the busiest desks, handling a higher vehicle load. All staff were therefore competent in operating the busier desks. We were told by a control room duty manager (CDM) in northern house that the west desk is often used to train new EDAs, as it is the least busy.
- EDs were required to complete a 'dispatch handover form' at the end of their shift. It included the current escalation level, technical problems, incidents of note, staffing issues and protected drive zones. CDMs carried out a verbal handover although these were not recorded. The HEMS desk carried out a clinical handover at the end of their shift.
- A relief team and EDAs staffed the indirect resources (IR) desk and dispatched ambulances for health care professional (HCP) calls, community first responders (CFRs) and co responders.

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- CFRs were volunteers, trained to attend a call and offer basic life support until an ambulance arrived. They carry a defibrillator and basic life support equipment, including oxygen, in their own vehicles and reported to a community liaison and training officer (CLATO). The IR desk carried out welfare checks on each CFR who attended a call. The CLATO was responsible for ensuring all CFRs were up to date with their training.
- Some staff who worked in the EOCs also worked as CFRs. Staff we spoke with said that if the EOC was fully staffed that they would sometimes attend a call.
- Operational managers did not always have control over operational staffing matters as the scheduling team managed staffing rotas. This meant making changes to the service was sometimes difficult. We saw, that decisions about rotas and staff swapping shifts taken out of managers' hands. Therefore, managers were not able to be flexible with staff when they needed to take time off outside of their rota pattern.
- There were procedures to contact the commercial telephone company and other EOCs in the event of the telephones not working procedures. IT failures were reported to IT on call 24 hours a day.
- There were delays to hospitals receiving patients. On several occasions during our inspection, ambulances were waiting over two hours to hand patients over to the care of hospital staff. This created capacity risks for the ambulance service. The trust had an agreed "immediate handover policy" with local emergency departments to manage this situation. This policy was used with most emergency departments. However, during our inspection we identified that staff in one of the emergency departments did not recognise this procedure and this meant ambulance crews were unable to hand patients over to the care of hospital staff. There had been major ambulance delays at this hospital because of this.

Anticipated resource and capacity risks

- The trust had procedures in place to manage changes in demand at both centres. The two emergency operating centres (EOCs) worked as one 'virtual' EOC, with each 999 call directed to the next available emergency call taker (ECT) across the two centres.
- If the call demand increased, it was the responsibility of the senior SECT to determine what stage the ECTs would be escalated to. For example, if the centre was escalated to stage one, urgent disconnect, the ECT scripts would be shortened in order to answer more calls quickly. At stage two, only emergency high priority calls would receive an emergency vehicle, all other calls would be triaged to the clinical support desk. There was also an escalation policy for the dispatch team, ranging between levels one to five. The duty shift manager assessed levels one to three, whereas higher level management determined levels four and five.
- In the event of a major I/CAD system failure or planned shutdown, the EOC would revert to a paper management system. In the event of critical system failure, the ECTs would record all calls on appropriate documentation templates. All operational vehicles would be notified of system failure by any means possible including broadcast by mobile data, radio, paging or mobile phone.
- On display within the EOC were details of the duty control room manager and lead managers on duty for that shift. Also identified were the bronze, silver and gold personnel on duty who would be responsible for dealing with major incidents.
- The resilience team carried out major incident training for staff. During the last two months, this had focused on hazardous chemicals. Staff who had completed the training described it as 'beneficial' and felt more prepared if a serious incident were to occur.
- The trust had clinical guidelines for major incidents based on National Ambulance Resilience Unit (NARU) command and control guidance. We saw a call taking, folder for staff to use in the event of receiving a call from a terrorist or a member of staff under extreme threat. This included instructions to inform the duty manager immediately who then implemented major accident procedures.
- The EOC could dispatch specialist resources in the event of a major incident. The Hazardous Area Response Team (HART) were a specialised team of medical personnel who attended and supported serious incidents including firearms incidents, collapsed buildings, and exposure to harmful materials, water rescue and flooding. The incident command desk was responsible for dispatching the HART team. Senior staff identified when to deploy the HART to emergencies by using the dispatch procedures.

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- Managers were trained in the Joint Emergency Services Interoperability Programme (JESIP). JESIP supported the ambulance service working together with the police and fire and rescue services when responding to major multi-agency incidents. However, none of the call takers or dispatchers we spoke with knew what JESIP was.
- There were dedicated major incident rooms at both EOCs for EDs and ECTs to work in if a major incident occurred.

Is emergency operations centre effective?

Good



By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Overall, we rated effective as good:

- Staff used evidence-based; up to date systems to provide care, advice and treatment to patients.
- The clinical support team assessed pain and discussed care and treatment with patients.
- There was evidence of good multidisciplinary working and the EOC's worked effectively with other emergency services.
- Calls were monitored for consistency and to ensure staff provided advice in line with agreed clinical protocols. All calls were categorised in line with the national guidance.
- The trust was performing better than the national average for responses for calls resolved by telephone advice and support ("hear and treat").
- The trusts had decreased the number of calls abandoned before being answered and was now in line with the England average.
- The trust had hospital advice liaison officers to assist with communication between EOCs and the hospitals where they were based.
- There was a comprehensive induction and mentorship programme for all new starters.
- There were support mechanisms for when staff had taken distressing calls

However,

- The average time to respond to emergency calls was worse than the England average and the trust had some of the longest call waiting times.
- Not all staff received an annual appraisal and the trust's own target of 95% was not met.
- Staff did not have a clear understanding of the different parts of the Mental Health Act, even though they had to ask patients about this.

Evidence-based care and treatment

- The trust was operating on the most up to date version of NHS Pathways. This system delivers a single clinical assessment tool that provides effective triage over the telephone in any setting, which takes calls from the public. This included calls to 999, GP out-of-hours and NHS 111 services. The emergency operations centre (EOC) used the NHS Pathway triage software system to manage 999 calls and ensured that patients received the appropriate care for their clinical needs.
- All policies and procedures were accessible to staff via the trust's intranet, and we saw these had been updated in line with national guidelines. Staff told us that changes in policies and procedures were passed on to them via email or the 'Staff Matters' newsletter.
- The trust used clinical guidelines produced by the Joint Royal Colleges Ambulance Liaison Committee (JRCALC). The clinical support desk worked to the National Institute for Health and Care Excellence (NICE) and JRCALC guidelines.
- Clinical advice and support for the emergency call takers (ECT) was available from the clinical support desk (CSD) staff. The CSD could listen in to calls and provide information to ECTs via real-time electronic notes. Dispatchers could also ask CSD staff for advice and support in person or by phone.
- Discussion with staff and review of documents showed that local Standard Operating Procedures (SOPs) for resilience planning were based on agreed national interoperability standards developed by the National Ambulance Resilience Unit (NARU). HART staff were proactively engaged with NARU in the ongoing development of nationally agreed SOPs.
- There was a dedicated team to audit who performed audits of 999 calls for clinical and non-clinical NHS Pathway users. Audits were performed against standard operating procedures and quality indicators and feedback was given to staff.

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Assessment and planning of care

- ECTs triaged all 999 calls through NHS Pathways. This system provided strict prompts and scripts so ECTs could assess the care and treatment needs of a patient, which influenced the response sent by a dispatcher.
- Data from the trust showed that in the month of January 2016, 52% of calls resulted in patients taken to hospital, a four per cent reduction on the previous year. This meant more patients were treated in their own home, over the phone or in the care of community based services and reduced unnecessary admissions to busy emergency hospitals.
- The clinical support desk (CSD) were a team of registered nurses and paramedics including specialists' midwives, paramedics and emergency care practitioners. They conducted a detailed assessment of a patient's needs. The CSD had a responsibility for supporting ECTs with advice for more complex calls, ensuring welfare checks were made (particularly if there has been a delay in a vehicle arriving on scene) and providing advice to emergency responders. The clinicians were able to take over calls and downgrade or escalate as necessary to ensure appropriate assessments took place.
- The CSD clinicians would assess green (non-life threatening) calls to hear and treat suitable patients. They would utilise the directory of service (DOS) to locate local services available and appropriate for each patient dependent on the Pathways assessment. The clinicians always offered safety net advice to patients and advise them to call back on 999/111 if their condition deteriorated.
- CSD staff used pain scores to assess a patient's level of discomfort and pain. We observed staff asking patients how bad their pain was between one-to-ten; 10 being the most pain.
- ECTs were supported by the clinical support desk and were able to transfer calls to them if they felt it was appropriate to do so.
- There were arrangements to receive NHS 111 referrals. NHS 111 is a telephone service the public can use if they are unwell and need advice or where to go to get treatment. NHS 111 could refer patients to emergency ambulance services. We observed the CSD triaging 111 calls and at times, they changed the patient pathway to prevent an inappropriate response. The trust monitored all inappropriate calls received from NHS111 and was able to discuss, and learn from issues at governance meetings.
- Community First Responders (CFR) provided life-saving support to patients in their workplace or community until the arrival of an emergency ambulance. Dispatchers in both EOCs were responsible for deploying CFRs. Dispatchers did not deploy CFRs as a replacement for an emergency ambulance. However, CFRs we spoke with from the North stated they were not being utilised, as the IRD (indirect resource desk) was not staffed 24 hours a day. The service recognised this and was planning to move the IRD to the south where it would be staffed every day.
- Dispatchers used dispatch protocols, which provided the guidance and framework for when and what to dispatch to different coded emergency calls. We saw dispatchers used these protocols appropriately and referred to them if they needed further guidance.
- Dispatchers had challenges sending appropriate responses because crews were waiting for long periods at hospitals. A senior manager said it was hard to free resources and the majority of staff said they needed more resources out in the field.
- Two mental health nurses worked in northern house. They had improved the management of frequent callers and the care of mental health patients. The services were available during peak times, and Thursday to Sunday evenings and offered advice over the phone to ECTs, emergency dispatchers and crews. The ECTs said they were happy for the support the mental health nurses offered as they had access to patient notes and would often deescalate a situation so an ambulance did not need to be dispatched.

Response times

- The trust monitored call answering times as a way of measuring the performance of staff in EOC. The average time taken to answer a call by EOC was three seconds between January 2015 and January 2016. The trust target was 1 second. The average time to respond to emergency calls was worse than the England average and the trust had some of the longest call waiting times. In February 2016, the longest waiting time was 1 minute and 49 seconds. The trust was taking action on this.
- The proportion of the calls abandoned before being answered had decreased and was now better than the

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England average. The trusts proportion of calls abandoned before being answered was worse than the England average between July 2014 and August 2015. Since September 2015 the trusts performance had improved. In March 2016, the proportion of calls abandoned before being answered was 1.2% against the England national average of 1.3%.

- The percentage of emergency calls between August 2015 and January 2016 resolved by telephone advice had been comparable to, or higher than, the England average. The proportion of calls resolved by telephone advice in March 2016 was 13.5%, above the England average of 10.2%.
- Between July 2014 and January 2016 the proportion of patients who re-contacted the service, following discharge of care, by telephone within 24 hours was higher than the England average by 6% per month. However, the trust told us it was due to how they captured this information and they were assured they were compliant. The trust had their figures audited externally and were found to be compliant with national data despite showing higher comparative rates.
- The proportion of calls from patients for whom a locally agreed frequent caller procedure was in place had been consistently higher than the England average for the whole of July 2014 to January 2016
- The trust dispatched a Hospital Ambulance Liaison Officer (HALO) to manage the situation when ambulances were “stacking” at the hospital emergency departments. The role of the HALO was to assess the needs of the patients waiting and release some of the ambulances from the emergency department.
- There was an increase in the handover delays from the NHS hospital in Portsmouth from 521 hours in December 2015, to 967 hours in January 2016 and 1198 in February 2016. This increase had a significant impact on trust response times. The trust had undertaken an audit and implemented an action plan in conjunction with the acute trust.

Patient outcomes

- The trust had the best compliance rates in the quality audit of NHS Pathways. Trust rates were 88% compared to the national average of 80%.

- The trust collected and monitored information about outcomes for patients. They produced trust board and performance reports each month, which included information about, patients treated at the scene, treated over the phone, or taken to hospital.
- The trust had recently introduced the National Ambulance Resilience Project (NARP). This allowed an additional 2 minutes of triage time on top of the existing 1 minute to enable further triage of the patient before despatching an ambulance, for calls that would fall into the Red 2 category. The expected benefit was to reduce multiple vehicle attendances and increasing hear and treat calls, thereby reducing ambulance demands. The EDs told us that NARP could be difficult to implement when the service was busy.
- Hear and treat is a term for callers who dialled 999 and received telephone triage and advice from trained clinicians. The Care Quality Commission conducted a survey of people who had used hear and treat between December 2013 and January 2014. The trust performed about the same as most other trusts that took part in the survey. The percentage of emergency calls resolved by telephone advice and support (hear and treat) had increased. Between April 2015- March 2016, the percentage of patients treated over the phone had increased from 6.1% to 13.5%. This meant there were more calls closed by hear and treat outcomes, therefore avoiding an emergency response and possible transfer to hospital.
- There were processes to support appropriate deployment of the Hazardous Area Response Team (HART). A dispatch protocol provided guidance and escalation procedures to determine whether deployment of the HART was necessary. The shift leaders were immediately responsible for the deployment of the HART. One control duty manager told us that they deployed HART appropriately and the HART managers did not report any inappropriate deployments. If HART were deployed this was reviewed by the HART manager and other senior managers on an incident-by-incident basis.

Competent staff

- There was an induction programme for all new staff and staff who had attended this programme felt it met their needs.
- Emergency call takers (ECTs) received four weeks of classroom training and spent time observing with a

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mentor or buddy. There was a structured induction programme, which covered NHS Pathways training, safeguarding, conflict resolution and customer service. Two ECTs said they felt prepared for their role and well supported throughout their induction period. After the induction process, new employees were given a mentorship period, which meant they were supported for at least 18 shifts.

- Emergency assistant dispatchers (EDAs) received one week of classroom based training before being paired up with a dispatcher. All staff had their competencies assessed before they started working unsupported.
- Most staff training was provided online, the ECTs and dispatchers completed training during quiet periods. Managers told us the ECTs used to have their training time included in their shift rotas but this had been recently changed with the introduction of new rotas.
- Staff told us they had regular annual appraisals, however, the data provided by the trust demonstrated that between April 2015 and January 2016 the appraisal completion rate for both EOCs was between 81% to 92%, which was lower than trust target of 95%.
- Staff we spoke with confirmed they had received an annual appraisal with their line manager, which was recorded electronically. Appraisals included objectives (with reference to their performance targets) and a discussion about their development including training.
- The CSD team had training time as part of their scheduled rota and they had access to a wide range of continuing professional development (CPD) material and regular CPD workshops. The team could access the Simulance for scenario based learning. The Simulance was a specially modified ambulance used to simulate emergencies. The CSD team had to complete one reflective piece a month and had face to face with their team leader for reflective discussion as part of their revalidation process.
- ECTs had monthly meetings with their team leaders to discuss their performance from audits, waiting times, average call length. The dispatch team also had a monthly meeting with their team leaders to discuss their performance.
- The dispatch duty managers produced monthly reports from the computer aided dispatch system (iCAD). The reports enabled managers to identify gaps in performance and missed targets. Managers addressed staff performance through one to ones and support and mentoring by managers.
- The service had processes to challenge and deal with poor staff performance. If a member of staff had not performed well against their call audits, they received an action plan and there would be an increase in the number of monthly audits taken. Managers would sign off the action plan and reduce the number of audits taken when satisfied the member of staff was performing at the desired level. Alternatively, the service could dismiss staff because of poor performance.
- Quality Assurance Coaches (QAC) offered support in southern house by monitoring calls and coaching staff through difficult calls. They also supported managers to address performance issues. The QACs wore pink shirts so they could be easily identified. Staff told us that a QAC role had been advertised for northern house but the role had not been filled.
- There was support for staff following a distressing call or a safeguarding issue. All staff told us they could access traumatic incident management debriefing. Peer support was also available for staff as additional or alternative support routes. Staff could refer themselves for counselling. Staff told us managers allowed them to have “time out” after a distressing call.
- The National Ambulance Resilience Unit (NARU) works with ambulance trusts to support the development of properly trained, equipped and prepared ambulance responders to deal with hazardous or difficult situations. Staff received training which met NARU standards. The duty manager on each shift had received NARU approved training so there was at least one manager trained to support staff in dealing with difficult situations.
- Calls were saved and available for audit; each call taker had five calls audited per month. Call takers had to achieve 86% compliance to continue operating under their Pathways licence. Failing a further audit meant that the call taker would require further training and supervision, and would have to write a reflective piece to show understanding. Staff we spoke with told us that the results were emailed to them and fed back face to face.

Coordination with other providers

- Information was received from GPs and recorded on the computer-aided dispatch (iCAD) system. This included

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'Do not attempt cardio-pulmonary resuscitation' (DNACPR) instructions. Staff in emergency control rooms shared this information with ambulance crews as needed.

- Patients with DNACPR orders were not routinely identified on the 999 (iCAD) system. If a caller telephoned about a patient in cardiac arrest, and felt CPR was in the patient's best interests, the call taker would support the caller until a clinician arrived on scene. Staff informed ambulance crews or clinicians attending the scene there might be a DNACPR in place
- We observed multidisciplinary working between staff and other organisations, when listening to calls, including Thames Valley Police, Royal Berkshire Fire and Rescue Service and local GP surgeries. Since April 2016, southern house had twice daily phone briefings with Hampshire police control centre for area status briefings.
- A cross-border policy was observed to be used by EDs when they contacted adjoining trusts for ambulance support. Neighbouring ambulance trusts provided a buddy service and would assist in times of high demand.
- We saw there was regular communication and sharing of air ambulance resources. The helicopter emergency medical services (HEMS) desk called the neighbouring air ambulance services each morning for a brief update on any issues or incidents.
- The trust had procedures for inter-hospital or inter-facility transfers and responding to urgent GP calls. If requests from health care professionals ran over the designated response time, the emergency dispatcher would call to advise them and extend the pick-up time.
- The trust had instigated a project to improve the level and use of information recorded on 'special notes'. This had been agreed with commissioners. This was to ensure a patient's special notes were up to date and contained information, that was useful for call takers in supporting safe, quality care.
- In the Hampshire areas two hospital trusts had commissioned the labour line based at southern house. The line was staffed by midwives 24/7 and they offered advice to women in labour from their own trusts. They also supported ECTs and any crews who needed help when speaking with or conveying women in labour.
- In southern house, there was a mental health practitioner on duty for NHS111 at weekends and some

evenings. They were not employed for the EOC service but they operated from the same room so provided advice when asked. The duty manager told us that this was particularly beneficial to patients.

- Two local hospital trust had commissioned two mental health nurses who worked in northern house. They were available during peak times, Thursday to Sunday evenings and offered advice over the phone to ECTs, emergency dispatchers and crews.
- Section 136 of the Mental Health Act 1983 allows a police officer to remove a person they think is mentally disordered and "in immediate need of care or control" from a public place to a place of safety. The trust had protocols for transporting patients detained under section 136 of the Mental Health Act to and from places of safety. We observed staff using the protocol when receiving calls from police to transport patients.

Multidisciplinary working

- We observed shift handovers with ECTs, CSD clinicians and the dispatch team. The handovers were smooth with effective communication involving any issues with crews or incidents, vehicles not tracking, which crews were due breaks and ongoing incidents or emergencies. There were handover sheets so the incoming dispatcher had a hard copy of the information to hand.
- We observed good multidisciplinary team working with ECTs, CSDs and dispatch staff. However, there were limited opportunities for cross team communications and no team meetings arranged in the south. In the north, there had been three external meetings, which included team building exercises arranged to forge relationships. Staff stated that this had been successful and highlighted what pressures other members of staff had in the EOC.
- Dispatchers and frontline crews were observed as being polite friendly and professional with each other.
- Dispatchers responded to calls in the order of priority and geographical areas. We observed dispatchers liaising with colleagues in the EOC and passing calls to other dispatchers if crews in those areas were closer. This ensured the patients were attended to as soon as possible.
- Both EOCs were organised so staff had easy access to each other, therefore if any call taker required support with a challenging call, there was always an experienced member of staff to assist close by.

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Access to information

- Staff across both EOCs used the same systems. All staff could see calls and incidents come in to the EOC in real time. Staff could see any electronic notes added in real time by other teams and members of staff. Staff could listen to each other's calls in order to provide information or responses that were more appropriate. This instant access to information enabled staff to make decisions and send an appropriate response more quickly.
- Staff referred people who called regularly (frequent callers or high intensity users) to the high volume service user lead. Staff told us the process to put alerts on the computer-aided dispatch (iCAD) system was slow because there were so many stages to go through. At the end of the process, the service placed the outcome or plan for the caller on the iCAD system. The trust had approximately 2,000 patients that were known to be frequent callers.
- Alerts were created on the iCAD system, which were visible at time of call and informed the call handler that information was available about the patient.
- The CSD team in northern house told us that the special notes created by the 111 team were not always accessible to them because they used different IT systems. The CSD team in northern house kept this information on a shared drive.
- Ambulance crews at the end of their shifts completed forms for special notes and these were sent to shift officers and placed on the system as SS notes (special situation at scene). For example, a crew member might describe a patient who was violent or who had mental health issues.
- As ambulance crew had limited access to patient notes, the EDs would ring the crew if they need briefing before attending a scene.
- An information folder containing common policies and procedures was attached to each ECT workstation for easy access.
- Community first responders were provided with suitable patient specific information over the telephone, as they were not equipped with mobile data terminals used to pass details of jobs to the crews.
- Emergency ambulances, response cars and other vehicles were fitted with mobile phones, two way radios,

global positioning systems (GPS) and automatic vehicle location system. Staff working in both EOCs were able to access this information in order to make decisions related to response and dispatch.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- It was difficult for staff to judge whether a patient or caller had capacity simply by speaking to them over the phone.
- A person's mental capacity could be assessed using the mental health care pathway and, if necessary, the ECTs told us they would hand the caller over to the CSD clinicians for further assessment and advice.
- Training on the Mental Capacity Act, learning disability and safeguarding was included in the face to face statutory and mandatory training for all clinical staff. The training included consent and capacity, best interest decisions and restraints, advance decisions and deprivation of liberty.
- We listened to calls from mental health professionals and ECTs asking patients if patients were under any section of the Mental Health Act. However, when questioned the ECTs did not have any knowledge as to what the different sections of the Mental Health Act indicated. Staff reported that they had received mental health training as part of their induction only. Staff did not receive any further training in mental health after their induction meaning staff that had worked in the EOC for many years may not have had up to date knowledge.

Is emergency operations centre caring?

Good



By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Overall, we rated caring as good:

- Staff were compassionate and caring towards patients and callers. Staff treated patients with dignity and respect.
- The service had systems and processes in place to assist clinicians to advise patients to manage their own health. Clinicians would also provide information to patients about managing conditions if symptoms worsened.

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- Staff were passionate about care and providing the best response possible and they spoke with the patient on all possible occasions.
- Staff supported patients to cope emotionally with their care and treatment. They were also supportive and reassuring when dealing with patients who were distressed.

Compassionate care

- We listened to 55 calls. Staff were reassuring, empathetic and kind. Staff were patient with callers when they became anxious. This enabled the caller to relax and answer the questions required to obtain information about the patient.
- We observed calls where patients were seriously ill or had attempted suicide and staff treated callers with dignity and respect.
- Patients and callers were treated with respect and the call handlers kept calm. They gave reassurance in a professional manner with instructions as required. One caller described an emergency call taker as 'a calming presence during a stressful situation'.
- The service had a standard operating procedure for staff to use when they received an abusive call. Managers we spoke with told us that abusive callers were given two warnings before they were referred to a senior emergency call taker (SECT); if the abuse continued and if it was appropriate, the call would be terminated.
- Staff we spoke with were concerned with the noise levels in both EOCs and found it distracting especially dealing with sensitive situations. Callers could hear dispatchers dealing with other calls. For example, one CSD clinician was talking to a relative about the last minutes of life for a terminally ill patient and the caller could overhear another call. In southern house, they had changed seating arrangements to reduce the impact of the noise.

Understanding and involvement of patients and those close to them

- Staff showed an understanding of the importance of involving patients and carers. We heard staff show empathy and understanding of potential changes to a patient's condition.
- We observed all staff communicating clearly and ensuring that the patient understood the proposed action of the call.

- Call takers and clinicians were heard to be thorough when explaining treatment and expectations to carers.
- We observed staff providing cardio pulmonary resuscitation (CPR) advice to callers. Staff involved the caller and provided clear, step-by-step instructions. Staff offered verbal support to the caller while they were resuscitating a patient.
- Staff recognised the importance of involving patients and if the caller was not the actual patient, they would routinely ask to speak to the patient.

Emotional support

- ECTs were polite, amenable and were observed giving positive verbal nods putting callers at ease.
- When staff talked with callers, they were kind, patient, caring, and reassuring in their responses to people calling in distress.
- We observed one ECT prevent a distressed frequent caller from abandoning the call by offering support. When the caller began to get angry about the delay, the ECT remained calm and polite at all times, reassuring the caller that help was on its way.
- The clinical support desk team showed empathy and understanding, for example, when supporting a caller who had been involved in a domestic violence situation, the clinician made sure the caller was safe and had someone with them for support. They allowed time for the caller to discuss the issues and reassured them that somebody was on their way.
- We observed one call where the patient had been involved in a road traffic accident and wished to leave the scene and go home. The ECT was firm and reassuring, advising them to remain where they were until assistance arrived.

Supporting people to manage their own health

- The CSD was staffed by nurses, paramedics and emergency care practitioners, who were able to provide immediate clinical advice and support to patients, ambulance crews and responders. The service offered 'hear and treat' to help patients, which advised them to contact their GP or advised the patients on how to manage their own health needs.
- During "hear and treat" calls we observed clinicians discuss treatment options with patients and contact the patients' GP.

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- Frequent callers were identified on the system and call handlers sign posted patients to other services. For example, the mental health nurses in northern house.
- Call handlers were observed to be calm with a reassuring manner throughout. They gave detailed instructions on managing “worsening symptoms” and would recap instructions to ensure correct understanding.

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

Good



By responsive, we mean that services are organised so that they meet people’s needs.

Overall, we rated responsive as good:

- The service had a number of different clinical specialist services designed to meet the needs of the local population. This included a dedicated mental health service in northern house, community first responders (CFR) and co-responders.
- When the service had too many calls and calls were ‘stacking’, the clinical demand management process was implemented effectively and enabled staff to be responsive to individuals’ needs.
- Demand practitioners worked with local providers to review high intensity users (frequent callers) and ensure these patients had individual care plans.
- Staff supported patients who were considering suicide until assistance arrived.
- There were processes in place to access interpreters, and services to support callers with hearing and speech impairments.
- There was real time data visible to staff in the EOCs regarding all aspects of performance across the trust.
- There was a complaints policy with a clear process to investigate, report and learning from complaints was shared.

However,

- Dementia awareness training was available for all staff within the trust, however the completion rate for staff within EOC was lower than expected by the trust The

NHS Pathway system does not contain prompts to assist an emergency call taker in recognising when a patients is living with dementia or cognitive impairment. Therefore this was reliant on the call takers knowledge and experience..

- Complaints were not being resolved promptly and were taking longer than the trust’s target time of 25 days.

Service planning and delivery to meet the needs of local people

- There were a number of different specialist clinical services designed to meet the needs of the local population. The trust had emergency and community first responder schemes to respond to life threatening emergencies in rural areas where ambulances might take longer to arrive. The trust could also deploy their air ambulance service to provide a quick response to major incidents or to incidents where it was difficult for ambulances to access.
- There was a helicopter emergency medical Services HEMS desk in northern house, used to identify major trauma calls that required an air ambulance. A HEMS paramedic staffed this. HEMS had recently introduced a partial night service, allowing the air ambulance service to be available from 7am until 2am the next day. We saw the HEMS desk liaising with the emergency dispatchers, ambulance crews and air ambulance crews to determine which emergency vehicle would be able to respond the quickest.
- The trust had a ‘hear and treat’ service. The clinical support desk (CSD) staff could assess and triage patients that required medical help without sending an ambulance. This meant more patients could be treated and assessed in their home allowing ambulances to be deployed more appropriately to serious incidents.
- The environment in the emergency operating centres (EOCs) enabled staff to focus on their particular roles and geographical areas as well as helping to ensure staff across different teams could communicate with each other. The regional operations manager, (HEMS), and the incident command desk were in the centre of the room so they could communicate with all teams and coordinate responses to incidents where necessary.
- The hazardous area response team (HART) is a specialised team of medical personnel who attend and support serious incidents involving hazardous materials or environments. Staff viewed the HART team as a specialist resource and staff told us they did not use the

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HART team for regular emergencies, but used when capacity demanded it. HART was managed entirely by HART managers and appropriate usage was monitored by them.

Meeting people's individual needs

- A proportion of the trust's income was conditional on achieving quality improvement and innovation goals agreed through the Commissioning for Quality and Innovation payment framework (CQUIN). The trust did not achieve the (CQUIN) target, one of the goals set was to improve staff awareness and provide training on dementia with an aim to improve the care for people living with dementia. The dementia lead, had implemented an eLearning package as part of mandatory training; there had been a 65% uptake for this training against the target of 80%. Staff in EOC were not routinely provided with dementia training to ensure they were able to recognise when a person may have dementia.
- The NHS Pathway system does not contain prompts to assist an emergency call taker in recognising when a patient is living with dementia or cognitive impairment and the emergency call taker decided if patients needed to speak to the clinical support desk (CSD) staff. We observed a CSD clinician listening to a call and asking to take over the call when it became apparent that the patient had cognitive issues. However, the CSD did not listen to all calls so some patients with dementia or cognitive impairment may not be recognised as needing further review by a CSD. If a frequent caller was known to be living with dementia a special patient note could be provided by their own GP, which would alert the call taker and should in these cases trigger the known frequent caller route from the declared screen in Pathways. For some patients there remained a risk that action would not take account of their cognitive ability.
- The dispatch team were alerted to patients with a known clinical condition or additional needs (for example, bariatric patients) to ensure an appropriate vehicle with the correct equipment was sent to the scene. Where a crew identified that a patient was bariatric and needed to be conveyed to hospital they passed this information to the ED, requesting a bariatric ambulance to attend. Bariatric equipment was kept at main stations; we observed crews contacted to be on standby if equipment was required for a particular patient.
- EOC staff had access to a language translation service and the call centres provided access to services for patients with hearing and speech impairments via Type Talk.
- Mental health nurses based at northern house were commissioned by another trust. They worked at weekends and at other peak times; they provided support in Oxfordshire and Buckinghamshire only. They could access mental health patient records to provide accurate information on care plans. There were no mental health practitioners based at southern house in the EOC. There was one mental health practitioner based in the 111 service who would support the EOC if requested. However, this was not part of routine service provision for EOC.
- The mental health practitioner and CSD clinicians would support patients who were attempting or contemplating suicide. They stayed on the phone and supported patients until help arrived. The mental health practitioner gave us an example where they had stayed on the call for two hours until the patient was safe.
- The trust had recently invested in demand practitioners (who were paramedics by background) to review high intensity users and ensured appropriate plans had been put in place for these patients. This was decreasing the need to send out a vehicle. The practitioners worked within different localities and with local providers to review the support required for these patients.
- We were informed by senior management that the trust refers all patients that had fallen to the local falls teams, to ensure they received follow up support and advice.

Access and flow

- Dispatch staff experienced problems with some hospitals in the region relating to patient handover. Crews were often waiting for long periods to hand patients over at hospitals. Crews had a target of 30 minutes to hand over a patient at a hospital and then get the vehicle ready for the next patient. The delays affected dispatchers who could not respond quickly enough to other patients and incidents. The emergency operating centres (EOCs) had a display screen showing the waiting times at each hospital.
- Staff in the EOC monitored the queue of calls in real time. The service had a display screen showing how

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many callers were waiting, how many staff were on calls and how many staff were available to answer calls.

Managers could use the screen to quickly identify and respond to a queue of calls.

- If calls were 'stacking' the clinical demand management process was instigated. CSD clinicians reviewed calls from patients and made an informed clinical decision with the patient on the suitability of them travelling by an alternative mode of transport to a point of care. We observed this resulted in patients being transported to an emergency treatment centre by other means, for example, by a relative. This was noted on the patient's records.
- The CSDs staff undertook welfare checks and called patients when an ambulance had not arrived within the target time frame, or if clinically appropriate to do so. Ambulance crews could also contact the clinical advisors while tending to a patient, if they needed support and advice.
- During busy periods, a duty manager would send texts to community first responders (CFRs) and ask them if they were available to respond to patients. This helped to minimise the time patients had to wait for treatment or care.

Learning from complaints and concerns

- Staff knew the different ways a patient could make a complaint and supported the patient to do so. Staff told us they would attempt to resolve issues early by first referring the caller to a duty manager. Staff also referred patients to the Patient Advice and Liaison Service (PALS).
- The PALS team initially received complaints, if a complaint was regarding a call the team leader in EOC would investigate and listened to a recording of the call. The team leader would then speak to the member of staff face to face, if they were a CSD clinician they would be asked to provide a reflective piece of work.
- Complaints investigated had appropriate actions and identified key learning points. Managers and call auditors investigated complaints and reviewed calls as part of the investigation. Learning was shared for example, through training, clinical case reviews and amendments to policies, procedures and practice. This was in line with the trust complaints policy.

- All staff we spoke with said that they had received feedback and learning from complaints in which they were cited. The CSD team told us that when they received a complaint it was discussed with them and they were asked to write a reflective account.
- The trust's standard operating procedure showed that it would provide a formal response to a complaint 25 days after the complaint had been received.
- The trust reported nine formal complaints across both control centres between 1 October 2015 to March 2016. Five complaints related to clinical care, four of which were upheld or partially upheld. Three complaints related to staff attitude, senior staff told us these calls were listened to by the staff member concerned and feedback was given to improve performance.
- Four of the complaints had taken in excess of 50 days to be closed. A further three complaints from February 2016 had still not been resolved.

Is emergency operations centre well-led?

Good



By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Overall, we rated well-led as good:

- The service had a clear vision and there were service changes made in support of the strategy.
- There was a clear governance structure with accountable roles for staff and managers.
- There was good local leadership in both EOCs and this was reflected by a positive culture and all staff felt supported by their immediate line manager. Most staff felt well supported within their teams.
- There were recognition and reward schemes for staff.
- The quality of the service was effectively monitored through audit.
- The trust could demonstrate improvements to the service following the last inspection in September 2014.

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However,

- Not all staff groups were given the opportunity to attend team meetings so had limited opportunities to raise concerns, share in learning or contribute to service development.

Vision and strategy for this service

- The trust's five-year written strategy for the emergency operation centres was to develop the 999 service and NHS services as a clinical coordination centre and ensure patients get the right care first time.
- The operations director and managers had a clear vision and strategy for the emergency operations centres (EOCs) which was based on '2 numbers, 1 service'.
- All staff we spoke with were aware of the vision and strategy for the service. They discussed moving away from the traditional see and treat service, with the focus being on hear and treat, achieved through triage services.
- We were informed that staff had input to the strategy and vision for the service through staff forums where ideas could be shared which also involved staff side representatives.

Governance, risk management and quality measurement

- The service had a clear governance structure with accountable roles for staff and managers. The service had roles to support staff on difficult calls as well as managers who would support and work with managers in the regions to deal with major incidents or delays in hospital handovers.
- Managers and staff knew of the key risks to the service. Staff and managers identified staffing shortages, lack of resources on the road, and loss of IT as the biggest risks. These were documented on the EOC risk register. However, the information governance risks around records had not been documented.
- The trust had an audit team that audited all 999 calls and monitored operational performance against national requirements. Calls were audited using the NHS Pathways call audit tool to ensure consistency and fairness.
- There was a governance structure relating to meetings. However, it was noted that although there were

meetings for ECT staff, team meetings for dispatch operators or CSDs were not defined within the meeting structure. Staff felt there should be team meetings for individual teams to improve communication.

- A joint management meeting for both EOCs was held fortnightly to discuss items such as sickness issues, complaints, investigations and recruitment which reported to the trusts level 2 meetings which in turn reported to the trust-wide senior EOC team meetings (level 3).
- EOC management team level 3 meetings were held quarterly the minutes of the meeting for November 2015 showed that strategic planning had been discussed and actions had been agreed.
- We reviewed the minutes for the senior emergency call takers (SECTs) quarterly meeting held in northern house April 2016. A range of issues had been discussed such as training, mentoring, sickness and performance. Some staff told us that they were expected to attend meetings in their own time but would be paid for their time.
- The trust had agreed an achieving quality improvement and innovation goal with commissioners as part of the Commissioning for Quality and Innovation payment framework (CQUIN). This was to support the improvement of the quality of special patient notes during 2016/17.
- Workforce plans were agreed and monitored by the workforce development board. Membership of this board comprised of accountable executive directors, including the director of quality and patient care. The primary purpose of this group was to oversee and agree workforce recruitment and development plans.
- The head of the EOC in southern house told us that recruitment was difficult as numbers of applicants and the quality of those applied had reduced. Eighteen out of 34 staff who left between November 2015 and April 2016 stated work life balance as the reason for their departure. The inability to recruit and retain experienced staff had been acknowledged by the trust and was on the EOC risk register. The EOC had a workforce plan for 2016/2017.
- The staff we spoke with were aware of the whistleblowing policy and said that they would use this approach if they had serious concerns and felt unable to raise them with their manager.
- The service could demonstrate improvements following the wave 1 pilot CQC comprehensive inspection in September 2014. There had been improvements in

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reducing IT vulnerability, incident reporting, learning from complaints, leadership and governance. The service could not demonstrate similar improvements in Mental Health Act understanding, safeguarding training and complaints handling times.

Leadership of service

- There was a clear leadership structure, with clearly defined roles and responsibilities. ECTs reported to senior ECTs who in turn reported to the shift leader along with the emergency dispatchers. CSD clinicians reported to the duty manager. The duty manager was accountable to the head of EOC, who reported to the assistant director of operations.
- The clinical support desk (CSD), dispatchers, and emergency call takers (ECT) all had an allocated manager.
- Staff told us that the managers were visible within both EOCs and the director of patient care would liaise with the clinical support manager regularly.
- Control duty managers (CDMs) described feeling proud of their teams and sent emails praise to team members when their performance improved.
- EOC staff worked under constant pressure, often being unable to provide support due to delays in response times and lack of ambulance availability. We observed staff being well supported by their manager and given time out after a stressful incident.
- Staff told us at weekends, team leaders often needed to take emergency calls and this could happen at other times to manage demand. This meant staff felt less supported and team leaders had less time to spend with their teams.

Culture within the service

- We found that staff in both emergency operating centres (EOCs) worked well together and were focused on providing a good service to the public.
- Three team building days had been organised for northern house by external providers and staff stated that this had improved changes in working practices.
- Staff told us that there was an open culture within the EOCs and they feel confident to raise any issues with their line manager. A 'circle of concern' had been introduced by a control duty manager (CDM) which gave staff a platform to voice their concerns.
- In April 2015, the trust introduced traumatic incident management. This included post-traumatic stress

debriefing, peer-to-peer support and access to pastoral care workers for staff who had experience difficult or challenging calls. Staff knew about the scheme and some staff said they had used it and that it had helped.

- All staff we spoke with said they loved their job and working in their own teams. We observed a supportive culture between staff and a desire to provide the best possible services to patients
- Teamwork across the different disciplines in both control centres was positive. However, the differences between rotas and training time allocated had a negative impact on morale.

Staff engagement

- Staff could be nominated to receive monthly awards in recognition of their hard work. There was a nominated emergency call taker, emergency dispatcher and dispatch team of the month. A prize was awarded for the team who won the team challenge. The audit and training team also issued certificates for outstanding audit compliance and exceptional customer service.
- The head of the emergency operations centre (EOC) personally wrote to staff after they had received a compliment or positive feedback from patients or visitors. Articles of commendation were published in the trust newsletter 'Staff matters'.
- The Health, Wellbeing and Attendance Project was implemented in September 2015, to support the trust focus on lowering sickness absence levels, whilst ensuring the health and wellbeing needs of staff were identified and supported. The project focused on all "operational" areas of the trust.
- Staff had received a survey about their car usage in an attempt at northern house to regulate the car parking. Currently the car park was over-capacity and causing issues for staff, including disruptions to their work. One control duty manager (CDM) described the car park situation as their 'biggest issue' to affect staff morale.
- Staff received an email each week from the chief executive describing updates within the trust.

Public engagement

- The trust had continued an inappropriate use campaign. This asked members of the public to call 999 for emergencies and life-threatening situations, and to

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directly combat hoax and other inappropriate calls. The campaign involved giving information and showing a hard-hitting video to the public that illustrated how lives were put at risk when 999 was called inappropriately.

- The service had participated in the national Hear and Treat survey and was similar to other trusts.

Innovation, improvement and sustainability

- The emergency operations centre was continually looking for ways to develop, improve and sustain the service. Achievements over the past few years were recognised by the trust in the 'What does SCAS do well' book
- The education and development department for the trust worked with the Health and Social Care Information Centre to deliver Simbulance workshops open to all National 999 services. The Simbulance was a specially modified ambulance used to simulate emergencies. The vehicle would be converted into a control and debrief room and the patient compartment of an ambulance for team training.
- A member of staff was currently introducing an initiative that involves the use of tablet devices in nursing homes to assess patients. This was being encouraged and promoted by the trust.
- The trust was engaged with many programmes of interoperability with commissioners and many health and social care service providers. These programmes formed a key part of the Digital Transformation / Digital Roadmap initiative for NHS England.
- The trust was participating in a trial with NHS England and the Health and Social Care Information Centre to improve the triage assessment of children with possible signs of Sepsis.

Outstanding practice and areas for improvement

Outstanding practice

We have identified many significant areas of outstanding practice when we inspected the trust in September 2014. The report is available on our website.

During this inspection, we have also identified:

- A smartphone triage app had been produced in conjunction with the Wessex Trauma Network. This meant clinicians could use the triage tool to identify if their patient needed to bypass a local hospital and be conveyed directly to a major trauma centre, and which one was the closest.
- The trust had introduced demand practitioners and emergency care practitioners (specialist paramedics) to support patients to manage their own health conditions at home and to treat patients without the need for hospital admission.
- The trust uses a mobile simulation vehicle which offers an innovative approach to training for staff.
- Mental Health practitioners are in control contact centres at weekend peak times. They are piloting direct referrals to Samaritans and local mental health teams. This has improved timely patient access to mental health services.
- The Berkshire Hub connects services together as a single point of access location. The Hub includes out of hours, community, minor injury and illnesses and mental health services. There are shared records and special patient notes for patients. The Hub has increased access to NHS, GP, dental, pharmacy, mental health and labour line services

Areas for improvement

Action the hospital **MUST** take to improve

Action the location **MUST** take to improve

The trust must ensure

- Staff in urgent and emergency care are supported with their development through supervision
- Response times for emergency and urgent care services are met.
- Governance arrangements in emergency and urgent care services must ensure that staff are aware of risks and safe practices are consistently applied.

Action the hospital **SHOULD** take to improve

Action the location **SHOULD** take to improve

The trust should ensure

- Staffing levels across all services meets planned levels identified by the trust.
- Review compliance with appraisals and mandatory and statutory training, including safeguarding training, to ensure that staff are supported to complete the required training in a timely.
- Ambulance response bags are appropriate for use and are replaced when necessary.
- Noise levels in Northern House are reviewed to minimise the risk of missing, miss-hearing or delays in recording patient information.
- Escalation procedures for the immediate handover of emergency patients are developed and agreed with all hospital trusts.
- The process for making safeguarding referrals to local authorities is reviewed and referrals happen in a timely manner to ensure safety of vulnerable patients outside of normal working hours.
- All medicines must be safely managed at all times, particular attention must be given to the safe management of controlled drugs.
- All staff should have adequate training in mental health and dementia awareness, which is updated at regular intervals to ensure that mental health knowledge is current.
- All complaints should be investigated and responded to in a timely manner in line with the trust policy.
- The structure of team meetings should be in place for all staff groups to ensure staff are given the opportunity to attend, share information and raise issues or concerns.

Outstanding practice and areas for improvement

- The processes for sharing the learning from incidents, safeguarding and complaints with staff is reviewed to ensure staff are using this information to improve the quality of care provided to patients.
- Health and safety risk assessments are completed at resource centres.
- Rest breaks for all ambulance staff should be planned into their schedule, compliance monitored and action taken to ensure staff well-being.
- Staff comply with hand hygiene and infection control policies with regular infection control audits to check compliance across the PTS.
- The risks associated with lack of connectivity for PTS staff working in rural areas is reviewed and ensure staff, particularly lone workers, are able to summon help through their PDAs in an emergency, and the reliability of this system is monitored.
- There is clarity in the standard operating procedure and policy for the administration of oxygen to patients by frontline PTS and this process is clearly understood by staff.
- Current systems for PTS are reviewed so patients with the greatest need are more easily identified as priorities for patient transport.
- There is a standard approach to record minutes for meetings across the PTS. These should be in sufficient depth and recognised as being a formal document, with the content written in a style to reflect this.
- Improve the recording of the authority to administer or supply a medicines under a PGD
- Medicine modules are managed correctly, and tamper evident tags are consistently recorded.
- All patient records are kept securely and disposed of in line with trust policy.
- Staff are given the time and opportunity to report incidents in emergency and urgent care services and they have appropriate feedback.
- The time allocated for staff to complete vehicle checks at the start of each shift is reviewed and actioned appropriately so that staff have sufficient time to complete the task.
- The current recruitment drive continues, while monitoring and taking action on the health and wellbeing of the current work force, including the impact of shift rostering and any changes implemented.
- Continues to work with commissioners and other providers to improve response times and their ability to meet their key performance indicators and national targets..
- The reasons for staff turnover and low morale across all services is continually addressed.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Governance processes had not identified inconsistent practice in emergency and urgent care. There were safety issues that had not been identified appropriately through monitoring arrangements.