Care Quality Commission

East of England Ambulance Service NHS Trust

East of England Ambulance Service NHS Trust

Quality Report

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

Ratings

Overall rating for this ambulance location	Requires improvement 🟠
Emergency and urgent care services	**Requires improvement** 🟠
Patient transport services (PTS)	**Requires improvement** 🟠
Emergency operations centre	Good 🟢

Summary of findings

Letter from the Chief Inspector of Hospitals

The East of England Ambulance Service NHS Trust (EEAST) is one of 10 ambulance trusts in England providing emergency medical services to Bedfordshire, Cambridgeshire, Essex, Hertfordshire, Norfolk and Suffolk; an area which has a population of around 6 million people over 7500 square miles. The trust employs around 4000 staff and 1500 volunteers who are based at more than 130 sites including ambulance stations, emergency operations centres (EOCS) and support offices across the East of England.

The main role of EEAST is to respond to emergency 999 calls, 24 hours a day, 365 days a year. 999 calls are received by the emergency operation centres (EOC), where clinical advice is provided and emergency vehicles are dispatched if required. Other services provided by EEAST include patient transport services (PTS) for non-emergency patients between community provider locations or their home address and resilience services which includes the Hazardous Area Response Team (HART).

Every day EEAST receives around 2600 calls from members of the public dialling 999. The service provided by EEAST is commissioned by 19 separate Clinical Commissioning Groups with one of these taking the role as co-ordinating commissioner.

Our announced inspection of EEAST took place between 4th and 8th April 2016 with unannounced inspections on 19th April 2016. We carried out this inspection as part of the CQC's comprehensive inspection programme.

We inspected three core services:

• Emergency Operations Centres

• Urgent and Emergency Care including the Hazardous Area Response Team (HART).

• Patient Transport Services

Our key findings were as follows:

- The trust was under significant pressure and was failing to meet performance standards and targets for response to emergency calls.
- The chief executive had been in post for approximately 7 months and was developing new models of care and new strategies to address performance and recruitment concerns. These were yet to reach fruition.
- Resources were frequently unavailable as they were unable to hand over patients to acute providers in a timely way. This occurred throughout or inspection.
- There was ongoing significant issues in recruitment of paramedics across the trust with particular 'hotspots' in certain areas including Norfolk and Cambridgeshire.
- The trust had identified new models of workforce development and new roles to support the service. This was in the process of consultation and implementation during our inspection.
- There was variation across the trust in many areas including governance, medicines management and infection control.
- The emergency operations centres were recruiting clinical staff into 'clinical hubs' to dramatically improve the number of patients treated over the telephone or signposted to more appropriate services.
- All staff were passionate about providing the best possible service to patients. We consistently observed staff to be caring and compassionate and concerned for the welfare of patients.
- There were low levels of mandatory training and many staff were not equipped with the skills to care for people living with dementia and mental health problems and a poor knowledge of the Mental Capacity Act 2005.

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

Importantly, the trust must:

Summary of findings

- Improve performance and response times for emergency calls.
- Ensure that there are adequate numbers of suitable skilled and qualified staff to provide safe care and treatment
- Ensure staff are appropriately mentored and supported to carry out their role including appraisals.
- Ensure staff complete mandatory training (professional updates).
- Ensure that incidents are reported consistently and learning fed back to staff.
- Ensure that all staff are aware of safeguarding procedures and there is a consistent approach to reporting safeguarding.
- Ensure that medicines management is consistent across the trust and that controlled medicines are stored and managed according to regulation and legislation.
- Ensure that all vehicles and equipment are appropriately cleaned and maintained.
- Ensure all staff are aware of their responsibilities under legislation including the Mental Capacity Act 2005.
- Ensure all staff are aware of their responsibility under Duty of Candour requirements.
- Ensure records are stored securely on vehicles.

In addition the trust should:

- The trust should consider how all risks associated with PTS can be captured and reviewed on the risk register.
- The trust should improve the numbers of patients offered hear and treat services.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Emergency and urgent care services	Requires improvement 🟠	East of England Ambulance NHS Trust needed to improve several aspects of their services including practice and performance on medicines management, staff training, especially in meeting complex needs including mental health, mandatory training, supervision and appraisal and emergency vehicle response times.

East of England Ambulance NHS Trust needed to improve several aspects of their services including practice and performance on medicines management, staff training, especially in meeting complex needs including mental health, mandatory training, supervision and appraisal and emergency vehicle response times.

Current practice in medicines management did not comply with the trust policy and the risks to the public and patients was elevated due to poor practice.

Incident reporting and learning from incidents was not consistent across the trust.

Emergency calls to East of England Ambulance Service (EEAST) which were immediately life-threatening such as cardiac arrest and termed Red 1 required a response via an emergency vehicle within eight minutes. The trusts response rates from July 2014 to January 2016 were similar to the NHS ambulance trust average and followed the national trend. For Red 1 calls, the trust only reached the national target of 75% five times between July 2014 and January 2016. The lowest response rate was 66% in July 2014; however, data for April 2016 showed the trust as the fifth out of ten performing ambulance services in NHS with responses within target at 73%.

Policies were in place for deep cleaning processes for ambulances and staff followed trust policy on the prevention protection and control of infections. The make ready service provided at ambulance stations improved the quality of services provided for staff and patients due to the timely replenishing of equipment and the maintenance of vehicles. However, there was no overarching audit in place to check that vehicle daily inspections were at the correct standards.

The service had clear pathways for ambulance crews to follow when responding to life threatening conditions. Staff had a copy of the Joint Royal

Summary of findings

Colleges Ambulance Liaison Committee guidance (JRCALC) assessment and triage guidance available to refer to, either on their person or in the emergency response vehicle. Ambulance crews followed medical protocols to assess patients and plan their care. Staff made effective use of protocols, supporting guidance and pathways in their assessment of patients, for example the JRALC.

Staff treated patients with compassion, dignity, and respect at all times and patients were happy with the services provided.

Staff told us that there was very little support for them regarding helping patients with mental health and staff did not receive training to meet complex need, for example, mental health, dementia, or learning disabilities.

Access to mandatory training was not always possible and we found that consistently across the trust, staff was not accessing training relevant to their respective roles in a timely fashion. Skills mix on some emergency vehicles were not always appropriate.

Patient paper records were not always secure on emergency vehicles or in some ambulance stations, however the records we observed where in the main accurate legible and reflected the needs of patients.

EEAST had a valuable team of community first responders who offer support to their local communities and there were opportunities for staff to engage in community based emergency roles, including the Eastern Anglian Air Ambulance.

Staff appraisal and supervision is not carried out consistently across the trust, we found examples where staff appraisals were out of date and where staff had not had any clinical supervisions due to the demands of the front line service.

Governance of independent providers was robust and the service held a risk register to manage significant risks that could have detrimental effects on the service.

Staff often worked longer than their expected hours due to delays at hospitals and morale was affected by this, and some staff were disillusioned with the

Summary of findings

trust. However in the main staff were positive regarding the opportunity of working with the new trust Chief Executive officer to bring stability and direction to the service.

The trust vision and strategy was not widely known or understood by the staff teams and remote workers felt isolated at times due to the leaders not being visible.

Patient transport services (PTS)

Requires improvement ●

We rated patient transport services overall as requiring improvement.

There were a lack of policies and procedures to support staff within their roles and safeguarding processes were not clear to all staff and managers. Fire safety processes did not ensure staff and visitors would be kept safe. Staff were not always supported to participate in training and development opportunities and there were significant knowledge gaps in relation to consent, the Mental Capacity Act and how this is applicable to practice. There were no methods in place to monitor staff performance within the service.

Appropriate information was shared between multidisciplinary teams prior to the patients transport and there were good relationships were in place with local healthcare providers. The booking system was easy for people to access, with flexibility and choice of services and people living with disabilities could easily access the service and have their needs accommodated. Staff showed a good awareness of people's needs in relation to disability, race, religion and age.

There were some delays in sharing information relating to patients and their transport needs due to communication devices being unreliable and there were shortfalls in assisting communication with people who did not speak English.

Complaints procedures were not directly available to patients and staff did not know where to signpost patients and we found that learning from complaints was not shared across the service.

The culture within PTS was poor, with staff feeling a divide between PTS and the rest of the ambulance

service. Staff also felt unsupported by leadership teams and that there was a clear separation between them. Staff and managers did not understand the service's strategy or plans moving forward, due to uncertainty with contracts and due to lack of innovation or set objectives.

However, we found people were treated with dignity, respect and kindness during all interaction with staff. All patient facing staff showed an awareness of the importance of providing emotional support to patients during difficult times, including developing positive relationships with regular patients who were undergoing major healthcare treatments. Feedback from patients who used the service, and those close to them, was largely positive about the way staff treat people.

There were pockets of enthusiastic and forward thinking line managers who wanted to improve the service.

Emergency operations centre

Good ●

Overall we rated the emergency operations centre (EOC's) as Good.

Safety required improvement because incident reporting methods were inconsistent and not all staff received feedback about incidents. Mandatory training (professional updates) rates were low across the EOC's and safeguarding reporting methods were inconsistent and staff did not always know there was a safeguarding lead. Resource was limited for the EOC's because of delayed ambulance handover times which severely limited capacity to dispatch resources. Effectiveness was good because evidence based care and treatment was incorporated into systems used in the EOC's which followed national guidance and best practice and there was an ongoing programme of local and national clinical audit within the EOC's. Calls were answered promptly for almost all patients (greater than 99%) and staff were competent to carry out their roles and there were systems in place to support them. However, understand of the Mental Capacity Act 2005 was poor across the EOC's

Caring was outstanding. Staff consistently demonstrated compassionate care when dealing

with patients and made extra efforts to protect their privacy and dignity, including dispatching additional resources. We saw several examples of staff acting with the utmost professionalism and supporting patients and the public in the most trying of circumstances to provide positive outcomes for patients. Staff always ensured that patients or the public understood what they were being told and kept communication open throughout calls.

Responsiveness was good because there were examples of service planning to meet local needs including the increase in provision of hear and treat services. The EOC's met individual needs including using a variety of communication tools for callers and there were systems in place to try and manage the access and flow of calls and patients. Complaints were investigated properly and the old computer system had been maintained so that older complaints could still be fully investigated. There was evidence of learning from complaints.

Well led was Good. There was a clear strategy and vision in place for the EOC's including the development of clinical hubs. All the staff we spoke with were aware of the direction of the service and plans for the future. The EOC's had undertaken a major infrastructure change, done in a short period of time with comparatively small number of incidents for such a large change. There was a clear governance structure in place for the EOC's and regular audit and measurement. However, we also found staff felt under pressure because of rising call volumes and the lack of resource to send to some calls and there had been a high turnover and sickness at the Norwich EOC and some allegations of bullying. A culture project had been undertaken to address these concerns and the allegations properly investigated.

Care Quality Commission

Requires improvement ●

East of England Ambulance Service NHS Trust

Detailed findings

Services we looked at

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

Detailed findings

Contents

Background to East of England Ambulance Service NHS Trust

East of England Ambulance Service NHS Trust (EEAST) covers the six counties of Bedfordshire, Cambridgeshire, Essex, Hertfordshire, Norfolk and Suffolk. This is an area which has a population of around 6 million people and covers approximately 7, 500 square miles. The trust employs around 4000 staff and 1500 volunteers. The trust was formed in 2006 following the amalgamation of 3 ambulance services.

EEAST provides an emergency service to respond to 999 calls; patient transport service (PTS) in various locations across the trust for non-emergency patients between community provider locations or their home address and emergency operation centres (EOC), where 999 calls were received, clinical advice is provided and emergency vehicles dispatched if needed. There is also a Hazardous Area Response Team (HART).

The trust serves an ethnically and geographically diverse population including rural, coastal and urban environments. There are areas of high deprivation in Essex, Bedfordshire and Norfolk.

We inspected EEAST as part of our announced comprehensive inspection programme. The trust is not a Foundation Trust and this inspection has not considered any application for Foundation Trust status.

As part of our inspection we visited trust premises including offices, training areas, fleet workshops, specialist units such as Hazardous Area Response Team (HART), ambulance stations and emergency operations centres. We also visited hospital and other health care locations to speak with patients and staff about their experiences of the ambulance service.

Our inspection team

Our inspection team was led by:

Chair: Daren Mochrie, Director of Service Delivery, Scottish Ambulance Service

Head of Hospital Inspections: Fiona Allinson, Care Quality Commission

East of England Ambulance Service was inspected by a team of 42 people including specialist advisors with a variety of backgrounds including at director level, paramedics, and consultant paramedics, emergency operations centre team leaders as well as CQC inspectors, inspection managers, a national professional advisor, two pharmacist inspectors, and inspection planner.

Detailed findings

How we carried out this inspection

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

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

The inspection team inspected the following:

• Emergency Operations Centres

• Urgent and Emergency Care including Hazardous Area

Response Team (HART).

• Patient Transport Services

Prior to the announced inspection, we reviewed a range of information that we held and asked other organisations to share what they knew about the trust.

These included the 19 clinical commissioning groups (CCGs), the Trust Development Authority/ NHS Improvement, NHS England and local Healthwatch organisations through the lead Healthwatch in Suffolk as well as the local branch of Unison at their request. We held a week of focus groups for staff ahead of the inspection which was attended by more than 150 staff.

We held interviews with a range of staff in the service and spoke with staff individually as requested. We talked with staff from acute hospitals who used the service provided by the trust. We spoke with patients and observed how they were being cared for. We also talked with carers and/ or family members and reviewed patients' treatment records. We carried out the announced inspection visit between 4th and 8th April 2016 with unannounced inspections on 19th April 2016.

Facts and data about East of England Ambulance Service NHS Trust

Revenue (Apr 15 to Mar 16)

Income £246m

Surplus £998k

Demographics:

The area is made up of:

• more than 5.9 million people

• 7,500 square miles

• 19 CCGs

• 17 acute trusts

• one health authority.

In 2014/15 the Trust:

• received 964,917 emergency calls

• handled 464,194 non-emergency patient journeys

• delivered primary care services to more than

450,000 patients

Resources and teams include:

• 357 frontline ambulances

• 201 marked response cars

• 164 non-emergency ambulances (Patient transport service vehicles)

• 52 HART/major incident/resilience vehicles

• more than 130 sites

• three emergency operations centres (EOCs)

• more than 4,000 staff and 1,500 volunteers.

Detailed findings

Our ratings for this service

Our ratings for this service are:

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

Notes

Emergency and urgent care services

Safe	**Requires improvement** 🟠
Effective	**Requires improvement** 🟠
Caring	**Good** 🟢
Responsive	**Good** 🟢
Well-led	**Requires improvement** 🟠
Overall	**Requires improvement** 🟠

Information about the service

The main role of emergency and urgent care services is to respond to emergency 999 calls, 24 hours a day, 365 days a year. East of England Ambulance Service NHS Trust (EEAST) provides an emergency and urgent care service to a population of 5.8 million people across the East of England, which covers the counties of Bedfordshire, Cambridgeshire, Essex, Hertfordshire, Norfolk, and Suffolk.

The trust covers a total area of 7,500 square miles and has over 4,000 employees, 67% of which work in the emergency and urgent care teams. EEAST works closely with other emergency services, including the police, fire service, and coastguard to provide emergency services during major incidents. It also provides paramedic services for the Eastern Anglian Air Ambulance (EAAA), a local air ambulance charity that flies from its Norwich and Cambridge bases. The trust has approximately 774 vehicles including 68 all-wheel drive response cars.

On average, EEAST responds to a 999 call every 24 seconds, amounting to an average of 2,400 calls per day and 964,917 calls per year. This can increase to 3,000 calls per day during certain times of the year such as New Year's Eve and other significant events. EEAST supports the work of 1,400 voluntary community and emergency first responders across the region that gives basic lifesaving interventions prior to the arrival of the ambulance crew; this is co-ordinated by EEAST.

We conducted focus groups with staff from all counties prior to our inspection to hear their views about the service. This included frontline ambulance staff, mentors, support, and technical staff.

During the inspection, we visited 28 ambulance stations across the trust, in both towns and rural areas. We spoke with over 301 staff in various roles including paramedics, trainee paramedics, emergency medical technicians, emergency care assistants, supervisors, area locality manager, duty locality managers, and ambulance fleet technicians. In addition, we spoke with support staff including cleaners and those who deep cleaned and maintained ambulances. We observed ambulance crews treating patients. We spoke with over 48 patients, where appropriate to do so, and their relatives. These patients had used the service in their own homes or for conveyance to accident and emergency departments.

We inspected ambulances and reviewed patient care records. We visited hospitals in each area serviced by EEAST and observed the interaction between ambulance, accident and emergency department staff. We spoke with staff in the accident and emergency departments and asked their experience of working with EEAST staff.

Emergency and urgent care services

Summary of findings

East of England Ambulance NHS Trust needed to improve several aspects of their services including practice and performance on medicines management, staff training, especially in meeting complex needs including mental health, mandatory training, supervision and appraisal and emergency vehicle response times.

Current practice in medicines management did not comply with the trust policy and the risks to the public and patients was elevated due to poor practice.

Incident reporting and learning from incidents was not consistent across the trust.

Emergency calls to East of England Ambulance Service (EEAST) which were immediately life-threatening such as cardiac arrest and termed Red 1 required a response via an emergency vehicle within eight minutes. The trusts response rates from July 2014 to January 2016 were similar to the NHS ambulance trust average and followed the national trend. For Red 1 calls, the trust only reached the national target of 75% five times between July 2014 and January 2016. The lowest response rate was 66% in July 2014; however, data for April 2016 showed the trust as the fifth out of ten performing ambulance services in NHS with responses within target at 73%.

Policies were in place for deep cleaning processes for ambulances and staff followed trust policy on the prevention protection and control of infections. The make ready service provided at ambulance stations improved the quality of services provided for staff and patients due to the timely replenishing of equipment and the maintenance of vehicles. However, there was no overarching audit in place to check that vehicle daily inspections were at the correct standards.

The service had clear pathways for ambulance crews to follow when responding to life threatening conditions. Staff had a copy of the Joint Royal Colleges Ambulance Liaison Committee guidance (JRCALC) assessment and triage guidance available to refer to, either on their person or in the emergency response vehicle.

Ambulance crews followed medical protocols to assess patients and plan their care. Staff made effective use of protocols, supporting guidance and pathways in their assessment of patients, for example the JRALC.

Staff treated patients with compassion, dignity, and respect at all times and patients were happy with the services provided.

Staff told us that there was very little support for them regarding helping patients with mental health and staff did not receive training to meet complex need, for example, mental health, dementia, or learning disabilities.

Access to mandatory training was not always possible and we found that consistently across the trust, staff was not accessing training relevant to their respective roles in a timely fashion. Skills mix on some emergency vehicles were not always appropriate.

Patient paper records were not always secure on emergency vehicles or in some ambulance stations, however the records we observed where in the main accurate legible and reflected the needs of patients.

EEAST had a valuable team of community first responders who offer support to their local communities and there were opportunities for staff to engage in community based emergency roles, including the Eastern Anglian Air Ambulance.

Staff appraisal and supervision is not carried out consistently across the trust, we found examples where staff appraisals were out of date and where staff had not had any clinical supervisions due to the demands of the front line service.

Governance of independent providers was robust and the service held a risk register to manage significant risks that could have detrimental effects on the service.

Staff often worked longer than their expected hours due to delays at hospitals and morale was affected by this, and some staff were disillusioned with the trust. However in the main staff were positive regarding the opportunity of working with the new trust Chief Executive officer to bring stability and direction to the service.

Emergency and urgent care services

The trust vision and strategy was not widely known or understood by the staff teams and remote workers felt isolated at times due to the leaders not being visible.

Are emergency and urgent care services safe?

Requires improvement ●

We rated the safety of emergency and urgent care services as requires improvement because:

- Staff did not manage medication in line with the trust policy and medicines were not always stored safely or audited effectively.
- Incident reporting and learning from incidents was not consistent across the trust.
- Staff experienced excessive hand-over times at some acute hospitals which drained the trusts resources and reduced the ability to meet the service demand.
- Staff were dedicated to their roles however, staff reported regularly working more hours than their shift allocation. This was having an impact on morale and some staff told us they were looking to leave the service due to frustrations over workloads and working hours.
- Staff essential education or mandatory training, was not always undertaken because of operational pressures and rates of completion did not meet trust targets.
- Although processes were in place for responding to major incidents, many staff had not received training.

However, we also found:

- Staff knew safeguarding processes and reported concerns appropriately.
- Staff reported Incidents through a single point of contact (SPOC) and learning from incidents shared with the staff teams to improve practice.
- Policies were in place for deep cleaning processes for ambulances and staff followed trust policy on the prevention protection and control of infections.
- Staff used the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) to assess patients and responded appropriately to risk.

Incidents

- The trust had an effective policy and process for the reporting of incidents and near misses. Staff used a single point of contact (SPOC) to report incidents and staff were encouraged to report incidents and knew how to do so.

Emergency and urgent care services

- The trust reported 64 serious incidents (SI) and no 'Never events' between January 2015 and January 2016 this was a reduction of 28% based on the number of incidents reported in 2014 / 2015. Treatment delays meeting the SI criteria accounted for 34% of serious incidents and 31% of SI related to the suboptimal care of deteriorating patients. The service had nine open serious incidents in Hertfordshire, two in Bedfordshire, and one in Luton. In Essex, there were 16 serious Incidents reported and seven root cause analysis (RCA) were due to be uploaded. The majority of serious incidents were reported following; delays, non-conveyance, clinical assessments, equipment failure, or computer aided dispatch (CAD) system flagging issues. In Essex, we reviewed nine and the investigations were completed thoroughly. There was reference made to apologies and contact with families. 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. East and West Suffolk staff reported eight serious incidents following the incidents staff undertook investigations, and produced root cause analysis (RCA) and action plans to lower the risk of reoccurrence.

- Incidents were reviewed on a serious incident investigation template but did not fit the national patient safety agency (NPSA) framework for a serious incident, as they were confirmed as incidents but not serious. The trust informed us that these were incidents that, though not serious, required a RCA to be completed which is why they appeared on the template. Our review of incidents showed investigating and reporting to be inconsistent across stations. We saw recommendations for staff reflection and training after investigations. One staff member informed us they had only completed one electronic incident report in twenty years. In East Suffolk, senior staff did not consistently update action plans, following SI. Dates for completion of actions taken or changes implemented went unrecorded. Of the four action plans submitted, staff had documented some progress on only two and none were fully complete.

- In East Suffolk the duty locality officers (DLO) produced a report for 2015 that identified 316 incidents. The report included a trend analysis to identify the themes,

which included vehicle accident had accounted for 52 of the incidents, staff injury 28, staff experiencing incidents of violence and aggression 54, operational five, medicines management 32 and equipment 17.

- Senior staff had recognised the usefulness of a trend report, in December 2015, and suggested sharing on a wider scale to enable other stations to replicate. DLO from West Suffolk had discussed this with EEAST but at the time of inspection (could not replicate a similar breakdown when requested). Staff confirmed that this was planned for 2016.

- Staff told us they could choose to receive feedback on any individual incidents they had reported.

- In all stations, we visited in Cambridge and Essex feedback on incidents was available either on notice boards or in a single incident file that was up to date and referenced. These files were easily accessible to staff and stored safely in a private office space where public did not have access. Learning from incidents varied across Essex, in Clacton we saw good practice in relation to a serious incident that had occurred in January 2015. However in Norfolk, three members of staff stated that feedback from incidents either did not happen or was delayed. Another member of staff stated that they no longer reported incidents, as they did not feel it was worthwhile.

- Some staff were able to tell us about changes in practice because of incident investigation. For example, there had been changes to drug storage following an incident involving the theft of drugs from a staff member's private car. We reviewed the incident in detail and saw the trust carried out a root cause analysis of the incident and took action to ensure the staff had support following the incident and there were changes in practice.

- At Huntingdon ambulance station, staff kept a serious incident board with up to date information on incidents and showing how staff dealt with them and staff showed us the station SI folder (All incidents were collated here). The trust had reported some SI's relating to malfunction with defibrillators and pads and information on the notice board asked staff if they found any issues to note the batch number and report it immediately. The trust wide number of incidents chart on display showed that between April 2014 and January 2016 incidents had

increased. There was also information on display about safety netting showing the steps to follow when dealing with an incident, numbers to call and the names of patient safety team as well as examples of SI criteria and never events.

- The Hazardous Area Response Team (HART) learning from incidents is through the National Ambulance Resilience Unit (NARU). For example, in response to the London bombings HART installed satellite communication in the command vehicles, including body cameras for staff transmitting through to a laptop to improve communication and assessment of a scene.

- Staff knew of their responsibilities under the Duty of Candour. They described being open and transparent and admitting when something was wrong.

Mandatory training

- Mandatory training for emergency and urgent care staff at East of England Ambulance Service (EEAST) is supported by the trust Learning and Development Unit (LDU). Mandatory training is split into two categories, initial mandatory training required by all new staff entering the trust, and annual mandatory training to existing staff.

- The trust had a mandatory education programme, which ran over a 12-month period. Professional Updates (PU) days ran over an eighteen-month period due to capacity demands. Mandatory training included a wide range of subjects including, amongst others, fire safety, manual handling (Non-patient), slips trips, and falls, safeguarding adults and children and IPPC. Timescales for the required completion of the elements varied between one and five years depending on the subject matter and trust policy.

- Mandatory training performance data supplied by the trust showed that participation rates were intermittent and achievement against the trust varied between staff groups over time. Between April 2015 and April 2016, 25% of clinical patient facing staff, 14% non-clinical staff, and 80% of new staff completed their mandatory training across Cambridgeshire. Compliance rates across Bedfordshire and Hertfordshire included ambulance technicians 78%, clinical support 100%, emergency care assistants 63%, and paramedics 86% and student paramedics 30%.The trust target was 56%, demonstrating that staff groups in these areas were

exceeding this target. Between March 2015 and April 2016 in Norfolk, 40.38% of staff had completed mandatory training, 39.69% staff had completed statutory training and 6.46% staff had completed other training, for example management and leadership training. In Essex, mandatory training figures for all staff (including non-clinical) at 31st March 2016 were: Mid Essex 92.2%, North Essex 55.9%, West Essex 79.8%, South West Essex 87.5%, South East Essex 94.9%. Data showing completion rates provided by the trust for Suffolk were poor across the board and ranged from 0% to 65% over the last year. Resilience training (supplied via a DVD) was the only training shown as 100% across the whole Suffolk staff base. This meant that we could not be assured that all staff were trained in all mandatory aspects to ensure patients received safe care and treatment.

- In Suffolk staff were issued with mandatory and update handbooks for 2015/16 whilst the format of statutory and mandatory training were being updated. Staff had the responsibility for completing handbook which should then be assessed locally by the line manager and then sent to the trust compliance administrator for recording. Data provided showed that compliance varied across training and staff groups. For example out of 226 paramedics, 148 had completed airway skills level 2 training (65.4%) in comparison, for the same training, 34 out of 61 ambulance technicians (55.7%) were compliant and only 9 out of 65 (13.8%) for emergency care assistants (ECA).The average compliance across all groups and all training for 2016 was 21.8%.

- Paediatric assessment was part of mandatory training and was last recorded for the majority of staff in 2014, however this did not reach the required 95% completion suggesting that not all staff are up to date or competent in Suffolk.

- Emergency ambulance staff completed a three-week emergency driving training course during recruitment and following a further two weeks of training qualified staff can then drive on blue lights in an emergency. In Norfolk, staff did not receive any driver training once they were qualified. One staff member stated they had not received any driver training since joining the trust over 20 years ago. In Suffolk, updates or driving checks were inconsistent. Some staff stated they should have a supervised 'ride out' every five years whilst others were

unsure. Only one of the crew members in Suffolk remembered having had a supervisory driving check in the last five years. Data provided by the trust indicated that driving competencies had been checked and reassessed at the correct predetermined intervals.

- All staff required to drive under emergency conditions were trained to the national standard 3 week driving course. There is no national requirement or legislation for trained staff to undergo any additional training. The Trust is a national early implementer for a 5-yearly based assessment of high speed/ emergency driving skills in anticipation of new high speed driving legislation being brought forward.

- The trust recruited a significant number of student paramedics and emergency technicians whose training was prioritised by the trust. Established staff told us the training implementation had affected staff morale as some felt that new or trainee staff were often treated more favourably than more established staff. Student paramedics do not receive mandatory training whilst they are students in Suffolk. The reason given for this was that the training itself should cover the requirement however staff disputed this. It was unclear if data provided included student numbers. Following the inspection, the trust informed us that there were some challenges in Suffolk due to governance arrangements in place at the time making the evidence provided to the inspection team less robust.

- Completion rates for NHS Prevent training across the trust were 90%, Prevent is part of the Government's counter-terrorism strategy and aims to stop people becoming terrorists or supporting terrorism. NHS England guidance states staff must be able to recognise signs of radicalisation and be confident in referring individuals who can then receive support appropriate to their needs.

- Staff received two days professional update (PU) training, face to face every 18 months, based around themes identified by the clinical department. PU training had been annual however; due to increase clinical demands on the service, this had been changed to an 18-month programme in April 2015 in the hope that this might be more achievable. PU audit was undertaken in West Suffolk and data demonstrated that compliance with the two day PU was at 76%. Mandatory training remained at 12 month intervals.

- There was inconsistency with recording licence checks with some staff unsure when their last check had taken place. The trust policy on checking staff driving licenses states that driving licenses will be checked by the relevant Line Manager, as and when required or at least on an annual basis. East Suffolk records showed that 78 staff had their licences checked, the majority undertaken between November 2015 and March 2016. No data was provided for West Suffolk. In Essex the trust were non-compliant, out of 812 licences, 674 were in date, 32 had expired, 22 had no check completed and 84 checks were overdue. Of the 87 driving licenses within HART, 27 were in date, four expired, five had no check completed, and 51 were overdue, we escalated this at the time of inspection.

Safeguarding

- There were comprehensive policies for safeguarding children, young people and adults at risk and staff were aware of these policies and knew how to raise safeguarding concerns through a single point of contact (SPOC) dedicated phone line.

- Ambulance station notice boards displayed safeguarding contact numbers and safeguarding bulletins and ambulance staff kept mini reference cards in their pockets or on vehicles containing the SPOC details.

- All staff received an induction that included safeguarding as part of that training. All support service staff had to complete level one safeguarding training, and all ambulance crew staff level two.

- Frontline staff received training in relation to female genital mutilation (FGM) and child exploitation; with awareness information of FGM displayed in some ambulance stations. If ambulance crews had concerns around the safety of children they would alert the police if they were not for transporting to hospital. If the child went to hospital a referral was made to the single point of contact centre.

- All staff had recently received safeguarding adult's handbook incorporating mental capacity act and deprivation of liberty, 'Prevent' and female genital mutilation) which had recently been distributed across the stations.

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- Trust policy states that safeguarding training updates are required every two years. Staff completed mandatory sections of a training workbook mandatory training and updates manual 2015/16 to ensure they are competent in recognising, responding, and referring to a safeguarding issue.

- Data supplied by the trust indicated that in Cambridgeshire 73% of ambulance technicians, 77% of paramedics, 57% of emergency care assistants, and 34% of student paramedics had completed the safeguarding level 2 training within the last 12 months. Compliance to safeguarding level two training amongst clinical staff in Norfolk was 82% for technicians, 50% for clinical support staff, 58% for emergency care assistants, 8% for healthcare referral teams, 83% for paramedics, and 61% for student paramedics. In Essex 90.9% of staff had completed the training. Data provided by the trust showed that 65.4% in Suffolk last year with an overall 34.2 % across clinical and patient facing Suffolk staff. However, these figures differed from those supplied by the safeguarding lead that stated overall patient facing staff compliance at 74%. Regardless of the discrepancy, this meant that staff were not complaint with the trust target of 95%.

- The trust has a safeguarding committee that meets on a quarterly basis. Representatives from across the trust staff team are present at the meeting and they discuss key issues, for example, resources, training, and the outcomes of serious incident reviews.

- Feedback from raising safeguarding concerns or making safeguarding referrals was inconsistent in Norfolk. One staff member stated they had never received feedback from a safeguarding concern raised; another staff member was able to explain the feedback they received after making a safeguarding referral.

- In Suffolk, the number of safeguarding concerns raised by staff had risen over the last year with over 200 referrals in March 2016. This rise may reflect the increased staff awareness of safeguarding issues and senior staff saw this as a positive sign of staff taking their responsibilities for safeguarding seriously.

Cleanliness, infection control and hygiene

- We observed staff following the trust hand hygiene and 'Bare below the Elbow' policy, and staff in Cambridgeshire wore personal protective equipment at all times. Cambridgeshire staff washed their hands in line with the World Health Organisation's "Five Moments of Hand Hygiene" guidance between personal activities with patients. In Norfolk, not all staff were compliant with bare-below-the-elbows and good hand hygiene practice. Two staff were observed using alcohol hand gel before and after patient contact, however one staff member was observed not being bare below the elbows and two staff were wearing rings with stones in. In Essex, Bedfordshire and Hertfordshire all staff had supply of their own hand gel for decontamination. Overall compliance for hand hygiene in Essex was reported as 96.6% this result was obtained by completing 15 personnel hand hygiene audits each month. Overall compliance for hand hygiene in Bedfordshire and Hertfordshire was 96.6% this result was obtained by completing 15 personnel hand hygiene audits each month.

- Standards of cleanliness were not consistent across Bedfordshire and Hertfordshire with only one station employing an Ambulance Fleet Assistant (AFA). Other stations in this area confirmed it was something that they were implementing, as the AFA role demonstrated a higher level of cleanliness and preparedness with fewer out of date equipment as seen on our inspections of operational vehicles. AFA staff were available in Stowmarket, Ipswich, and Bury St Edmunds. These staff could deep clean a vehicle. At other stations, staff were responsible for cleaning vehicles and equipment. A vehicle-cleaning manual was available for all staff across the trust, and a cleaning specification frequency document detailing the required cleaning task and the location for that task, we saw completed records of the cleaning checklists.

- All operational vehicles seen during the inspection were cleaned between each patient episode but staff told us this was not always possible because they did not have protected time to do this before they were required to answer another emergency call. Operational vehicle audits completed monthly had an overall 95% trust target and every vehicle audited at least once per quarter. In 2015-2016 Bedfordshire and Hertfordshire achieved 94% operational vehicle cleanliness. In Suffolk vehicle compliance for cleanliness was 98.4% and had remained consistently above the national patient safety agency (NPSA) target level of 85% over the last 12 months. In Essex the HART site in Essex was 100%

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complaint. Vehicle cleanliness audit results for Essex stations were between 97-100%. At Chelmsford station there was a roster for deep cleaning of vehicles and the cleanliness audit for February 2016 was 94% and at Southend 100%.

- The trust offered Hepatitis B vaccinations to their staff. We spoke to three support staff and one identified that he had not attended for Hepatitis B vaccination. This was fed back to the locality manager who was not aware of this oversight.

- Thirty uniform compliance audits in Bedfordshire and Hertfordshire had been completed twice a month with an overall service target achievement of 95% for 2015. During the inspection, staff were observed wearing necklaces, rings and a wristwatch while dealing with patients. We were aware of management pressure to ensure uniform policy compliance as outlined in location meeting records. The uniform compliance audit for Essex between May 2015 to March 2016 was 100% for HART and between 97-98% for Essex stations which is above the trust target of 95%l. In Cambridgeshire staff maintained their uniforms in good order and all staff wore clean and well-presented uniforms. Huntingdon ambulance station had a dedicated waste bin for staff to deposit damaged uniforms for safe collection and disposal.

- Infection, prevention, protection, and control (IPPC) audits are done by staff on a monthly basis for vehicles and stations and bi monthly for uniforms. Staff can access the trust IPPC staff for advice on IPPC at any time via email and office hours by phone. The IPPC team carry out quality assurance across the stations and we saw the IPPC lead carrying out a routine audit during our inspection.

- Station cleaning compliance was 95% for Bedfordshire and Hertfordshire for 2015.

- Vehicle daily inspections (VDI) were carried out at all the stations we visited to ensure that vehicles were safe and fit for purpose. There was no effective system for auditing completed VD and we found no evidence of staff auditing the VDI documentation.

- Staff reported vehicles unfit for use to the duty location officer (DLO) and the vehicles immediately removed from services with an 'Out of service' sign placed in the vehicle window.

- During the inspection, we spoke with three cleaners based at three separate locations. We spoke with one cleaner who was at the centre of operations for the ambulance station. Staff told us that the cleaner worked seven days per week, even during Christmas. The cleaner had a big impact on morale and teamwork at the station due to their pleasant and caring nature and they always went the extra mile to care for staff. One cleaner we observed following the correct IPPC procedures and cleaning schedule and taking great pride in maintaining the ambulance station environment to a high standard.

- At Addenbrookes station staff were utilising a jet washer to clean both the ambulance exterior and interior / patient trolley prior to going back out on the road following an incident. The ambulance crews took great pride in maintaining their vehicles. However, the AFA at one station told us that some ambulance crews did not seem to care about the vehicles as they were only on relief or using the vehicle on an ad hoc basis and left them in a state of poor hygiene when they finished their shift. We saw no evidence of this during our inspection.

- Sterile consumables were stored correctly on ambulances. However, we found some equipment packaging damaged and brought this to the attention of the staff on duty and they replaced these immediately. On one ambulance, the ambulance crew had prepared a small emergency kit containing sterile dressings and fluids ready for use at an incident, our specialist advisor saw this as good practice.

- Advice regarding IPPC was available in prominent places at all ambulance stations including specific knowledge on the infection and hygiene risks associated with individual patients.

- When operational vehicles are contaminated crews clean them with wipes, which were available on each vehicle. The support staff used a decontamination fluid as part of the vehicle cleaning regime. Guidance for use was in the IPC manual and vehicle cleaning guidelines.

- All ambulance stations had clinical waste bins; these were marked as confidential waste only and locked when checked. Prominently situated on notice boards

next to the waste bins was advice for staff to follow the correct protocol for handling hazardous waste. We noted that on all ambulances we checked that the clinical waste and sharps were stored appropriately.

- At Huntingdon station, IPPC boards had a national colour-coding scheme for ambulance cleaning materials and equipment. Information was readily available for staff on the prevention protection and control champion role, uniform washing advice, what to do in the case of a sharp injury and the IPPC management policy. The vehicle cleanliness audit for February 2016 included the station, Norfolk, Suffolk and Cambridgeshire locality and the trust. Results of the audits showed vehicle exterior cleanliness at 100%, cab interior 100%, saloon interior 99.2% and the equipment checklist was 98.7%.

- There were 185 infection control incidents across the trust last year. Of these 54 were due to contaminated sharps, 42 to clean sharps injuries, 31 to splash incidents, 15 to exposure to infectious substances or patients and 43 labelled as other. The sharps injuries have been investigated and reported on the trust website with actions taken.

- The majority of consumables checked during inspection in Suffolk, were in date although two bottles of cleaner in the ambulance station at Beccles were out of date (2012), we informed a member of staff to ensure these were replaced.

Environment and equipment

- Staff had access to a wide range of resources to restock vehicles as and when they were required. At some stations, AFA were utilised to restock equipment and ensure that equipment was checked and replenished. Replenishment of vehicle equipment and supplies happened at ambulance stations or at local acute hospital trusts in between patient calls. In Luton, Peterborough and Hinchingbrooke we saw the make ready services being used that enabled ambulance fleet assistants (AFA) to prepare vehicles for the crews, make sure stock was resupplied and cleanliness of the vehicles was of the correct standards. There were other assisted stations throughout the East of England.

- The trust's Vehicle Daily Inspection (VDI) for emergency vehicles in Bedfordshire and Hertfordshire was not always completed as required at the beginning of each

shift. Staff told us this was because they did not have protected time to do this and were often asked to respond to emergency calls. The trust policy was only to disturb staff for the most urgent of calls (R1). We found vehicles in operation which had out of date equipment or medications.

- In Norfolk, the clinical engineering department undertook the maintenance and repair of medical devices. Clinical engineering staff routinely attended stations to maintain and repair medical devices on a weekly rota. Records of maintenance and repair were kept and equipment was maintained in accordance with manufacturers' guidance. Equipment was labelled showing the date of renewal or replacement, and when a service was required.

- Staff were aware of the process for reporting faults on vehicles or equipment but they expressed concerns that replacement vehicles and equipment repairs were not always available promptly. In Bedfordshire and Hertfordshire, we saw the medical device servicing which was up to date, but we found the majority of vehicle fire cylinders were overdue for servicing. In Cambridgeshire records of equipment maintenance and schedules including vehicles and medical devices were in date and followed a routine schedule of equipment renewal and repair. Staff informed the DLO of any faulty equipment and this was dealt with on a priority basis, for example, if a decision was required, that may result in a vehicle being taken off the road. Staff informed the DLO of any faulty equipment and this was dealt with on a priority basis, for example, if a decision was required, that may result in a vehicle being taken off the road. At the Waveney and Kings Lynn depots rooms were split into equipment not for use and awaiting the EBME, and equipment seen and ready for use. Logbooks were kept by the AFA's with details of all equipment in the room and its status. Not all equipment was within recommended service schedules in Suffolk. Two cardiac resuscitation device monitors were in use on ambulances that were at least eight weeks past their required service dates. Staff had not noticed this during vehicle checks at the beginning of the shift. We brought this to the attention of crewmembers and both pieces of equipment were replaced the same day. At Ipswich, there was a full process for service and maintenance for each vehicle.

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- At Ipswich, the logistic lead had complete oversight and knew vehicle numbers and exactly how many vehicles were available at any one time. A tracker spreadsheet was kept at both East and West Suffolk and was utilised to record and highlight service checks, servicing, location, mileage, MOT and vehicle tax. This meant that staff had oversight and a system in place to identify availability of double staffed ambulances and cars.

- The team had been proactive with arranging spare tyres at the station at Ipswich, as the tyre size for ambulances is not standard and this meant that should a tyre need replaced out of hours or at weekends crewmembers had this source available to enable the ambulance to remain roadworthy with the minimal delay. However on checking these tyres three out of the six stored at the garage had visibly too little tread to be safe or legal to use. We brought this to the attention of staff, who stated that crew would pick the best tyre available.

- In Norfolk, conveyance in vehicles was not always safe and secure. Two members of staff were observed not using seatbelts in the back of ambulances and one child patient was observed not appropriately secured in the back of an ambulance.

- Equipment was available for staff that was suitable to their roles including specific patient groups, for example children and bariatric patients. We saw that the trust had adapted an ambulance to take equipment specifically designed for use with bariatric patients and could transport them to appropriate location based on their needs.

- Crews were required to complete the trusts vehicle inspection record at the start of each shift, which checked the vehicle and equipment, for example drugs bag, were correct and present. We reviewed 47 completed audits across Essex and between October 2015 and February 2016, 10 were not fully completed. Staff told us that although they were allocated 15 minutes at the start of the shift to carry out the checks; this was not always possible as they were often asked to respond to emergency calls. Staff told us that they would often complete the checks whilst they were waiting to off load at emergency departments.

- Individual ambulance stations kept records of all emergency vehicles and their roadworthiness. Staff we

spoke with said that emergency vehicles were repaired in a timely fashion and we saw no concerns during inspection of ambulances being out of service for long periods.

- In Essex, we saw the HART secured locker areas where equipment and personal protective equipment such as water and ballistic uniforms were kept. There was a log for the checking of breathing apparatus that was in date and had designated breathing apparatus champions who carried out daily checks.

- Ambulance station facilities and premises in Suffolk were varied with some locations being of recent construction and built for purpose and others being cramped. At Bury St Edmunds station, crewmember's lockers for personal equipment were in an ambulance bay in the garage area and at Sudbury, the office and rest area were on the third floor of an old building with three flights of narrow stairs. A paramedic felt this potentially hindered the 9-second confirmation time when responding to a call.

- At Peterborough station we saw a member of Royal Mail staff enter into the ambulance servicing areas, unchallenged via a security door. We had previously checked the security of the door used, which only allowed access to the ambulance bay by a unique touch coded key pad. The Royal Mail operative must have used the keypad code to enter the building. We raised this as a concern with the ambulance station DLO at the time of the issue occurring. However, on our unannounced visit, staff had not changed the security key code and we were not assured this area was secure.

Medicines

- We found staff were not routinely following trust policy on the management of medication and in the majority of cases staff were unsure of the medications policy or if they were following its guidance. We also asked students if they were aware of trust policy in regard of medication, most knew the trust had a policy but were unsure if they were following this correctly or not.

- Staff administered medicines to patients with the legal authority to do so. The trust had Patient Group Directives (PGD's) in place to cover the administration of a list of authorised medicines. A PGD is a written instruction for the administration of medicines to a group of patients.

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- The management and access to controlled drugs was not always managed safely or following good practice. Controlled drugs (as defined in the Misuse of Drugs Regulations 2001 and its amendments) are medicines that should be stored with extra security and recording arrangements in place. We found variations in how medicines were stored at different locations across the trust. In Bedfordshire and Hertfordshire, medicines were not always stored safely outside of the station office area. For example, we saw poor medicine cupboard security, master keys for controlled drug medicine cupboards on ambulances held by staff which were able to access different vehicles and medicine storage rooms not locked in Cambridgeshire, and Bedfordshire. In Suffolk and Cambridgeshire CDs were stored in a locked locker box in the rear of rapid response vehicles and a double locked cupboard in ambulances. However, the keys were unsecure elsewhere in the ambulance. One paramedic in Suffolk, had CDs in his pocket which was questioned by an inspector and request made to secure them appropriately within the ambulance. We escalated this at the time to a senior member of the team. We observed ambulances waiting at accident and emergency departments across the Cambridgeshire area. In some cases, staff had fitted a small plastic envelope to the inside of cupboards inside the ambulance, for the purposes of depositing safe keys. Sometimes ambulance staff left ambulance tailgates down and doors open when taking patients into the accident and emergency departments of hospitals. We also noted that on occasion keys for safe storage areas were left inside the vehicle, this meant that a person could enter the vehicle, remove the key, and possibly access other vehicle safe storage areas.

- At Southend, we observed controlled drugs such as Diazemuls and Diazepam were kept in medication grab bags, which were left in the vehicle, whilst it was unattended and unlocked. One ambulance had the controlled drugs key left in the controlled drugs safe, which was against policy, in which the key was to remain with the paramedic.

- An ambulance arrived at Hinchingbrooke Hospital accident and emergency department and we noted that the ambulance crew had separated all of their respective safe storage keys leaving them inside the locks within the vehicle. Staff left the patients medication on a shelf inside the ambulance whilst the

ambulance crew took the patient into the accident and emergency department and the vehicle doors and tailgate were open. This posed a significant risk as a person could enter the unattended vehicle and take the medication unchallenged or enter any of the safe storage areas using the staff keys.

- All clinical staff at Peterborough ambulance station could access the medication store by using a key code, and staff told us that this key code is not routinely changed and there was no internal CCTV. The records within the monthly check book for signing out drugs packs were accurate and up to date. We checked three drugs bags, all medication was in date and records accurate and robust.

- In Suffolk, each paramedic carried a personal controlled drug (CD) record book for the issue of morphine booked out to them from hospital pharmacy. The trust policy was to audit and have these signed monthly. There was inconsistency in the signing and audit, some were signed regularly and others only once in the last six months. Data provided for Suffolk showed only 26 books out of 87 as audited between December 2015 and January 2016.

- In Norfolk, controlled drug checks should be completed monthly, with an administrator monitoring the checklists each month. If two months went by with no checks being recorded by any paramedic then this was raised with the DLO to chase the paramedic in question to complete their check the next month. This meant that controlled drugs sometimes went unchecked for up to three months.

- Local audit activity in Bedfordshire and Hertfordshire included the checking of controlled drugs. During the inspection, we found that the EEAST clinical manual guidance did not match the trust medications policy or practice observed (pages 485-492) as the clinical manual included some information relating to primary care centres which the trust no longer operates from. In Southend staff told us of discrepancies in drug counts and that stock levels were not recorded accurately. There were clear audit trails were in place for checking medicines at Chelmsford, Basildon and West Suffolk stations. We saw that the checking system ensured that the medicine packs were within date and contained the

required medicines for paramedics and technicians attending to sick or injured patients. Audit reports were sent monthly to the medicine management lead that checked to ensure there were no issues.

- At Colchester, we saw an electronic incident report raised following a patient missing a dose of adrenalin. This was tracked back to a member of staff who had administered the drug during a cardiac arrest, but had not recorded it; the crewmember was dealt with via the trusts disciplinary procedures.

- In Norfolk, controlled drug denaturisation was not conducted or witnessed by an authorised person. (Denaturing of controlled drugs (CDs) typically involves physically mixing the medicines with a binding matrix to make the material physically irretrievable in a safe waste chain). Controlled drugs were denatured by paramedics or managers with administrative staff signing as witnesses. This meant that the trust was not complying with controlled drug regulations

- Medical gases such as Oxygen and Entonox were stored according to trust policy at all stations we visited during the inspection.

- Medication "grab bags" were available at some station across the trust. The bags contained required medication for crew to carry. Once medication had been used, the crew could return to base, and rather than refilling the bag, had a dedicated area to return and pick up a new, tamper sealed "grab bag." Staff told us that this process was extremely helpful. The frequency of drug bag checks was inconsistent across Norfolk. In Kings Lynn, checks were completed weekly, in Thetford and Norwich checks were completed monthly. Drug bag checks were never audited, this meant that the trust could not be sure that checks were completed, and was in breach of the trust's own medicines management policy. In Suffolk, all medications checked during inspection were within their expiry date. There had been a change in the supply of some medications resulting in smaller vial sizes which did not fit snuggly in the 'pockets' of the bags. This meant that ampoules frequently worked free in transit and fell out when the bag was opened.

- Medicine fridges did not have recorded temperature checks in Norfolk. This meant that we were not assured that temperature sensitive medicines were consistently stored at the correct temperature in accordance with the manufacturer's guidance.

- At Basildon, medicines were locked securely in cupboards with access available only to paramedics; however, the medicine storeroom felt very warm. There were no arrangements in place to check the temperature of the room to ensure it was below 25 degrees centigrade for the safe storage of medicines. The DLO agreed it would be useful to check the room temperature especially as it was so warm.

- Across all sites in Essex, the expiry date of Glucagon (a treatment for severe low blood sugar) was not recorded on removal from a refrigerator. Glucagon is safe to use within 18 months out of a refrigerator, however it was not possible to know when the medicine had been removed from a refrigerator to ensure its safe use. The DLO explained that the Glucagon was received from Basildon hospital pharmacy and agreed to discuss this issue direct with the pharmacy.

- Storage of intravenous fluids (IV's) at ambulance stations was not always secure. At Stowmarket and Beccles ambulance stations the IV fluids were in an unlocked store cupboard which meant that there was a potential risk of unauthorised access.

Records

- EAAST had two forms of patient care record forms (PCR); an electronic version (EPCR) and paper version (PCR), however at the time of inspection all staff used written records only and not the electronic system due to concerns over the system not performing correctly. The format of the forms followed Joint Royal Colleges Ambulance Liaison Committee guidance (JRCALC) guidance.

- We reviewed 25 PCR's in Cambridgeshire and one referenced to a do not attempt resuscitation (DNAR) however end of life care was appropriately recorded and communicated when the patient was being transported. Of the records we reviewed, all were accurate, dated, and legible. In Bedfordshire, do not attempt resuscitation (DNAR) orders and end of life care planning was appropriately recorded and communicated when patients were being transported.

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Staff spoken with about DNAR confirmed that this was dependant on the dispatcher informing and communicating advanced directives to the crew. This would avoid any conflicting issues on conveyancing.

- In Norfolk, patient care records were not always completed thoroughly. We reviewed 20 sets of records, one record had the 'form completed by' box not signed, and one record had the box completed with a paramedic's identification number and not their name. Three records did not have the batch number of the medications recorded, two records had no record of whom the patient was handed over to, and one record did not have the mental capacity box checked.

- In Cambridgeshire, ambulance staff gave a copy of the PCR to the hospital staff on arrival and retained a copy, which they deposited back at the ambulance station in a designated record box. If a patient was treated and discharged at the scene or at home, the staff left a copy of the paper PCR with the patient. We found at St Neots ambulance station the record box for storing the PCR was unlocked and non-authorised staff could access patient records. Ambulance stations we visited all had access to confidential waste bins and the bins were collected and contents shredded by an external company, we found these bins locked at all times.

- Within Bedfordshire we found we could access one stations safe as the key was left clearly marked 'PCR safe key' hanging on the wall in the unlocked office. This was not secure and meant any staff could access confidential patient care records. We informed the DLO who immediately moved the key. Across Norfolk some stations had secure post boxes for staff to put the records in at the end of each shift ready to be collected for archiving. In Cromer, records were kept in an unlocked cabinet in an unlocked office although the station itself was secure and accessible only to staff. The DLO was aware and had ordered a combination lock for the office and a large letterbox for the forms to be posted securely. This meant there was an increased risk of potential breaches of patient confidentiality.

- PCRs were not always stored appropriately in vehicles across Essex, for example at Southend we saw that PCRs had been left folded in the front area of the vehicle, which meant that confidential information was exposed to the public. In Suffolk, staff acknowledged patient's

confidentiality, but there were times when patient record forms (PRFs) were left on a covered clipboard in an unlocked vehicle, although not obviously visible to members of the public, it was accessible.

- Staff told us that they had persistently had issues with the EPCR crashing during use and that the technology was 10 years old, often incompatible with other hospitals and the printer system didn't work effectively. Staff felt that the EPCR contained lots of irrelevant information and at the time of inspection all staff used the paper based PCR because of issues with the EPCR system crashing.

- Handover of records between ambulance crews and accident and emergency staff were accurate, timely, and professional.

Assessing and responding to patient risk

- Staff had a copy of the `Clinical Practice Guidelines 2016, JRCALC' to refer to, either on their person or in the emergency response vehicle. The service had clear pathways for ambulance crews to follow when responding to life threatening conditions. Staff demonstrated knowledge of how to treat and manage sick and deteriorating patients including children. We observed ambulance crews across the trust monitoring patient's conditions regularly and paramedics had a range of drugs they could use with deteriorating or seriously ill patients. However in Bedfordshire, the copy we were given by the trust included the Liverpool care pathway, which was phased out on Department of Health direction from July 2013-14, and replaced with an individual approach to end of life care for each patient. The trust informed us that the LCP had been phased out in 2014 but the reference remained in the handbook.

- EEAST staff had access to a dedicated clinical manual 2015/16 that compliments the JRCALC guidance on assessing and responding to patient risks. Guidance on the assessment, diagnosis, and treatment for patients was clear and reflected National Institute for Health and care Excellence (NICE) guidance on pathways for supporting patient trauma.

- The national early warning score was not a standardised East of England Ambulance Service (EEAST) tool but had been piloted in EEAST for pre hospital use. The scores were not validated on ambulance patients. National

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Early Warning Score (NEWS) was intended for people over the age of eighteen, and staff had received details that this should be used with caution in pregnancy. The NEWS score is based on a simple scoring system in which a score is allocated to six physiological measurements including pulse and respiration rates. Vital signs such as respiration and pulse rates, blood pressure, heart rate monitoring, and the patient's condition were recorded on the Patient Care Report (PCR) or on the electronic PCR (EPCR). Any changes or deterioration in a patient's condition informed the clinical decision-making process and urgency of the situation. Staff utilised the faces of pain scoring system in cases where a patient was incapacitated, for example intoxicated or unable to speak. If a patient's condition changed or deteriorated ambulance crews could contact the single point of contact team for clinical advice and guidance.

- The service had a large group of community first responders (CFRs). CFRs are volunteers who respond to life threatening emergencies in their own communities while an emergency vehicle is travelling to the patient. We spoke with some CFR's during focus group activity and they told us they had often waited extended periods for an EEAST vehicle to arrive but the support they received from the ambulance crews was good. We noted at Ely ambulance station that they were utilising a community based defibrillation system mounted prominently on the exterior of the ambulance station as part of the community first response support.

- The health care referral team (HCRT), pick up urgent work but are not trained to drive emergency vehicles under blue light conditions and travel under normal road conditions. These teams can give oxygen, defibrillation (not manual), basic life support and they assist the paramedic who arrives on scene to manage any deteriorating patients.

- Staff told us that there was very little support for them regarding helping patients with mental health conditions. Staff told us that support from the mental health crisis team was sporadic and often the police appeared disinterested if they called for advice or support. Staff had raised concerns with the mental health team regarding the lack of specialist mental health support but often when trying to support patients they felt they were passed around from service

to service without much clarity on the support on offer. In Norfolk, staff worked with the local police force who followed ambulances where appropriate. Only critical care practitioners would sedate patients where necessary, then stayed with the patient to monitor them. Staff based in Waveney had established a relationship with the psychiatric liaison nurse at a local hospital to provide a more effective handover of care for patients experiencing a mental health crisis.

- Policies and procedures were in place to manage disruptive behaviour through the trust policies, clinical manual and safeguarding book dated April 2015 which all staff spoken to confirmed they had received. Staff did not receive any training in restraint or de-escalation to support patients showing violent or challenging behaviour due to mental health. There was no restraint policy in place at the trust as the trust did not advocate restraint unless under common law principles or best interests decisions and was awaiting national guidance in safer holding. Staff did tell us that general practitioners (GP) would offer support via sedation where possible.

- The majority of patients that required admission required a double-crewed ambulance (DCA) to convey to hospital. This meant that a solo responder might have a delay waiting with a patient until a DCA became available. Staff stated that at times the solo responder would travel alongside the DCA to provide support if required. This depended on the skill mix of the crew on the DCA and the clinical acuity of the patient. In Bedfordshire we saw one team of two ECTs who required a paramedic review following patient assessment, which was not immediately available. This meant the risk to patients could be increased because of a delay in getting to a hospital.

- In Suffolk, the trust had clear pathways in place for ambulance crews and rapid response staff to follow. For example, the East Suffolk vascular (AAA) pathway which also identified the primary divert hospital. This meant that the patient would be transferred to the most appropriate place for clinical care or the nearest depending on clinical risk.

Staffing

- During our inspection of the trust in April 2016, we found the trust had recruited 400 new student paramedics to

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its service due to the trust increasing the number of employees required to meet the needs of the service. This meant that in the majority of cases ambulance crews had a student member as part of their team. Ambulance crews therefore had a range of experienced and suitably qualified, skilled, and experienced staff to meet the needs of people who used the service in a timely way.

- The staff vacancy rate differed across the trust. The rate on 1 April 2016 was 34% for the overall trust. Within Bedfordshire 26.93 whole time equivalent (WTE) 9.58% and Hertfordshire 67.19 WTE 13.9 % vacancies; the total numbers of employed staff was 658.09 WTE. In East Suffolk there were 169 whole time equivalent WTE staff and West Suffolk 138 WTE. East Suffolk had higher numbers of all staff with the exception of emergency care practitioners (ECP) and health referral carers (HRC). The overall vacancy rates for Norfolk, Suffolk and Cambridge combined showed the highest vacancy rate was for ECP at 58.6% at the end of December 2015. There was a 35% vacancy rate for paramedic supervisors and 20% vacancy rate for technicians and emergency care assistants.

- In Essex the vacancy rates were; paramedic supervisors 36.5%, emergency care practitioners 1%, paramedics (including students) 1%, technicians (including emergency care assistants) 25.8%, divisional locality managers 0.2%, other (including administration and depot staff) 16.2%, Essex had the highest vacancy rate across the trust of 14.1%. Norfolk, Suffolk, and Cambridgeshire had a vacancy rate of 3.24%. This was the lowest in this core service for the whole trust. For the period April 2015 to March 2016, 20.53 whole time equivalent (WTE) qualified staff had left the trust.

- The Duty Locality Officers were over established by 14.81% in Bedfordshire and Hertfordshire. The remaining vacancies submitted by the trust showed that there was a paramedic supervisor's vacancy of 56.35%, emergency care practitioners (ECPs) vacancy of 57.31%, paramedic vacancy of 3.61%, technicians 21.81% and depot and administrative staff vacancy at 35.66%.

- Data provided by the trust showed during 2015, 66% of the staff establishment were permanent employees and staff bank usage was 34%. Agency costs against the staff establishment were 7%during the same period.

- Staff turnover for 2013/14 was 7.52%, in 2014/2015 this increased to 7.72% and during 2015/2016, this dropped to 7.34%. Senior staff informed us that 'there were not enough paramedics to crew every vehicle and car in Suffolk. If the budgeted quota was reached, it was still 20% short of safe working levels and national guidance. Results from the Trust staff survey 2015 showed that 89.9% of staff were working extra hours against a national average of 83.4%. Data supplied by the trust showed the HART team establishment was 80 WTE between April 2015 and April 2016, with a vacancy rate of 5%.

- Lack of resources meant that sometimes-double ECT crews were sent to emergency calls, who then had to wait with the patient until a solo paramedic with appropriate skills attended and treated or accompanied the transfer of the patient to hospital.

- Staff had mixed views on staffing rotas and shift allocation, in the main staff felt that the twelve-hour shift rota was good for staff as it gave a balance between working hours and days off. However late shift finishing times due to waiting at hospitals or staff being placed on jobs at the end of their shift which took them out of region was having an impact on staff morale.

- The emergency operations administrator alongside the DLO planned the staff shift patterns and allocated ambulance crews to vehicles on a six weekly rotation to ensure that staff skill mix and abilities matched the needs of the service. There were two types of staff rota in Suffolk. 80% of staff were rostered on a permanent rota with the benefit of regular shifts booked weeks in advance. 20% of staff were relief which meant that they did not follow a rota shift patter but were used fill gaps in shifts. This meant that they worked more nights and weekend shifts. Most shifts followed a 12-hour pattern.

- Staff spoke very positively regarding the student pathway and felt that in time the service would have more highly qualified and competent staff, but there were worries amongst staff that these staff may then leave the service once qualified. However the mentor to student ratio in Norfolk was unbalanced, the mentor to student ratios for in April 2016 were 29 mentors with four students, 21 mentors with three students, 11 mentors with two students and two mentors with one student each. This was contrary to one paramedic stating that some mentors had between six to eight students.

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- Between September 2013 and August 2015 the trusts sickness, absence rate did not rise above 10% and was in line with the average sickness absence rates of other trust during this time. During inspection of March station, we observed the DLO dealing with a staff member who had attended for shift and was unwell. The DLO was extremely sensitive to their needs, spoke in a private office, and gave time for the staff member to make decisions on how they would deal with their absence together. Staff said that in the main, the trust was responsive to their needs, but some staff felt the absence management procedure was being used as a disciplinary tool rather than a supportive way of helping people to maintain their well-being.

- Data provided from the trust showed that staff sickness levels were higher in West Suffolk than in East Suffolk for both long and short-term sickness. The average long-term sickness rate in East Suffolk between April and December 2015 was 3.2% which was similar to the average the year before (3.1%). For West Suffolk, the staff sickness rate between April and December 2015 was 5.6% and this had increased from the year before (4.1%). Similarly the average of short-term sickness for East Suffolk between April and December 2015 was 2.6%, reduced from 2.8% for the same period the year before. For West Suffolk this was 2.6%, between April and December 2015, which had improved from 3.4% the year before.

- Many staff finished their shifts late to complete their work with a specific patient or complete an activity. Some did not take their assigned meal breaks because of high numbers of emergency calls and staff routinely commented on being disturbed during breaks. Staff also felt that stand down points were often difficult for them due to having no access to hot meals or toilets close by, but some staff felt this was part of the job and had a "Just have to get on" approach towards break times. In Essex, between November 2015 to February 2016 4527, late and missed meal breaks were claimed. Where staff finished late, they often had to delay the start to their next shift because they were required by law to have an 11-hour break between shifts. This affected the remaining numbers of staff available to respond to calls on subsequent shifts. Staff in Waveney were leading a support desk project to address the number of staff late finishes. This project was on going at the time of our inspection so we could not assess any impact.

- Staff received training on the specific needs of children during their initial qualification period. Staff also had access to guidance for the treatment of children in the JRCALC and felt confident they could call a GP for guidance, either out of hours or in hours to speak to the patient's own GP.

Anticipated resource and capacity risks

- The DLO worked closely with the resilience manager on a daily basis to understand and manage foreseeable risk including, changes in demand on the services, seasonal or weather, loss of facilities or infrastructure, disruption to staffing levels or disruption to hospitals receiving patients.

- The Senior Locality Managers (SLM) held a silver call daily at 8.30am to discuss any issue, which could have a direct effect on the services and liaised with the stations DLO to ensure services were planned effectively.

- The trust used the national indicator resourcing escalatory action plan (REAP). This is an indicator of pressure in ambulance services and can be used to trigger specific actions when a trust is operating with significant and sustained levels of increased activity.

- There was a comprehensive business continuity plan for all services. This identified and mitigated risks which could disrupt services and affect the performance of the trust. In addition to the business continuity plan a winter, operational plan was in place for 2015/16.

- The trust would not implement changes in practice or bring new equipment into use unless they had been through the clinical quality safety group for review. This was to assess any impact of risks to the service and to maintain consistency in quality and services across the divisions.

- Scheduling took place for Norfolk from one team, however scheduling for Waveney was done by Waveney staff due to the increase in population numbers in the area during the summer months.

- Ipswich and East Suffolk had produced a winter scheme for 2015/16. An information briefing sheet was produced that signposted staff to various teams that could assist with admission prevention in an effort to be able to respond effectively to an increase in demand and attempt to maintain support for people in alternative care settings or their own home. These included the

crisis action team (CAT) and frailty assessment base (FAB) which were six month pilots based in Ipswich. Both of these could refer to community reablement beds.

- The admissions and readmissions avoidance scheme (ARAS) in Suffolk, helped support people being discharged from hospital by co-ordinating support services within the initial 72-hour period to avoid the need for readmission. The Early intervention team was available 24/7 and worked with voluntary services to provide care and support for people experiencing a health or social care emergency.

- Due to current capacity issues within all hospitals across the six counties, there was additional risk for the trust that ambulances were not cleared from calls as they were delayed, at times of high capacity, in patient handovers at hospitals. The DLO would monitor backlog at the trusts and keep staff informed as far as possible.

- Ipswich ambulance station had flooded during heavy rain in 2015. Despite the station being evacuated for a period of two weeks, no substantial changes have been undertaken to prevent a similar reoccurrence. Staff stated that this was on the risk register but no plans were in place to undertake any major structural refurbishment.

Response to major incidents

- A major incident is any emergency that requires the implementation of special arrangements by one or all of the emergency services and will generally include the involvement, either directly or indirectly, of large numbers of people. EEAST had a major incident plan, which was comprehensive and identified types of major incidents as detailed in the NHS Commissioning Board Emergency Preparedness Framework 2013.

- All staff were aware that the trust had a major incident plan, however not all had been involved in training to deal with a major incident. We spoke to a paramedic at Addenbrookes who told us they had been involved in a desktop exercise for a flu pandemic, but would like more training in case there was a major emergency. Two emergency training exercises took place in Suffolk in 2015, one in June, and one in October. These included the emergency operations centre (EOC), accident and emergency operations, resilience teams and the

exercise in June involved the HART team. In Bedford 100% of staff had received emergency planning update training. Six staff had been involved in live major incident scenarios and others in desktop exercises.

- Staff could explain the roles conducted by staff if a major event occurred, for example, gold, silver, and bronze command. Plans for major public events across the divisions included processes to respond appropriately should a major incident occur at any of these.

- Major incident plans followed the requirements of the Civil Contingencies Act and were up to date. The plan stated that procedures were to be reviewed annually or more frequently if required. The trust's major incident plan 2015/16 was reviewed at the time of our inspection.

- Senior managers had on-going major incident training in combination with the police and fire service. However, there had been no capacity to release frontline staff to attend major incident training because of increased demand for the service. For example, in one division we spoke with a paramedic who had received no training in involvement of major incidents. An emergency care assistant (ECA) told us there was no major incident training for them and no learning had been shared from any of the training sessions attended by other staff.

- If hospitals were temporarily unable to receive ambulances because of capacity issues, the Emergency Operation Centres (EOC) diverted them to other hospitals. Addenbrookes hospital used a red or green light system, if an ambulance arrived and the red light was on outside the accident and emergency bay, stay knew they must keep the patient on board their vehicle until the light went to green. Staff told us they did not like the system and felt it was unfair to leave patients in vehicles having treatment until the lights changed.

- We spoke to staff in Addenbrookes accident and emergency department who told us they have regular meetings with the ambulance services with regard to bed capacity and participated in tabletop exercises of major incidents with NHS England, Department of Health, local councils, environment agency, and local schools.

- Norfolk held two major incident rehearsals in March 2015 and July 2015. One session covered military

support in the event of threat levels increasing to critical and was specifically for the resilience and hazardous area response teams. The other session was a workshop in preparation for a chemical, biological, radiological, and nuclear (CBRN) attack for emergency and urgent care teams too.

- Escalation plans were in place for the Norfolk emergency and urgent care teams, in partnership with other providers. These included the mortuary winter capacity arrangements and joint working with the county council and local acute hospitals. NHS England, the coroner and local funeral directors. The Midlands and East 12 hour breach reporting protocol (which was a tripartite arrangement set by NHS England, Monitor and the trust development agency), and Norfolk, Suffolk and Cambridge joint communicable disease incident or outbreak management plan.

Are emergency and urgent care services effective?
(for example, treatment is effective)

Requires improvement 🟠

We rated the effectiveness of emergency and urgent care services as requires improvement because:

- Emergency calls to East of England Ambulance Service (EEAST), which were immediately life threatening such as cardiac arrest and termed Red 1 required a response via an emergency vehicle within eight minutes. The trusts response rates from July 2014 to January 2016 were similar to the NHS ambulance trust average and followed the national trend. Between January 2015 and January 2016, the trust average response rate was 73% against a target of 75%, which placed them in line with the England average and the fifth best performing trust in England. However, performance deteriorated during February 2016 with 64.6% response rate and in March 2016 data showed a response rate of 55.1% against an England average of 66.5%. This coincided with an increase in hospital handover delays and black breaches at NHS acute hospital trusts in the region.

- Calls, which were serious, but not the most life threatening, for example, chest pain and termed Red 2, required a response from an emergency vehicle within

eight minutes. The trusts response rates from July 2014 to January 2016 were consistently slower that the NHS ambulance trust average. Between January 2016 and January 2016, the trust average response rate was 63% against a target of 75%, which placed them 6% under the England average of 69% and made them the second worst performing trust in England. Performance continued to deteriorate in February 2016 with data showing a 53.5% rate and in March 2016, response rates were 48.8% against an England average of 58%. This coincided with an increase in hospital handover delays and black breaches at NHS acute hospital trusts in the region.

- 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), the NHS target states an ambulance should arrive on the scene within 19 minutes in 95% of cases, these are referred to as A19 calls. Between January 2016 and January 2016, the trust average response rate was 91% and only met the 95% target once over the year. Performance deteriorated further during February 2016, with a 86.1% response rate and an 82.6% response rate in March 2016, making the trust the second worst in performing trust in England during this period.

- Prolonged delays at some acute hospital emergency departments reduced the capacity of front line staff to respond to patient's needs.
- We were not assured sufficient training was in place to support staff or that supervision and appraisals were undertaken in order to provide staff effective guidance and training opportunities.

However, we also found:

- EEAST followed both National Institute for Health and Care Excellence (NICE) and Joint Royal Colleges Ambulance Liaison Committee (JRCALC) clinical practice guidelines and had access to a clinical advice team when necessary although this was sometimes not available in a timely manner.
- Front line staff worked effectively and professionally with other healthcare providers to comprehensively meet patient's needs.

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- Between April 2014 and October 2015 the proportion of patients receiving angioplasty (unblocking of a coronary artery) within 150 minutes was better than the NHS average; 93% as opposed to 87%.
- Staff obtained consent from patients prior to treatment and were aware of how to apply the Mental Capacity Act (2005) in practice though understanding and training were variable in some areas.
- Record keeping and care planning was of a good standard.

Evidence-based care and treatment

- Staff carried a copy of the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidance and referred to it in their assessment and documentation of patient care. We carried out vehicle checks on 12 emergency vehicles. Care-bundle or pathway information was available in all the vehicles outlining the accepted steps required for patients who were experiencing for example, a stroke, heart attack, or asthma.

- All of the paramedics, emergency care technicians and emergency technicians were able to give us detailed accounts of the various care pathways they followed including, stroke pathway, falls, and transient ischaemic attack (TIA) amongst others. All the care described was in line with the JRALC guidelines and NICE guidance.

- Notice boards in most ambulance stations had specific areas dedicated to providing staff with clinical updates, these included care pathways, latest audit results and ambulance care quality indicators (ACQI). We spoke to the trust clinical lead who assured us that duty location officer (DLO) are routinely updated with any changes in clinical practice and the outcomes of clinical audits. Some stations had the audits visible on notice boards, whilst others did not.

- There was evidence of self-care pathways for issues such as falls, epilepsy, hypoglycaemia (low blood sugar), head or neck injuries and some staff had pocket books with these details in. Inside some ambulances, we found small portfolios containing up to date guidance on conditions staff may come across.

- The trust was part of a mental health concordat across the trust, led by the police and crime commissioner, with national guidance for service provision under section 136 of the Mental Health Act 1983. This meant that there was a jointly agreed and supported approach between the police and the trust for the appropriate transfer of patients with mental health needs to an appropriate provider.

- In Norfolk, staff involvement in audits was inconsistent. One paramedic said they were not aware of any on-going audits, another member of staff said they performed audits due to being on light duties. One DLO, in Norfolk, said they had the responsibility for monthly morphine checks, uniform audits, vehicle audits, drug bag checks, and a weekly pharmacy audit. West completed an audit tracker. Whilst this detailed compliance with audits taking place, it did not display results or identified actions for improvement.

- Quality Assurance visits are undertaken by the quality development team (QDT) to inspect against the CQC key lines of enquiry. Newmarket visit was undertaken on 1 February 2016 and a report was produced outlining positive evidence found, such as security of the building and cleanliness. One negative comment was an unlocked filing cabinet containing PRFs. Consideration for a locked wall box was noted; this had been addressed and was in situ at the time of inspection.

Assessment and planning of care

- Ambulance crews followed medical protocols to assess patients and plan their care. They made effective use of protocols, supporting guidance and pathways in their assessment of patients, for example the JRALC.

- All ambulance crews were required to take patients to the nearest appropriate hospital for their needs. For example, pregnant women were conveyed to the nearest maternity unit if they were unwell or there was a risk to the unborn baby. However, if there was no medical emergency they would, where practicable, be conveyed to their booked unit.

- We observed ambulance staff following their assessment processes and documenting their findings clearly and accurately on the PCR. Staff demonstrated a clear understanding of the use of alternative care pathways for example, the Joint Emergency Team (JET) programme, and out of hours GP services.

- Enhanced clinical advice and support was made available to crews following patient assessment 24 hours a day. For example staff told us they could seek

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guidance in relation to the administration of amiodarone (amiodarone is an antiarrhythmic agent used for various types of cardiac dysrhythmias, both ventricular and atrial).

- EEAST used 10 alternative care pathways to redirect appropriate patients with a variety of conditions. For example, minor ailments and injuries, older patients with a history of falls and children with a fever and respiratory illness.

- In Bedfordshire and Hertfordshire staff described using ATMISTER, a trauma triage acronym tool which can be used when pre-alerting or handing over patients (Age and other patient details, time of incident, mechanism of injury, injuries sustained, signs and status, treatment given, estimated time of arrival and requests e.g. The trauma team are required).

- Protocols and care bundles were in place for patients who had had a stroke or a heart attack in line with national quality standards. The trust target was 56% and the service had achieved 47% with an overall trust total of 96% against the national average of 97%.

- The Crisis Action Team (CAT) aims to prevent avoidable hospital admissions in Suffolk. Paramedics referred directly to the team, which consists of district nurses, occupational therapists, mental health nurses, and social services. All diabetic hypoglycaemic patients were referred and a leaflet left for the patient to cancel the appointment if they did not wish to attend.

Response times

- Emergency calls to East of England Ambulance Service (EEAST), which were immediately life threatening such as cardiac arrest and termed Red 1 required a response via an emergency vehicle within eight minutes. The trusts response rates from July 2014 to January 2016 were similar to the NHS ambulance trust average and followed the national trend. Between January 2015 and January 2016, the trust average response rate was 73% against a target of 75%, which placed them in line with the England average and the fifth best performing trust in England. However, performance deteriorated during February 2016 with 64.6% response rate and in March 2016 data showed a response rate of 55.1% making them one of the worst performing trusts against an England average of 66.5%. Data received after the

inspection showed that this coincided with high levels of ambulance handover delays and black breaches (delays to handover patients by over 60 minutes) in the East of England.

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- 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), the NHS target states an ambulance should arrive on the scene within 19 minutes in 95% of cases, these are referred to as A19 calls. Between January 2016 and January 2016, the trust average response rate was 91% and only met the 95% target once over the year. Performance deteriorated further during February 2016, with an 86.1% response rate and an 82.6% response rate in March 2016, making the trust the second worst in performing trust in England during this period.

- Suffolk response times for DSA did not meet target in quarter one 2016. Data showed that between January and March 2016 the average response time for Red 1 calls was 15.09 minutes and Red 2 was 21.01 minutes. For the same period, average response times for green one was 26.11 minutes, green two was 38.1, green three was 50.51 minutes, and green four was 105.05 minutes. Limited knowledge of out of area geography could also affect response times, as drivers were reliant on satnav and did not necessarily know any local shortcuts.

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- Prolonged delays at some acute hospital accident and emergency departments reduced the capacity of front line staff to respond to patient's needs. This was because ambulance staff needed to stay with their patients to deliver care and support until they handed the patient over to hospital staff. Handover rates in Suffolk, did not meet national targets of 15 minutes with the average from January to March 2016 rising to 30 minutes.

- Information received from local Healthwatch groups showed patients had raised concerns regarding delayed response times. Response times were affected by patient handover delays at acute trust accident and emergency departments and in some cases, these delays extended over several hours. This meant staff were unable to respond to emergency calls in the community, as they were caring for patients awaiting transfer to the care of hospital staff for on-going care. Ambulances held at acute hospitals awaiting handover were not available to support solo responders and community first responder volunteers who were waiting in the community with patients who required transport. Senior managers and locality managers had held meetings with commissioners and other stakeholders and the trust deployed staff as Hospital Ambulance Liaison Officers (HALOs) to support teams in processing patients and managing risk. However, the HALOs role was discontinued in many trusts due to a change in commissioning arrangements. Local managers said this was beginning to have a detrimental effect on the services in some accident and emergency departments.

Pain relief

- Patients who required pain relief, told us that pain relief had been administered quickly and that staff had fully explained what they were doing and why.

- During our observations with ambulance crews and via our audit of PCR's we noted patients assessed for pain appropriately and relief provided in accordance with the NICE guidance for example. Patients were informed about medicines and their effect before they were administered.

- The trust used a numerical rating score of 1-10 for scoring pain. For adults who could not communicate verbally or for children different systems were in place such as faces of pain diagrams. The trust had also developed a pocket book prehospital communication guide that used symbols and prompts to encourage patients to direct staff towards clarifying their symptoms.

- Patient care records showed that ambulance staff had offered pain relief in line with the NEWS scores and based on clinical decisions when reviewing the patient at the point of need.

- Each operational vehicle had Entonox and paracetamol which given as appropriate when the patient was able to confirm their pain score.

- As patients arrived in the accident and emergency departments, ambulance staff clearly and accurately handed over information in relation to the patient NEWS score, we also observed ambulance crews reassuring patients waiting on trolleys and routinely asking if they were in any pain.

- Ambulance staff used the 'Abbey Pain Scale' for assessment of pain in patients who cannot verbalise, for example, patients with dementia or communication difficulties.

- We saw one patient care record in Bedfordshire and Hertfordshire that showed an elderly patient had fallen acquiring a potential fractured neck of femur injury. The patient had a pain score of 10 but was given paracetamol and transferred back to the local station before being transported to hospital as the crew were at the end of their shift.

Patient outcomes

- The trust routinely collected and monitored information about people's care and treatment and produced these as Ambulance Clinical Quality Indicators (ACQI) to measure the overall quality of care and end-results for patients following care and treatment. The 11 ambulance quality indictors (AQI) in total include both operational and clinical factors to enable measurement of both performance and clinical care. This allows staff to identify what is going well and where improvements are required. The AQI use a care bundle approach as a measure, for example, for STEMI and stroke services the AQI includes a measure of how many patients receive a full care bundle. A care bundle is a collection of interventions for the management of certain conditions

that act as a minimum standard that patients should receive. Ambulance stations had these published on notice boards in clearly visible areas for staff to see and discuss with colleagues.

- Heart attack or ST segment elevation myocardial infarction (STEMI) is caused by a prolonged period of blocked blood supply within the coronary arteries. Reductions in STEMI mortality and morbidity is affected by those patients who received the appropriate care bundle, those who have timely delivery to the cardiac catheter lab for intervention, and those who have timely thrombolysis or clot busting medicines. Between April 2014 and October 2015 the proportion of patients receiving angioplasty (unblocking of a coronary artery) within 150 minutes was better than the NHS average; 93% as opposed to 87%. The number of patients who achieved an appropriate care bundle for angioplasty at EEAST was better than the NHS average between April 2014 and October 2015, although this was not always the case. The NHS average saw a downward trend ranging from 83% to 77% during the same period. EEAST ranged from 89% in April 2014 to 78% in December 2014 and 75% in October 2015. There were regional variations in the data. For instance between April 2015 and November 2015, patient outcomes for acute ST-elevation myocardial infarction (STEMI) in East Suffolk ranged between 81 and 100% against a trust target of 80%. Comparatively in West Suffolk data showed a downward trend in the last three months of the same period at 75% in September and October 2015 and 66.7% in November.

- As set out in the NICE national quality standards GP, health outcomes of patients can be improved by staff recognising the symptoms of a stroke or 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 EEAST stroke patients receiving thrombolysis within 60 minutes between April 2014 and October 2015 was in the main lower than the NHS average, ranging from 60% in April 2014 to 55% in November 2014, 52% in March 2015 and 51% in October 2015. The proportion of suspected stroke patients assessed face to face who received an appropriate care bundle between April 2014 and October 2015 met the NHS average of 97%. There were regional variations in the data. For instance the proportion of stroke patients

receiving thrombolysis within 60 minutes between April 2015 and November 2015 in East Suffolk ranged between 56% and 83% in four of the eight months. However there was a downward trend with October and November 2015 achieving 50% and 20% respectively. In West Suffolk data showed target was achieved in only two of the eight months (May and June 2015) and performance ranged between 167 and 50% in the other six months.

- The proportion of patients who re-contacted EEAST following treatment and discharge at the scene, within 24 hours was 11.2% which is higher than the NHS average of 7.1%.

- The proportion of patients who had return of spontaneous circulation (RSCOA) on arrival at hospital was 25%; the NHS average is 28%. Between April 2014 and October 2015 rates ranged between 25% and achieved 30% in August, September 2014 and June 2015. For Ipswich and East Suffolk, the results between April and November 2015 ranged between 30% and 61.5 % (all rag rated as green) with only July 2015 dipping below target at 21.9%. Data for West Suffolk for the same period was a less positive picture with only three of the eight months achieving target ranging from 0% to 20%.

- National clinical performance indicators (NCPIs) provide a focus on clinical indicators to assess and monitor the delivery of care. These were developed as an alternative to indicators based solely on response times. The trust submits NCPI data to the national ambulance service clinical quality group (NASCQG). NCPI are in place for a variety of conditions to enable benchmarking of performance and ensure that interventions are evidence based and used to improve care. NCPI include asthma, febrile convulsions, lower limb fracture, elderly falls, mental health (self-harm) and epilepsy.

Competent staff

- Data provided by the trust shows that the overall EEAST staff appraisal completion rate was l 9.7% for 2015/16. The trend from 2012 shows a significant fall in the appraisal rates over the last two and a half years. The trust had recognised this as an issue and had increased the number of appraisals completed before our inspection. Trust staff appraisal completion rates in Bedfordshire and Hertfordshire at the time of our inspection were 76%. Staff with completed appraisals in

2015 by location were in North East Herts 89%, West Herts 58%, North Bedfordshire 84%, and South Bedfordshire 75%. Areas of concern related to the low level of administration staff who had completed appraisals 38% and only 23% student paramedics in west Hertfordshire had completed appraisals.

- Overall, the trust did not confirm how many staff were responsible for delivering appraisals or had been trained to do so. Staff told us consistently that they did not receive appraisals due to capacity and protected time was not made available

- In Harlow, the mentor had arranged a drop in day for student and mentors to provide support reflection and debriefing. However, this was on the staff member's day off. Staff from all areas told us that other than the two day mandatory training, all other education, and training had to be done in their own time. There were inconsistencies across the locality, with some staff being paid overtime and some not.

- Staff told us that there was no time for supervision from managers and that they felt the needs of student roles came first in terms of support and guidance from managers. Most staff accepted the need to train the new staff, but felt this left a gap where established staff were left without supervision, clinical guidance, or support. Staff were also concerned regarding the level of clinical supervision offered by the trust and paramedics in particular saw the lack of clinical supervision as a significant concern. Clinical supervision was not provided in a timely way in Norfolk, the DLO aimed to do one clinical ride out with ambulance crews once every 12 months, but this was not happening due to an increase in service demand.

- The trust provided the HART annual training plan as part of their pre-inspection data, which included HART training, activities, and exercises during 2015/2016. Topics included, Combustion Induced Toxic Injury Course, Norwich Airport Live Emergency Event, Safety Response Team Outreach programme, 6x6 and 4x4 driving and various other lifesaving events and courses.

- We spoke with two relief staff who told us they never access supervision and rarely see any managers. They were concerned about career progression or accessing support due to how their roles sat remotely outside of the core teams.

- Training on mental health awareness or guidance on support strategies for patients with mental health needs was varied across the trust. Across the trust it was part of the professional updates, although one member of staff stated that they felt the training was out of date. Another member of staff confirmed they had received this training within their professional update. However, the majority of the staff said they need this training and support due to the number of calls to treat patients with mental health issues increasing over time and they often feel unprepared to deal with the patient's complex needs.

- We attended 15 calls in Suffolk and the majority of staff and crews were confident and competent. However, there was a witnessed event where the crew members were obviously overwhelmed by a lack of mental health knowledge in treating a patient with psychological and neurological issues. Staff made several appropriate attempts to seek advice from the patient's GP, the EOC and the Clinical Advice line. The GP took over 25 minutes to call the crewmembers back. The correct treatment and clinical decisions were made however; the length of time to treat was extended whilst they awaited support from external health care providers which meant that the crew were delayed in becoming available for further emergency calls.

- Paramedics are required to re-register with the Health and Care Professions Council (HCPC) every two years. As part of that process, they are required to undertake continuous professional development (CPD) and receive clinical supervision. Paramedics told us because of operational pressures on the service, insufficient time was given to support them in this process and training sessions, including mandatory training, had been cancelled. Professional registrants have a responsibility to ensure they remain up to date with CPD.

- Although the trust had access to NHS management training courses most of the newly appointed managers, such as those in seconded posts told us they learned their role 'on the job' and from shadowing other managers if the opportunity arose or by using past experience in leadership or managerial roles. Some managers had taken the decision to stand down from substantive management roles to be closer to patients

and front line activities; this had proved beneficial for the individuals and their colleagues as they shared their knowledge and experience of management across the teams.

- Established paramedics raised concerns with us about the lack of career progression opportunities. We spoke with a number of paramedics who felt they had no opportunity to progress further in their careers. Some of the paramedics told us pay scales within EEAST were higher in comparison to other services, but the inability to access courses they wished to attend and having to do training on days off made the role less attractive.

- The trust was in the process of rolling out new defibrillators (machines which deliver therapeutic dose of electricity to the heart) in Essex, 93% of staff had been trained in the new piece of equipment, with a plan for all staff to complete the training by the end of May 2016.

- In Suffolk, road ambulances did not always have a fully qualified paramedic on each shift. Some crews consisted of a student and technician and on one occasion in a rural area, one crew paired together was a student paramedic and emergency care assistant (ECA), who was training as a technician. This meant we were not assured that staff received adequate support and supervision to ensure patient safety. This occurred on a comparatively small number of occasions and the trust had mitigated the risk such as ensuring these crews attend as back up to other crews and not answering all call types.

- Staff were keen to extend skills but opportunities for development were constrained due to access, availability, time and funding. There was no financial support for staff from the trust to undertake degree qualifications. Senior staff were frustrated that access was difficult for ongoing personal development, however they were expected to train and assess degree students. The trust did support some staff with Level 6 mentoring qualifications so they could effectively supervise students.

- The Mental Health Act 1983 (MHA) Code of Practice (Parts 17.3 to 17.6) states that consideration should be given to the most appropriate method of transport for mental health patients. East of England Ambulance Service (EEAST) staff routinely informed us that support for patients with mental health symptoms was poor and

they had limited training to meet individual needs. Ambulances were not risk assessed for ligature points (Places were a patient could hang themselves) and staff were not aware of any specific action taken by the trust to reduce risks to patients suffering a mental health crisis.

- A draft Dementia strategy was produced in December 2015, which set out the trust's aims for the next three years, but this has not yet been ratified. Only the more senior members of staff (Band 7 and above) were aware of this. There was no coordinated training for staff in dementia awareness or mental health. This meant services delivered might not take account of the needs of patients and callers living with dementia or mental health although some staff gave us examples of how they would communicate with patients living with dementia or mental health.

- Although the trust's capacity to consent policy contained reference to patients with a learning disability there were no policies and processes to ensure they were identified. The trust informed us that it was because all patients were treated equally. The trust did not provide any training to staff to raise awareness and education for learning disabilities. Staff were unable to give any examples of meeting the needs of people with learning or physical disabilities. However there was a patient passport system for patients with a learning disability and it was included in the staffs manual. The trust had produced an accompanying workbook in easy read format to assist people with learning disabilities to access the ambulance service and reduce their anxieties when doing so.

- Staff told us that they receive conflict resolution training to deal with violent or aggressive patients. However, staff felt that this did not really prepare them for the level of violence or aggression displayed by some patients and that police services were often reluctant to support them or under resourced at busy periods.

Coordination with other providers

- EEAST operational managers met with other NHS trusts on a regular basis to discuss concerns and issues that involved their trusts including delayed handover times. They also represented the trust at bed meetings with

local hospitals to discuss capacity and flow issues to minimise impact on patients from waiting in ambulances or in the accident and emergency areas of the hospital.

- EEAST had agreed care pathways with other providers to ensure patients were treated in order to achieve the best outcome for them. These included out of hours GP services, the use of the 111 service, minor injuries units, ambulatory care units, JET and Night Owls (A night sitting services for patients who were unwell and needed a sitter).

- During the inspection, we noted that patients were transported by ambulances to the appropriate service based on their needs.

- In Waveney, staff worked with the local hospital to develop an ambulatory care pathway, which improved flow through the emergency department. For example, the local hospital had closed their ambulatory care unit, leading to an increase of people being conveyed through the emergency department. The hospital raised this issue with the trust and through discussion, discovered it was due to the ambulatory care unit being closed, this led to the reopening of the unit.

- Independent providers used to support the emergency and urgent care service are scrutinised by the governance and quality manager to ensure they are safe and effective. Independent providers were checked against the Health and Care professionals Council to ensure staff were safe and competent to carry out their duties. EEAST staff carried out checks to ensure equipment used by independent providers was fit for purpose and safe to use.

- EEAST had established links with other specialist emergency services, but mostly this was coordinated through the hazardous area response teams (HART).

- We asked two DLO if they were aware of the UK Ambulance Services National Memorandum of Understanding Concerning the Provision of Mutual Aid, none of them were aware of this memorandum.

- In Waveney, training was delivered to external providers, for example a local mental health trust and the police, including intermediate life support, basic life support,

burns and drowning. This enabled other providers to support patients appropriately instead of calling the emergency services, or until the emergency services could attend.

- If calls are graded as serious, life threatening by the 111 service the trust cannot downgrade them. Staff verbalised many examples of attending calls that were not graded appropriately. One paramedic described attending a call where the patient had burns, which in reality was spilt tea and area of redness on the skin. Staff stated that the trust was preparing their own bid for responsibility to run the 111 service in Suffolk in September 2016 and felt that this would be a positive step, as they would be managing the calls directly. There was a lack of coordination between the trust and the 111-telephone service provider in Norfolk. Inappropriately triaged calls meant staff were diverted to patients who did not require urgent care. These incidents were logged and reviewed by the trust and referred back to the 111-telephone service provider. One paramedic mentor said they had logged numerous occurrences and believed they were investigated but had never received any feedback.

- When a major incident occurs that requires multiagency involvement, such as the fire service and police, the DLO will attend the scene and liaise with the seniors from other agencies according to the Joint Emergency Services Interoperability Programme (JESIP) framework. The JESIP was a two-year programme (2012-2014) primarily aimed at improving the way the police, fire & rescue and ambulance services work together when responding to major multi-agency incidents. The JESIP course set out working principles and models that can be applied and utilised at multi- agency incidents to ensure more effective joint working.

- To identify and recognise the lead staff member at the scene, staff wear a tabard and the fire crew on scene lead a hot debrief which includes the paramedic team. Staff said that they also perform a debrief after a major incident.

- A senior paramedic in Ipswich was working closely with the clinical commissioning groups (CCGs) to raise concerns, discuss improvements in care plans, and do not attempt resuscitation DNACPR forms in care homes.

Multidisciplinary working

Emergency and urgent care services

- We observed that handovers between EEAST ambulance staff and hospitals staff were extremely professional. Information shared regarding the patients' needs was comprehensive. Written records used for the handover were of a very good quality, reflected the patient's initial diagnosis, and enabled the staff to agree the most appropriate care pathway on handover.

- Ambulance crews had access to the JET which is an urgent two-hour responsive service with multidisciplinary staff, for example, physiotherapists to support people over the age of 65 years in their home environment when they become unwell or need urgent care.

- An enhanced GP triage service enabled ambulance staff to call a dedicated assistance telephone line between the hours of 4pm to 11pm weekdays and 11am to 11pm at weekends and bank holidays to access clinical advice and support from a GP regarding treating patient conditions and reduce admissions or conveyance.

- Hospital staff told us that EEAST staff were extremely professional and easy to work with when bringing patients into their department. One hospital explained how they had changed their arrival activities for ambulance staff, who now had to wait in a designated area inside the accident and emergency department prior to the patient being triaged by the rapid assessment team. The teams had agreed to this new working practice to promote the safety of patients waiting to be seen and reduce congestion issues.

- Inconsistent handovers between ambulance and hospital staff was demonstrated at the hospitals visited in Bedfordshire and Hertfordshire but staff we spoke to were not aware of any improvement opportunities to reduce delays at hospitals. We were told there was no Hospital Ambulance Liaison Officer (HALO) network and little opportunity of sharing good practice across the county where hospitals had reduced the waiting times at accident and emergency departments.

- EEAST teams met weekly with hospital staff to discuss issues around capacity within the hospital and to establish practise to improve flow and access by patients. Staff also engaged in joint working to deal with major incidents and took part in scenarios and desk top exercises together, for example flu pandemic, in order to promote joint working and effective response to major incidents.

- Staff who "see and treat" patients were referring them to appropriate alternative providers of health or social care as required. We saw an ambulance team respond to a patient who was alcohol dependent and called the emergency service for support. Staff offered the patient information in relation to other services including alcohol advisory teams, and ensured they found an appropriate person to stay with the patient on leaving the scene.

- Staff treated patients at the scene of incidents and offered advice regarding follow up and seeing a general practitioner if symptoms worsened. One call attended in Suffolk, involved an elderly patient that had fallen at a care home. The patient was assessed and given assurance throughout, the ambulance crew provided advice to the care home staff on monitoring of the patients, and a referral to the falls team was undertaken on site. This meant that ongoing care was arranged appropriately.

Access to information

- All emergency and urgent care ambulance staff had access to a wide range of information, written and electronic. Policies and procedures were available on the trusts intranet system, on notice boards, in dedicated folders and staff had access to dedicated IT equipment at all ambulance stations. However, staff informed us they did not always have time to look at them as they were busy responding to emergency calls. Clinical updates or changes in procedures were generally emailed to staff, but some stations had dedicated notice boards for this purpose and these were up to date.

- All paramedics had access to the JRCALC ambulance guidelines (2013) on expert clinical advice. Ambulance staff had been given a pocket version of the guidelines and the guidance was in a number of ambulances we checked.

- All ambulance staff had access to a pre-hospital communication guide, for use with patients when they arrived on scene. Some ambulance staff carried these in the pockets and the guides were in some emergency

vehicles. These simple guides enabled ambulance staff to use pictorial prompts with patients who may not speak English, have poor communication, a learning disability, or cognitive impairment to help assess their condition quickly and effectively.

- In one ambulance there was a guide written by the trust to help staff prepare for and engage in the CQC inspection. We felt this guide was excellent and encouraged the staff to engage in the inspection process, be honest and transparent and gave a comprehensive guide to the CQC inspection process.

- Staff had access to the EEAST clinical manual 2015/16, which complemented the Clinical Practice Guidelines (ACCE 2013) and designed to help support the delivery of high quality care to patients by providing a comprehensive clinical reference guide to EEAST clinicians. Guides were available to all clinical staff, often they carried them in emergency vehicles or they were prominently situated in offices or staff areas.

- At Ely ambulance station staff had developed an open information / resource area with various manuals, articles and guides to enable staff to increase their knowledge and understanding with regard to end of life.

- In Norfolk, the ambulance fleet assistants (AFA) used communications books to handover important information to the next AFA on shift, such as which jobs were required next, and what jobs were still incomplete.

- Performance information was available on each ambulance and conveyed to ambulance crews when they logged onto the emergency vehicles each day. Ambulance crews were informed by their operations centre if a call they were attending had been 'flagged', these 'flags' included any risk of violent or aggressive behaviour towards staff by the patient, or a frequent caller to the service.

- We asked staff what action was taken to address NHS England's 2015 Patient Safety Alert: Harm from delayed updates to ambulance dispatch and satellite navigation systems. Staff were unaware of this update.

- Trust policies and procedures were available to staff on the trust's intranet site. They could access this at trust premises or via a dedicated log in on the trust's public website from home.

- In Bedfordshire and Hertfordshire, ambulance crews had access to patient information and two operational vehicles were seen with a blue filing system that included additional paperwork and patient information following treatment, e.g. avoiding hypos leaflet for Diabetics. There was no evidence of bereavement leaflets for relatives or contact numbers for additional support for the bereaved following a family member or friend's sudden death.

- Knowledge of do not attempt cardiopulmonary resuscitation (DNACPR) records was inconsistent across Norfolk. One paramedic stated that they had never seen any DNACPR policy and that they would use the JRCALC guidelines if they were unsure. An emergency care practitioner and critical care practitioner had thorough knowledge of DNACPR and stated that they would expect a written, valid, original and in date record. If the DNACPR record was inappropriate then they would call the clinical desk for support. A student paramedic explained that they always asked to see DNACPR records in care homes, and that records must be original copies that would be taken to the hospital with the patient.

- In Suffolk, staff stated that do not attempt cardiac pulmonary resuscitation (DNACPR) forms and advanced care directives/plans (ACD/Ps) were a concern. Originals were not always available as required under trust policy. Other issues described included difficulties when general practitioners do not complete forms, inaccessible forms at nursing homes (where they are often locked away at night) or the form not being available. This meant that attempts to resuscitate may occur against a patient wishes and cause distress to relatives and staff having to perform the CPR. Staff reported that the CAD system did not always have the most up to date information

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff are provided with pocket handbook guidance on mental health issues however training content for mental health conditions was limited. Staff in Suffolk, stated the MCA training covered anxiety and depression and not psychotic illness which can be very challenging.

Staff felt generally supported and said that the police did attend promptly if requested. We spoke with over 50 staff during the inspection and only two stated they felt unsafe at times when responding to certain calls.

- The mental capacity policy was reviewed in December 2015. Circulation was by e-mail, CAD and disseminated by supervisory staff. Crew members had knowledge of the Mental Capacity Act 2005 (MCA) and the need to assess patients and produced assessment documentation.

- The trust provided staff training performance data on the Mental Capacity Act 2005 (MCA) across Cambridgeshire, which showed the number of staff who had received training between 2015 and 2016, was low, varying from 16.2% of paramedics to 38.2% of the clinical support team. During 2014/2015, trust data showed that training participation varied again with 1.5% of health referral carers, 18.6% of paramedics 17.5% of ambulance technicians completed MCA training. However this training uptake was variable cross the service. Training compliance in mental capacity for Norfolk was 78% for technicians, 75% for clinical support staff, 68% for emergency care assistants, 30% for healthcare referral team staff, 86% for paramedics, and 43% for student paramedics. This meant that not all staff had up to date understanding of the MCA and how this affected their roles.

- All the emergency vehicles we checked contained advice and guidance for staff on the MCA and staff had access to a specific capacity and consent form, we did not see any staff use this during our inspection as they were not required during the care we observed. There was a mixed understanding of mental capacity amongst staff groups in Norfolk. One paramedic and one technician were able to demonstrate a good understanding of mental capacity. However, one paramedic and one student paramedic had a limited understanding of mental capacity, and these staff relied on the capacity to consent form to ensure that a patient's capacity was appropriately assessed.

- Ambulance crews that attended a patient with mental health needs in Cambridge carried out a risk assessment of the situation and if necessary could request the police for assistance at the scene if a patient was or may become aggressive or likely to cause

themselves or others harm. During our inspection, an ambulance crew treated a patient with a mental health illness in a calm, caring, and respectful manner showing very good people skills.

- Section 136 of the Mental Health Act (1983) refers to legal powers to take a patient to a place of safety from a public place when there is reason to believe that the patient may have a mental illness and are in need of care. A place of safety can be a hospital or a police station. The design of ambulances has changed over the past 10 years to ensure that transport can be undertaken safely. There is no access to the driver and staff stated that police would sit in the ambulance if required.

- Arrangements for conveying patients suffering from mental health conditions requiring medical care to hospital were not consistent across Suffolk. Staff described occasions where police assisted in ambulances and occasions where ambulance crew travelled in the back of a police van. However, this was reflected in guidance by the Mental Health Crisis Care Concordant as acceptable practice.

- The trust did not provide any break away training and was awaiting national guidance due shortly before commissioning any training of this kind. Breakaway training covers breakaway and restraint techniques, advanced physical skills and self-protection techniques to equip employees to deal with different levels of risk and to manage challenging and aggressive behaviour safely. This meant there was a risk to both patient and staff safety.

- Ambulance crews were aware of the importance of obtaining consent from patients who were conscious and able to do so before giving any form of care and treatment to them. For patients who were on their own and who were unconscious on staff arrival, the staff acted in the patient's best interest if it was a lifesaving situation.

- During our observations staff gained verbal consent prior to treatment being given and staff were confident in gaining consent from patients.

Are emergency and urgent care services caring?

Emergency and urgent care services

Good ●

We rated caring of emergency and urgent care services as good because:

- Feedback from people who used the service and those who were close to them about the approach of staff was very positive.
- Frontline staff treated patients with compassion and respect whilst promoting their dignity and respecting their individual needs.
- We observed patients being involved in their care and treatment throughout our inspection. Ambulance crews explained what they were going to do and why, before treatment was given and ensured the patient understood fully what was going to happen.
- When appropriate, patients were supported to manage their own health by using non-emergency services such as their GP or local urgent care centre, family and friends.
- Staff showed patience and sensitivity to the needs of patients. Ambulance crews asked patients how they wished to be addressed and introduced themselves; staff used appropriate humour and dialogue with patients to provide reassurance and kindness.
- The trust worked with other agencies, for example, the local authority, the police, mental health teams, or GP to follow up on frequent callers in case there was a safeguarding concern that may be causing the individual to frequently call their service.

Compassionate care

- During our observation of care, delivery by front-line East of England Ambulance Service (EEAST) staff that staff gave compassionate care to patients in ambulances, patients' homes and in the accident and emergency departments of hospitals.

- Staff consistently ensured that patients' dignity was maintained. We observed internal doors being closed when transferring patients on to trolleys in patients' homes, house and ambulance doors being closed if patients had no clothing on their chests when 12-lead electrocardiograph's (ECG's) were performed. Every patient was covered with a blanket when they were on a trolley. Staff knocked on ambulance doors before entering the vehicle when a patient was aboard.

- We observed patients treated with respect by ambulance staff throughout our inspection in Cambridgeshire. Patients conveyed to hospital were covered appropriately with a blanket to maintain their dignity 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 and their privacy maintained. Ambulance crews maintained the dignity of patients when transferring them from a stretcher to a hospital trolley or bed.

- During our periods of observation, patients and relatives in various hospital and home settings told us they were very happy with the treatment and care they received from ambulance crews.

- Staff showed patience and sensitivity to the needs of patients. Ambulance crews asked patients how they wished to be addressed and introduced themselves; staff used appropriate humour and dialogue with patients to provide reassurance and kindness.

- All the interactions we observed demonstrated that staff respected patients and relatives as individuals, including those from particularly vulnerable groups such as frail elderly and those requiring emotional support.

- Patients told us ambulance crews were professional and had a warm and understanding manner which reassured them. One patient told us they felt confident about the service and another described it as, excellent, very quick being taken to the hospital that they wanted and that ambulance staff were caring and polite, "I give them 10 out of 10. Another patient said, "They explained everything to me, I felt safe and had no worries, a relative didn't come on the ambulance due to having young child so came separate."

- In Essex, we visited four emergency departments and crews were seen delivering compassionate care to patients whilst waiting. For example three patients who we spoke to at Southend told us that crew were "all lovely," had waited with them, "very kind" and kept patients informed.

- Staff were observed providing compassionate care. On one occasion when staff attended a sudden death in Suffolk, they made the elderly relatives a hot drink, and

at their request informed a further family member of the circumstances on the telephone in a calm and supportive manner. On another occasion, staff gave a hug to an emotionally distressed mother.

- Patients' basic needs were accommodated in a calm and professional manner while making patients as comfortable as possible in the ambulance. Regular checks for patient's comfort were made during transfer to hospital and at the emergency department on arrival before handover.

- In Suffolk, staff provided an example of a visit to a patient where no medical treatment was required but the paramedic remained to liaise with GPs and a care home for social care and the then conveyed the man to the care home and saw him settled in. On another occasion a passer-by reported a man lying in the middle of a roundabout, the ambulance crew ascertained that he did not require any medical care but personally went and bought him a hot drink and sandwich and provided him with a warm cover. They also made a referral to social services, as he was new to the area.

- Forty-eight feedback comments relating to the local emergency ambulance service were registered on the Suffolk Healthwatch website since April 28th 2015. The majority of comments were consistently positive with patients and relatives describing care as, excellent, efficient, considerate, compassionate, reassuring, and outstanding. Negative themes centred on waiting time for an ambulance and patient transport services with only two negative comments relating to care.

- Friends and family test for Bedfordshire and Hertfordshire in January 2016 was via a postal survey which had 32 responses, 81% respondents said that they were extremely likely to recommend EEAST to family and friends. 9.4% were likely to recommend EEAST to family and friends,3.1% neither likely or unlikely to recommend EEAST to family and friends,3.1% unlikely to recommend EEAST to family and friends, there was no score for extremely unlikely to recommend EEAST to family and friends and 3.1% didn't know to recommend EEAST to family and friends.

Understanding and involvement of patients and those close to them

- We observed patients being involved in their care and treatment throughout our inspection. Ambulance crews

explained what they were going to do and why, before treatment was given and ensured the patient understood fully what was going to happen. If the patient or family members required further explanations, the ambulance crew gave these in a timely and appropriate manner.

- Staff utilised and involved relatives in the care of patients. The relative of a patient with a degenerative disorder was able to support staff in the most appropriate way to mobilise the patient without causing distress. Another relative stated that staff were fantastic, that they had used them many times with an end of life relative, and that staff always explained all of the care they gave.

- Staff were observed during the inspection responding to both acute situations, where timely treatment was essential, and less critical situations when patients were discharged after examination and did not need conveying to hospital. Patient and relative's opinions and preferences regarding treatment were taken into account by staff and adhered to where possible.

- Staff involved patients in handovers at the emergency department (ED) and patients were encouraged to participate and ask questions if they had any concerns. Handovers were conducted as privately as possible but sometimes this was within hearing of other patients and relatives due to the volume of patients in an ED.

Emotional support

- We observed that ambulance crews consistently reassured patients and providing emotional support whilst they were in their care. Routinely ambulance crewmembers crouched down to the eye level of patients on trolleys to talk to them and give reassurance.

- We observed an ambulance crew arranging for a friend of a patient to stay with the patient when they were leaving, as the crew were mindful of the patient's emotional wellbeing due to their mental health condition. Staff offered calm supportive treatment and non-confrontational advice in a non-judgemental way to the patient who was experiencing alcohol addiction.

Emergency and urgent care services

- An ambulance crew that had just returned to base following the unexpected death of a patient had stayed with the family until the local funeral home came and gave reassurance to the family members.

- The trust appointed a chaplain in 2014 to support patients and staff across all locations.

- In Norfolk, a patient told us they had used the ambulance service before and that the crew had been very caring and supportive during the long wait to be handed over at the hospital, ensuring they remained comfortable and calm.

- Staff were aware of the impact of emotional distress and continuously reassured both patients, relatives and carers. Crews showed empathy and compassion to patients and relatives. This was seen in the manner in which people were spoken to and treated. A hug for an emotionally distressed mother, handholding for nervous patients and contacting loved ones for support in the event of a sudden death.

Supporting people to manage their own health

- Data provided by the trust shows that between July 2014 and January 2016 0.3% of calls across EEAST had been classed as 'repeat callers' that is people who telephone the service on a regular basis. Trust staff in the emergency operations centre identified repeat callers, and ambulance crews were informed before they attended the patient. The trust had a number of alternative care pathways they could follow to ensure that these frequent callers were not readmitted to hospital or conveyed unless it was necessary. The trust worked with other agencies, for example, the local authority, the police, mental health teams, or GP to follow up on frequent callers in case there was a safeguarding concern that may be causing the individual to frequently call their service.

- In Norfolk, access to other services, if required, was arranged by staff on scene. Staff were observed to be in contact with social care and primary care as well as out of hospital teams.

- A healthcare advice following assessment information sheet was provided to patients. This had general information, alternative help contacts and provided details of how to raise compliments, concerns, or complaints.

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

Good 🟢

We rated responsiveness of emergency and urgent care services as good because:

- The trust had a 'see and treat' service. The clinical assessment team (CAT) 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 without conveying them to hospital seeing ambulances deployed more appropriately to serious incidents.
- The crisis assessment and treatment team (CAT) had information on their systems on receiving calls for people with complex needs. They included plans for taking people to specific hospital wards rather than an accident and emergency department.
- The trust comprehensively managed complaints and ensure staff had opportunities to learn from when things went wrong without fear of retribution.
- The trust had developed a strong volunteer team to support the local community and staff had opportunities to pursue roles in the Eastern Anglian Air Ambulance (EAAA) and local community volunteer emergency response activities.

However, we also found:

- There was no coordinated training for staff in dementia awareness or mental health.
- The trust did not provide any training to staff to raise awareness and education for learning disabilities. Staff were unable to give any examples of meeting the needs of people with learning or physical disabilities.
- Staff were consistently concerned that they were not meeting needs of patients with mental health issues and we saw no care pathways or specific training or support for staff in this area.
- Frontline staff said that sometimes no vehicles were available to attend a 'red' call in a specific area, especially rural areas. This happened when ambulance crews were responding to other calls and delayed in

handing over patients to accident and emergency department staff in acute hospitals. In such circumstances, a call would go out to all available ambulance crews in the area to assist.

Service planning and delivery to meet the needs of local people

- 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 was commissioned to provide services by five clinical commissioning groups (CCGs) across the region. In Southend the local services work with commissioners and other providers to meet the needs of patients who need to be transferred, including neonatal, paediatric or specialist centres.

- In their own time, members of staff were able to be on-call as Medical First Responders (MFRs) in the communities where they lived. They acted in a similar way to CFRs in that they responded in their own cars, but were able to take more equipment with them and carry out appropriate life saving techniques.

- A range of specialist clinical services were available in Bedfordshire and Hertfordshire to meet the specific needs of local populations. These included a falls service, a mental health triage car and liaison officers for the frail and elderly. We heard the 'falls bus' had been decommissioned which did not meet the needs of the local population. Staff at Southend told us that there had been a dedicated "falls car," which ran between 7am and 7pm, seven days per week. The service included an emergency care practitioner, and attended calls deemed as a fall, and often involved admission avoidance to hospital or default position of accident and emergency. Staff told us that this had been a successful service but had been decommissioned.

- The trust had a 'see and treat' service. The clinical assessment team (CAT) 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 without conveying them to hospital seeing ambulances deployed more appropriately to serious incidents.

- At Ely ambulance station the trust had worked with the local CFR's to install a defibrillation unit to provide emergency treatment to any member of the public suspected of having a heart attack.

- In Essex, plans were in place to respond to any large influx of people into the region for special events such as festivals or motor racing events.

- The trust's fleet services team provided a 24-hour telephone line for the reporting of vehicle faults. A mobile engineer was available to visit ambulance stations for minor and running repairs and up to date records of vehicle servicing and maintenance were held.

- The SOS bus operated in Colchester on Friday and Saturday nights to help with the night time economy, and managing those people who may be at risk or intoxicated. This service formed in partnership with a range of voluntary and public sector groups including East of England Ambulance service.

- The trust had multiple treatment and care pathways with specific recommendations for conditions such as stroke, and information on conveying a patient for treatment at the most appropriate hospital. Staff carried laminated cards and the information was available in the trust clinical manual. Staff stated that often only local pathways for their area were carried on the ambulance. If they were responding to a call out of area then the appropriate place of care pathway may not be available in hard copy but they would contact the emergency operations centre for advice.

- The trust had two hazardous area response teams (HART) that provide 24-hour cover. This team have specialised training and can work in difficult or hazardous environments such as at height or in a confined space. Vehicles are equipped with specialist equipment, which enables a co-ordinated and early lifesaving treatment at the scene of major incidents.

- A paramedic and research manager had implemented a new care home initiative in Ipswich following published research and the introduction of a new traffic light assessment tool based on the national early warning system (NEWS) for care homes. It was designed to assess acute illness severity and guide to the appropriate pathway i.e. the 111 service, or calling for an ambulance. The trust, in conjunction with Ipswich and East Suffolk Commissioning Group, introduced a falls assessment

tool, ISTUMBL for local care homes to reduce the number of 999 calls to 'no injury falls'. A new patient identifier document has been circulated to care homes to be completed by care home staff with medical and medication details as well as DNA CPR status and other relevant information. As this is a new initiative it has not yet been audited at time of inspection.

- Within Suffolk there are a number of caravan parks and emergency calls to the parks often resulted in confusion regarding the location of a specific caravan. Staff at Ipswich produced a laminated map of certain holiday caravan parks which meant that patient safety was improved as first on scene responders reached the casualties quicker.

Meeting people's individual needs

- Ambulance staff had a copy of the trust prehospital communication guide. The guide enabled staff to support patients with a wide range of needs and used a combination of signs and symbols to promote effective communication.

- For patients whose first language was not English the trust used a translation service via a telephone system.

Competent sat

- The service had one vehicle equipped with specialist equipment for the moving, handling bariatric patients and an ambulance equipped to transport patients. Bariatric patients are those with excessive body weight which is dangerous to health. The trust has a bariatric suitable (Harrier) stretcher, which can be separately requested via the duty locality officer when required, and a bariatric ambulance could be requested from the St Johns Ambulance Service. There was a complex patient liaison officer (bariatric lead) based at Ipswich that staff could contact for support and advice.

- In Suffolk, staff had some training in caring for patients with dementia and when questioned were able to describe how they would accommodate the needs of a patient. We observed staff, in Norfolk, conversing with a patient living with dementia and interacting with them at their current need. This led to the patient feeling relaxed whilst the staff assessed their physical health.

- In East Suffolk, staff had information, including criteria and contact numbers, for the dementia intensive support team (DIST). The DIST were available between

9am and 5pm and referral criteria included patients with a diagnosis of dementia or patients aged over 65 with suspected dementia or delirium. There was also a flexible dementia service available between 8am and 5.20pm Monday to Thursday and 4.20pm on Fridays that staff could contact. This was a flexible social care reablement support service enabling people to remain in their own homes.

- The CAT team had information on their systems on receiving calls for people with complex needs. They included plans for taking people to specific hospital wards rather than an accident and emergency department. However, if ambulance staff judged the patient should be taken to an accident and emergency department, they would be.

- Staff in Cambridgeshire were consistently concerned that they were not meeting needs of patients with mental health issues and we saw no care pathways or specific training or support for staff in this area. However in Bedfordshire and Hertfordshire the trust had designed pathways for mental health care and reducing clinically inappropriate conveyancing of patients with mental health conditions. A mental health triage car was available in Bedfordshire staffed by a paramedic and a registered mental health nurse from a mental health trust. They could assess the needs of the patient and provide appropriate care which in some cases avoided the use of a Section 136 detention under the Mental Health Act 1983 and hospital admission.

- In Norfolk, 86% of staff were trained in mental capacity assessments and were aware of how to interact and assess patients living with dementia. We observed staff conversing with a patient living with dementia and interacting with them at their current need. This led to the patient feeling relaxed whilst the staff assessed their physical health.

- We found there was no available loop system fitted currently in the emergency ambulances. The trust website had a "browse-aloud system" to assist the partially deaf or partially sighted viewing the trust page.

- Staff provided examples where they had attended inappropriate call but had given assistance to the patient to ensure that ongoing care was provided. For example, one call was to a person who was sleeping rough but had no medical needs. The team bought

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them a cup of tea, supplied a blanket, and contacted social services, as the individual was new to the area. Another example was of an elderly patient that had fallen in a public place. They had no injury but were unable to use public transport and the crew took the patient home in the ambulance.

Access and flow

- The symptoms described by a caller in the call made to the emergency operations centre (EOC) determined how quickly an ambulance was sent to meet the patient's needs. Large areas of the county covered by East of England Ambulance Service (EEAST) were rural and the roads difficult to navigate due to farm traffic and the general road layouts.

- Hospital admissions and liaison officer (HALO) information submitted for West Suffolk compared data from November 2014 to March 2015 with the same period 2015-2016. Average arrival to handover time had increased in February and March 2016 by 5 minutes as opposed to the year previous. Average handover to clear time had improved in 2015/16, which meant that ambulances were made available sooner (although the improvement was only around one minute).

- Frontline staff said that sometimes no vehicles were available to attend a 'red' call in a specific area, especially rural areas. This happened when ambulance crews were responding to other calls and were delayed in handing over patients to accident and emergency department staff in acute hospitals. In such circumstances, a call would go out to all available ambulance crews in the area to assist. The HALO's employed by the trust had made a difference in terms of improving flow rates; however, these had been removed in some areas of the trust as part of cost saving activities. Managers told us that the transient posts were instrumental in improving performance in access and flow and they were starting to see a negative impact on the service since their removal.

- We reviewed a week's data for hospital delays and found that for the week ending January 17 2016 the following delays occurred:
- Bedford had 393 transports into hospital of which 182 arrivals to clearance over 30 minutes (46%) which gave

hours lost over 30 minutes delays totalled 48 hrs, equivalent whole ambulance shifts (12 hours) lost totalled 4 and number of arrivals to clearances over 60 minutes 22 (6%).

- Lister had 602 transports into hospital of which 446 arrivals to clearance over 30 minutes (74%) which gave hours lost over 30 minutes delays totalled 107 hrs, equivalent whole ambulance shifts (12 hours) lost totalled 8 and number of arrivals to clearances over 60 minutes 43 (7%).

- Luton and Dunstable had 642 transports into hospital of which 305 arrivals to clearance was over 30 minutes (48%) which gave hours lost over 30 minutes delays totalled 60 hrs, equivalent whole ambulance shifts (12 hours) lost totalled 5 and number of arrivals to clearances over 60 minutes 27(4%).

- Watford General had 543 transports into hospital of which 428 arrivals to clearance over 30 minutes (79%) which gave hours lost over 30 minutes delays at 118 hrs, equivalent to whole ambulance shifts (12 hours) lost totalled 9 and number of arrivals to clearances over 60 minutes 53 (10%).

- In Norfolk, staff felt that the advanced medical priority discharge system (AMPDS) was not always efficient in telephone triage and resulted in them having to do primary care and non-emergency call outs. We observed crews being stood down from calls to attend calls that are more urgent instead. This enabled prioritisation of care and treatment to those with more urgent needs. However, staff felt that calls were not always stood down appropriately due to the lack of understanding of telephone triage by the 111 service.

- One week's data from March 2015 was reviewed for Essex. Over the five acute trusts in the Essex locality 2915 patients had been conveyed, with 802 exceeding the 30 minutes for arrival to hand over time and 315 exceeding 60 minutes arrival to hand over time. Between 6th September 2015 to 29th November 2015, the number of hand over delays in Essex (handover to clear over 15 minutes) was 17,074; this issue was being managed at executive level.

- In Essex, the trust experienced significant handover delays at some of the acute hospitals. These delays affected the capacity to respond to patients in the community waiting for an emergency ambulance. We observed crews and vehicles at hospitals waiting to

hand over patients to the care of the emergency departments. For example, one trust had four vehicles to offload and three patients waiting in the corridor. This had been escalated to the Hospital Ambulance Liaison Officer (HALO), who was working in conjunction with the trust to try and accept patients into the ED department

- There was a trial undertaken where a general practitioner was available at the emergency operations centre to help triage calls and could reassign or de-escalate the call. Staff felt that this helped and was a positive but were unsure of results from trial or any decisions made.

Learning from complaints and concerns

- All staff was aware of the complaints process at the trust. Staff were able to describe the process of making a complaint and how to get information for patients if they should wish to complain. However, we found no details of the complaints process on any emergency vehicles. Staff told us that patients and families did not complain to them but would wait until later and then contact the Patient Advice and Liaison Service (PALS). However, staff informed us they would always give people who wanted to complain the correct phone numbers for EEAST complaints services.

- The trust board meets bi-monthly and the board report contains an extensive section on both patient experience and complaints to include themes and patient stories. The trust board also receives anonymised case studies on a bi-monthly basis, which are published on the trust website.

- There is extensive guidance and literature on the trusts website on how to contact the ambulance service, how to raise a complaint, concern, comment, or compliment (including access to the Trusts Complaints Policy), and how to request advice or information. The information detailed on the website is available in a variety of formats including multiple languages and easy read formats. The website itself also has the 'Read Aloud' function, which enables members of the public to listen to the information contained on the trust website. However in Bedfordshire and Hertfordshire there was no information on how to make a complaint on ambulances. Frontline staff did not have any information to give to patients or relatives about how to make a complaint but when asked confirmed they

would provide the telephone number for trust headquarters. One paramedic, in Suffolk, admitted to concerns that offering an apology might lead to risk of litigation against the trust; however he did agree that ambulance crews would apologise directly to patients with regard to delays in arriving on scene. Another commented that they felt that the trust admitted responsibility, or said sorry too quickly in response to complaints when they were not at fault.

- The trust logged complaints onto their electronic incident reporting system and the complaint acknowledged as received within three working days of receipt, an appropriate investigator was assigned, and the trust aimed to investigate and respond to complaints within 25 working days. Trust data showed 23 complaints against its service in Cambridgeshire between August 2015 and April 2016. Fifteen complaints related to ambulance delays, four were in relation to staff attitudes, three related to clinical assessment and treatment, one regarded damage to a patient's property and one complaint was not categorised by the trust. The trust dealt with complaints in line with its complaints policy and within the set periods for responses to complaints.

- Essex received 258 complaints between April 2015 and April 2016, 44 were about staff attitude, 38 clinical treatment, one communication, 9 call handling, 143 delays, equipment four, patient property four, property damage two and transportation 13. We reviewed three complaints, there were actions in response to the complaints for example crew completing reflective pieces and points from learning to be published in clinical quality matters. However, we were not assured that there were robust actions plans in place, or the robustness in sharing learning with staff across the organisation. Staff told us that they were only aware of complaints if it involved them directly, and did not see shared learning or changes in practice.

- Complaints had risen over the last 2 years in Suffolk, with March 2016 showing the highest monthly number (123) of complaints. The trust complaints policy was to acknowledge receipt of a complaint within three days and complete and respond to the complainant within 25 working days but overall achievement was 62% at time of inspection. This has been recorded on the trust's risk register.

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- During April 2015-February 2016, Bedfordshire and Hertfordshire received 721 complaints. This service received 60 complaints (including concerns raised through patient advice and liaison service (PALS)) Policy and Procedure which had been updated on 4th March 2016, this area had 17 open complaints of which 11 were within the deadline and six outside the deadline. Themes showed 61% were delays in ambulance attendance, 14% for staff attitudes and 105 clinical treatment and assessment. We found no evidence of any action plans following incidents or complaints. There was no evidence of shared learning implemented to avoid further complaints.

- Learning from complaints is shared through a mix of local and regional professional updates, trust wide bulletins are sent out by the internal communications team via the intranet / internet 'Need-to-Know' site, e-mail and targeted campaigns such as notice board posters / notices. Where appropriate, the trust corporate induction may be updated to include learning from complaints. Individual staff feedback / appraisals are also employed to share learning from complaints or incidents which may incorporate action plans or reflective pieces where appropriate. Two case studies each month are also published on the trusts website.

- The Clinical Quality and Safety Group (CQSG) receive details around lessons learned from complaints and recommendations are cascaded out to both senior and locality managers to discuss and take forward local.

- At Peterborough and Huntingdon ambulance stations staff kept up to date folders containing details of complaints and lessons learned accessible as part of team briefings or to discuss at appraisal. One staff member said they were made aware of complaints, but only usually if the complaint was about them, not in the wider context of learning.

Are emergency and urgent care services well-led?

Requires improvement ●

We rated the effectiveness of emergency and urgent care services as requires improvement because:

- All staff commented on the constant change in leadership they had seen in the last few years and they saw this change as detrimental to the service as no one stayed long enough to see things through to the end.

- The majority of the staff, including relief workers, were not aware of the trusts vision or strategy for the service.

- Most communication with staff across East of England Ambulance Service (EEAST) was via emails, however the trust had no system in place to record or audit which staff had seen any of the communications sent.

- Some staff did not always feel they were supported after responding to a traumatic call but often this was due to workload.

- Most of the staff gave us examples of working shifts without rest breaks or not being able to finish their shift on time.

However, we also found:

- Leaders knew their responsibilities in relation to the 'Duty of Candour' and how to apply this within their respective roles.
- At Peterborough, staff demonstrated an 'Android App' that was being piloted with staff and funded as a partnership with the local Clinical Commissioning Group. The app enabled staff to use an android phone to access an app that gave details of alternative care support, for example, pharmacists that were open, GP out of hour's service, mental health, and community nursing amongst others.
- The trust employed a full time Community First Responder Manager who oversaw the governance of Community First Responders (CFRs are volunteers who give their own time to respond to emergency calls made to EEAST in their own community).
- Governance systems were in place for third party private and voluntary independent ambulance providers working for EEAST. The trust employed a Governance and Quality Manager who oversaw independent providers to ensure clinical quality was being appropriately identified and monitored.

Vision and strategy for this service

- The majority of the staff including relief workers was not aware of the trusts vision or strategy for the service despite these being visible on notice boards in all of the ambulance stations we visited.

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- Some of the operational staff, in Cambridgeshire, were aware of the trusts values, 'Care, Teamwork, Quality, Respect, and Honesty' and these values were on notice boards at various ambulance stations in offices and staff rest room areas. Not all staff in Suffolk could describe what these values were. However all staff stated that the aim was to ensure patient safety and improve the quality of care for the patient. Staff that worked away from their main bases or who were lone workers in Bedfordshire and Hertfordshire were engaged with strategy, vision and values through clinical quality matters, There was a Whip and feedback newsletters for staff across this service. All staff we spoke with confirmed that they had frequent communication and sometimes it was too much information all at once.

- Senior staff, in Suffolk, said that they believed an improved strategy would be to move to a central reporting system where there was one main depot. This would allow the system, response and staffing to be monitored and led from one location. This would enable better flexibility of staff and improve communication.

- The majority of the operational staff demonstrated a high level of commitment to provide a good quality and safe service for patients and they were extremely committed to their roles. Although they were frustrated at not being able to always achieve national target times for responses to emergency calls and felt it was unfair when hospitals failed to meet their targets that the ambulance services were affected. Some staff were very disillusioned with the ambulance service and one member of staff we spoke with was leaving the service due to what they felt was persistently heavy workloads for little reward.

- Most communication with staff across EEAST was via emails, however the trust had no system in place to record or audit which staff had seen any of the communications sent. Because of the limited time staff spent at ambulance stations and varying staff, shift patterns there time as limited for group or face-to-face meetings.

Governance, risk management and quality measurement

- Senior Locality Managers kept risk registers at divisional level, and the trust had 14 risks on its register at the time

of inspection. Risks were graded according to severity; failure to provide a safe service for patients during industrial action and failure to deliver the service due to increased abstraction levels were given a high priority.

- Sub committees of the board included Quality and Governance, Workforce, Finance and Performance. A non-executive director chaired the quality, safety and governance committee and the board sub-committee. A strategic learning and review group, chaired by the Director of Nursing reported into the quality, safety, and governance committee and was responsible for cascading information out to the organisation via team leaders.

- Although incident reporting was centralised via an electronic system, the trust had an incident review panel responsible for grading the incidents and who undertook investigations. This gave them an overview of themes and trends locally and individual staff members received feedback when and where it was appropriate.

- Across the trust a bi-monthly clinical quality and safety group met and shared both regional and individual locality themes with recommendations for action. A quality governance committee reviewed clinical governance issues. However, clinical governance was not robust in Norfolk. Regular meetings took place where incidents, complaints, staffing and quality issues were discussed and actions raised. However, the impact of these meetings was not effective. For example, incidents were discussed for learning to be shared; yet individual incident reporters did not always receive feedback. Increase in service demand had led to mandatory and statutory training levels, appraisal levels, and audit completion decreasing and this was highlighted at governance meetings, yet no actions had improved any of these issues

- The trust employed a full time Community First Responder Manager who oversaw the governance of Community First Responders (CFRs are volunteers who give their own time to respond to emergency calls made to EEAST in their own community). All community first responders were required to attend on-going professional development and refresher training which was monitored by the CFR Manager and records maintained.

- Staff completed patient care records (PCR) for each patient they attended. These were either in paper format or via an electronic hand-held system. Clinical team leaders sampled and reviewed them against a pre-determined set of criteria. For example, clinical impression, pain score and whether oxygen was administered. Records were available to evidence this was an on-going review process.

- Governance systems were in place for third party private and voluntary independent ambulance providers working for EEAST. The trust employed a Governance and Quality Manager who oversaw independent providers to ensure clinical quality was being appropriately identified and monitored. Reviews included resource levels, ambulance condition, and safety checks, regulation of medicines and complaint management this ensured these providers were operating to EEAST standards and expectations.

- In Norfolk, risk management was not robust. There were four risks identified for Norfolk, Suffolk, and Cambridge on the risk register, and five regional risks. Risks were not always current, for example, a risk regarding the inconsistent use of the electronic patient care record was on the register with an action for the continued prioritisation of its use, despite the electronic patient care record no longer being in use. Another risk was the failure to provide incident feedback in a timely manner; however, the risk had no associated actions for plans for improvement on the register. The trust informed us that risks were managed centrally and local risk registers were used as a local repository only. This meant local risk registers may be out of date and not reflect the wider trust risks.

- A locality standards officer had been seconded in Waveney, this role was responsible for monitoring reported incidents within the locality, checking infection prevention, promotion, and control audits every month and following up the actions. The locality standards officer toured the ambulance stations to ensure that information displayed for staff was up to date, and to identify any problems and take action to resolve these. For example, patient report forms were not stored securely before sent for archiving; as a result, secure post boxes were ordered.

- A combined Norfolk, Suffolk and Cambridge locality risk register was administered by a business support manager. The risk register was only accessible by band seven staff and above and although DLO staff could access the register they could not amend or make changes to it. This meant that local areas did not have direct control over their own local risk register. The risk register was owned by the locality director and reported into the directorate risk register that then fed into the trust risk register. Senior staff at Ipswich identified three top risks as the estate, staffing levels and vacancies, including experience and skill gap deficits and the management infrastructure that did not support clinical supervision.

- Senior Locality Managers (SLM) were responsible for investigating complaints and serious incidents and sitting on the local adult safeguarding board and trauma network. In addition, they dealt with requests for information from coroners as well as supporting staff during coroner's hearings. They informed us they did not receive any formal training for their current role; they shadowed other SLM's and learned from them. This group of managers held daily conference calls with other SLM's across the trust to discuss performance, availability of staffing and sickness levels. It was also a forum for sharing of good practice.

- There was a designated duty locality officer (DLO) at Ipswich each day. This DLO was responsible for coordinating the staff, responses and team skill mix for that day. However they were not supernumerary and responded to requests for additional support. When this occurred the other DLOs at Ipswich would cover any immediate issues or questions until the DLO of the day returned.

- Staff recognised that skill mix, supervision and competency as a risk however the managers and DLOs did not have any input into what training is provided and do not have individual training budgets. At Ipswich 31 staff out of 56 staff had expressed a wish to undertake wound closure, the Senior Locality Managers (SLM) was arranging this but the cost was being taken out of the station budget.

Leadership of service

- All staff commented on the constant change in leadership they had seen in the last few years and they saw this change as detrimental to the service as no one stayed long enough to see things through to the end.

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- Staff were positive about the new Chief Executive Officer (CEO) and said they were hoping they could make positive changes to the service. One member of staff told us that they were in the staff room one day, talking to colleagues and the CEO was sat amongst the staff, being friendly and listening to their views. Some staff had not met the new CEO yet, but all staff were looking for stability in the service and in leadership roles.

- Each of the divisions had a Senior Locality Manager responsible for its operational management. Their role included both a corporate and divisional focus. Staff generally felt supported by this level of management; however, some staff did describe a culture of bullying and an operational friend's network that saw people being promoted into roles due to personal friendships rather than professional abilities. A number of duty location officer (DLO) and SLM were acting up into roles due to changes in the managerial team, but the majority of staff found these approachable and easy to get along with.

- Support mechanisms were in place for staff. An employee assistance programme was in place for all staff to access counselling called trauma risk management (TRiM) and details regarding the blue light programme to help staff manage stress and anxiety was displayed in all ambulance stations. Staff told us that they knew how to access the service and a number of staff had done so, but in the main staff talked to each other as a way of coping.

- Some staff did not always feel supported after responding to a traumatic call but often this was due to workload. Staff did also offer examples of being 'stood down' from calls to take time after events. We saw an ambulance crew given excellent support from a station DLO following an unexpected death. The DLO was supportive and sensitive to the staff whilst understanding the pressures of the service and ensured that another ambulance crew was available to pick up any calls whilst the ambulance crew took time to recuperate.

- All staff knew of the national targets for response times. They were frustrated that they were not able to achieve targets but were focussed on good clinical care for patients.

- Due to the remote working nature of staff most of the communication from senior managers was via email although there were no systems in place to monitor whether staff had read the emails. The trust was not assured staff had seen and read messages sent out which sometimes included clinical updates. Some staff told us communication was a problem, especially those working relief shifts.

- Most of the staff gave us examples of working shifts without rest breaks or not being able to finish their shift on time.

- Although the trust had scoped various initiatives for leadership development, only one locality manager officer (LMO) confirmed he had completed the leadership academy programme.

- Senior leaders were visible to staff across Norfolk, staff confirmed that board members had visited, including the chair, the chief executive officer, the nursing director, and a non-executive director. The locality manager visited stations approximately twice a year and held open surgeries, advertised to staff. All staff were aware of who their SLM were and had met them.

- Across the trust the nursing director sent out a regular communication to all staff named Clinical Quality Matters. This provided articles around clinical issues with guidance for staff around conditions, site management, and helpful tools. SLM sent out monthly newsletters to their staff with staff news, reminders, and updates and shared learning.

- In an attempt to improve communication there was a conference call facility introduced in west Suffolk instead of a meeting where staff could dial in however not all staff were aware of this facility.

- Staff in East Suffolk said that there had been an action plan produced in response to the NHS staff survey however, this had just been written and given to the senior team to implement with no input from the staff directly. This meant that staff had no ownership of the actions and that senior staff were missing the opportunity to get input and ideas from the staff working in that environment.

- There was a disconnect at the director and sub director level with limited autonomy given to the SLM in each area. Staff in East Suffolk stated that the distribution of

teams and crews should be reviewed. More consideration should be given to geographical location and the draws from certain areas to enable crews to distribute more fairly. The SLM for East and West Suffolk across the county meet every Tuesday to discuss issues, share practice and ensure communication across the patch.

Culture within the service

- There was not a cohesive culture amongst staff working at the trust. The trust had performed poorly in the 2014/15 staff survey in respect of bullying and harassment from staff at work. The survey reported 30% of staff had experienced this more than once. IN the latest survey in 2015/2016 this figure had increased to 32% which was just over the national average of 30%. However in this survey the numbers of staff reporting this had increased as had improved communication with senior managers. However the 2015/2016 survey also shows that staff motivation at work had increased. We found a mixed picture across the service. There were pockets where teams worked well and felt supported and others where they felt disengaged with the senior managers. Staff at focus groups reported a negative culture however when we spoke to staff during our inspection we found a more positive picture.

- Staff, in Cambridgeshire, told us they were proud to work for EEAST and loved their jobs but felt the organisation did not value them. Some staff told us goodwill was being eroded because of this and that they were working long hours without any real reward. In Suffolk, there remained an overwhelmingly positive culture amongst the staff to maintain patient focused and provide care to a high standard. Staff felt proud of their job and in general, felt direct teamwork was cohesive. Staff, in Hertfordshire and Bedfordshire, told us there was a culture of silo working. Although there were trust wide policies in place, there were divisional differences in interpretation. Frontline staff and managers in Norfolk consistently stated that service provision felt stretched, and that key performance indicators (KPI's) would not be possible to reach in Norfolk due to the rurality of the county. This led to staff feeling frustrated that their efforts and skills were not as valued as reaching KPI's. Staff, In Essex, told us that there was little engagement with the trust when they were making decisions. For example, the introduction of

designated lunchtime breaks. The trust informed us they had engaged locally with staff concerning these issues. Staff told us that duty rotas for relief staff were often published with three to four weeks' notice, which meant that planning and balancing family life was difficult.

- During our observations all EEAST staff were committed to ensuring patients received a good quality service and we noted that staff behaviours and conduct reflected the values of the organisation at all times.

- We heard negative concerns from some staff, in Cambridgeshire, about lack of support by the organisation and inconsistent management practices between the various teams. Staff said that the DLO roles were in the main supportive but there was a clear undercurrent amongst the staff that some DLO managed on a personal rather than a personnel basis. We could not be assured that the culture in the service encouraged openness and transparency, although we observed good teamwork and patient care.

- In Essex, a number of staff raised concerns with us about a bullying and harassment culture amongst some of the frontline managers, particularly in relation to management of complaints and incidents. Some staff told us that there was an "accusatory" culture of blame, before finding out facts, or staff being given the opportunity to respond. However in the main, the majority of staff felt supported by their managers and able to seek advice and guidance.

- Results for the trust in the NHS Staff Survey for 2014 showed that the percentage of staff receiving an appraisal was 29.13%; the national average for NHS ambulance trusts was 67.40%. Staff routinely told us they had not had appraisals for one, two, and three and even in some cases six years. The appraisal culture was very much a tick box exercise and staff felt devalued without a real opportunity to discuss their performance or aspirations for the future.

- Leaders knew their responsibilities in relation to the 'Duty of Candour' and how to apply this within their respective roles. Leaders gave an example of a serious incident that led to the death of a patient and how the leadership team had been open and honest with the patient's family. This included a written apology, the opportunity for family to visit the ambulance service

and experience front line activities to gain an understanding of the issues that led to the incident occurring. However, front line staff were not aware of the duty of candour or how to apply this within their roles.

- In Essex, staff told us that the system for booking annual leave was fraught with difficulties. For example we were told in peak times staff would have to book annual leave a year in advance which was in line with trust policy, and "wait until midnight" to enter a request on the system on a day by day basis. Staff told us that often annual leave was declined with no reason and no opportunity to discuss with line managers.

- The trust operated an excellence award named "Hidden Gem." We saw the certificates that had been presented to the ambulance fleet assistants displayed at Chelmsford.

- There were some concerns identified by staff, in Suffolk, that there was a lack of understanding between the different services, such as urgent and emergency care, emergency operations centre, and patient transfer services. A supportive joint approach was not evident due to the increasing pressures separately felt from each of these services.

Public and staff engagement

- Each area had its own mechanisms for engaging the public in the work that they undertake. In Cambridgeshire, staff interact with the public via emergency service days, attending local schools and shopping centres to put on displays and raise awareness of what the services can offer to the public. In East Suffolk, there were monthly meetings with community first responders and the team frequently attend schools, social clubs such as the Brownies, and any large social events. In Hertfordshire and Bedfordshire we heard that the trust engaged with the public to ensure that the service was used appropriately by use of the trust webpage which featured the channel 4 programme "999 what's your emergency," this included blogs and the use of social media to educate the public in relation to finding the most appropriate method of assessment and treatment in non-emergency situations. Materials for the public

explaining how emergency calls are graded and alternative pathways to emergency care were available at public events and via social media, such as Facebook and Twitter.

- The trust held annual public membership meetings where members of the public could meet key individuals and hear performance feedback as well as discuss concerns and plans for the future of the services.

- The trust worked with frequent callers, for example nursing homes, to try to reduce calls and find the right services for the care homes to access. Staff gave an example of a local nursing home, who frequently called EEAST due to falls by residents. EEAST staff worked with the care home, local authorities and safeguarding teams to identify why the falls were prevalent. The care home then accessed specialist training and equipment in order to reduce the risk of falls to residents and reduce calls to the service.

- Evidence we gained from ambulance stations showed the public appreciated and respected the skills of ambulance staff. In many ambulance stations, we saw newspaper clippings and 'thank you' cards on notice boards thanking the ambulance crews for their help, care, and support to either the patients or members of their families.

- The trust engaged with the Mind Blue Light Programme supporting ambulance workforces in England with practical ways to stay mentally well.

- In Norfolk, the executive and non-executive team engaged with staff by attending ambulance stations and depots regularly to meet with staff. Newsletters were sent out from the chief executive officer (CEO) to all staff and one student paramedic stated that they had emailed the CEO a several times and received a personal response each time. In Suffolk there are localised trust user groups (TUG) which meet bi-monthly and senior managers attend these meetings. Minutes from meetings demonstrated engagement with the trust although there was no recent evidence of change instigated because of the interaction.

- Multidisciplinary meetings are held with local services, for example, GP's, mental health services, the police, to discuss locality needs and prioritise services.

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- Peer to peer and pastoral care workers schemes were available to support staff who had experienced traumatic events or increased levels of stress.

Innovation, improvement and sustainability

- At Peterborough, staff demonstrated an 'Android App' that was being piloted with staff and funded as a partnership with the local Clinical Commissioning Group. The app enabled staff to use an android phone to access an app that gave details of alternative care support, for example, pharmacists that were open, GP out of hour's service, mental health, and community nursing amongst others. This was still in a trial phase so we were unable to measure any impact on the service during our inspection.

- North Bedfordshire had introduced the partnership for excellence in palliative support (PEPs) scheme (end of life care support scheme) to support patients, families and others close to them with end of life care advice, support, and guidance.

- South Bedfordshire participated in the local ambulance fleet assistant implementation trial and the mid shift rota/family friendly hours trial. They had also introduced the EMT course run by local staff for local staff.

- Trust wide the clinical manual for staff and volunteers had been introduced and the "Need to know" staff news website was the winner of 2015 UK public sector communications awards.

- Trust wide hidden gems staff awards had been received by two staff, who displayed certificates they had been presented.

- Innovation, improvement, and sustainability initiatives took place across Norfolk across different staff groups. In Waveney, the ambulance fleet assistants (AFA) initiated and arranged for the implementation of a diesel pump at the depot. This meant that AFA could refuel vehicles instead of crews and helped to reduce late finishes as well as saving money.

- A clinical assessment and treatment hub was piloted in North Walsham for a period of three weeks in conjunction with local GP's. An emergency care practitioner (ECP) worked with GP's to see and treat patients in North Norfolk with the aim of reducing

ambulance crews based in North Norfolk being drawn into the local hospitals. The results of the project were being reviewed at the time of our inspection so we could not tell the effectiveness of this pilot.

- A falls project was being carried out in Norwich by the falls coordinator. Five care homes had originally been identified by the amount of patient falls the service had been called to. Any issues were evaluated as cause for the number of falls, and the coordinator had attended the homes to educate and suggest alternate pathways where appropriate, including the provision of flowcharts. The project had expanded to include 15 care homes recently. The project was not complete at the time of the inspection so we could not assess its effectiveness.

- A member of staff has written a suggested guidance document that is currently being reviewed by the clinical directorate with potential for wider trust publication.

- One paramedic in Ipswich has worked for three years on an initiative with East Suffolk care homes to reduce the number of 999 calls. They have developed ISTUMBL (falls assessment), patient identifier forms, research paper on falls, costs, resources and a traffic light assessment. ISTUMBL – was an anagram to help care homes identify if ambulance needed. The "I" stood for injury. If the patient had no bleeding, no pain and could move limbs then an ambulance was not required. A traffic light system was based on the national early warning score (NEWS and is designed to guide care home to the appropriate pathway. The traffic light system correlates to the patient injuries and gives a red, amber or green result. Red means 999 required, amber indicates GP referral and monitoring, green indicates GP and self-care. With the exception of 20 hours, the work had been undertaken in the individuals own time. They deliver training on an adhoc basis and said despite being asked frequently for information there was still no formal way of sharing good practice throughout the trust.

- Patient identifier forms (PIF) in Suffolk, helped to address the limited information at care homes for past medical history. The PIF was a front sheet that when completed held all required information that a paramedic would need to know. However, it was a struggle to get all care homes to participate.

Patient transport services (PTS)

Safe	**Requires improvement**	🟠
Effective	**Requires improvement**	🟠
Caring	**Good**	🟢
Responsive	**Requires improvement**	🟠
Well-led	**Requires improvement**	🟠
Overall	**Requires improvement**	🟠

Information about the service

Patient transport services (PTS) provide non-emergency transport for adults and children who are unable to use public or other transport due to their medical condition. This includes those attending hospital out-patient clinics, being discharged from hospital wards and those who need treatment such as chemotherapy or renal dialysis.

East of England Ambulance Service (EEAST) is commissioned to provide PTS in Cambridge, Suffolk, Great Yarmouth, Waveney and Norfolk. There are 157 PTS vehicles operating across these areas, with Cambridge and Suffolk having the highest volume of vehicles. The service is assisted by volunteer drivers using their own cars to support this service.

The patient transport service recorded approximately 460,000 patient journeys between April 2014 and March 2015.

There are 482 staff employed in the service consisting of 332 patient facing staff and 35 administrative and control staff. Within patient facing roles there are ambulance care assistants (ACAs), drivers and volunteer drivers. Within the control and administrative teams there are patient liaison assistants (PLAs), senior patient liaison assistants (SPLAs) and operational resource assistances (ORAs). Within managerial roles there is one head of PTS, four locality business managers (LBMs) who report directly to the head of PTS and nine ambulance liaison officers (ALOs) who are immediate line managers of patient facing PTS staff.

During our inspection, we visited six ambulance stations where we spoke with 32 staff including ambulance crews, managerial staff, maintenance staff, administration staff and control staff. We spoke with six volunteer drivers and observed six patient transport staff during their shift. Our observations included patient journeys from their home or care home to outpatient departments and a renal dialysis unit.

We spoke with 23 patients using the patient transport service in a variety of settings. This included patients on ambulances and those waiting for collection from the hospitals or the renal dialysis unit. We were also able to speak to four patients who had previous experience of using the service and four carers who were accompanying patients on their journey.

We spent time in two PTS control centres where all aspects of booking and transport are coordinated. We also visited two acute hospitals and spoke to ward staff and discharge lounge personnel.

Patient transport services (PTS)

Summary of findings

We rated patient transport services overall as requiring improvement.

There were a lack of policies and procedures to support staff within their roles and safeguarding processes were not clear to all staff and managers. Fire safety processes did not ensure staff and visitors would be kept safe. Staff were not always supported to participate in training and development opportunities and there were significant knowledge gaps in relation to consent, the Mental Capacity Act and how this is applicable to practice. There were no methods in place to monitor staff performance within the service.

Appropriate information was shared between multidisciplinary teams prior to the patients transport and there were good relationships were in place with local healthcare providers. The booking system was easy for people to access, with flexibility and choice of services and people living with disabilities could easily access the service and have their needs accommodated. Staff showed a good awareness of people's needs in relation to disability, race, religion and age.

There were some delays in sharing information relating to patients and their transport needs due to communication devices being unreliable and there were shortfalls in assisting communication with people who did not speak English.

Complaints procedures were not directly available to patients and staff did not know where to signpost patients and we found that learning from complaints was not shared across the service.

The culture within PTS was poor, with staff feeling a divide between PTS and the rest of the ambulance service. Staff also felt unsupported by leadership teams and that there was a clear separation between them. Staff and managers did not understand the service's strategy or plans moving forward, due to uncertainty with contracts and due to lack of innovation or set objectives.

However, we found people were treated with dignity, respect and kindness during all interaction with staff. All patient facing staff showed an awareness of the importance of providing emotional support to patients during difficult times, including developing positive relationships with regular patients who were undergoing major healthcare treatments. Feedback from patients who used the service, and those close to them, was largely positive about the way staff treat people.

There were pockets of enthusiastic and forward thinking line managers who wanted to improve the service.

Patient transport services (PTS)

Are patient transport services safe?

Requires improvement ●

We rated patient transport services as requiring improvement because:

- There was little evidence of learning from incidents within the service.
- Standard operating procedures and policies were not fit for purpose and did not support staff in their daily duties.
- All staff groups had minimal knowledge of the role the service would play should a major incident occur.
- Safeguarding was not always prioritised and concerns raised in a timely manner to ensure patients are kept safe.
- Sufficient cleaning processes were not in place to prevent the risk of spread of infection.
- Mandatory training attendance did not meet the trusts target, including basic life support and safeguarding.
- Fire safety processes were not sufficient to ensure staff and visitors would be kept safe in the event of a fire.

However

- Premises were suitable for the role of the service and were kept clean and organised.
- Staff knowledge of DNACPR forms and their importance was consistently good across all areas of PTS, ensuring that patients' wishes would be respected.

Incidents

- There had been no Never Events reported within PTS between January 2015 and January 2016. A never event is a serious incident that is wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- There had been one serious incident between January 2015 and January 2016, this related to information governance and a breach of confidential data. A root cause analysis (RCA) was completed and lessons learned and appropriate future actions identified, including improving information governance training. The appropriate action was taken to inform those whose information had been breached.

- When things go wrong, thorough and robust reviews or investigations are not always carried out. An electronic system was used for reporting untoward incidents. All staff understood their responsibilities to raise concerns and near misses. However, staff told us that they didn't always report incidents formally and would discuss with their line manager instead.
- Three staff we spoke with told us they felt there was a reluctance to report incidents amongst PTS staff due to being frightened of repercussions and that they would be questioned over the reported incident in an accusatory way.
- We did not see evidence that lessons learnt following incidents were shared or that action is taken to improve safety beyond the affected team or service. Staff we spoke with told us that feedback was not routinely given following the report of an incident, if the reporting member of staff wished for further information they would have to approach their manager who would then provide feedback on the incident. Staff felt that this inhibited learning lessons from incidents as feedback was not shared individually or as a workforce.
- Between October 2015 and April 2016, there were 239 incidents reported onto the electronic system. We asked the trust to provide us with incidents only but they were unable to provide this. From the 239 incidents we saw that whilst complaints generally had actions taken completed and documented the responses, incidents did not always have clear and concise actions documents or any lessons learnt. 78 out of the 239 incidents (32%) recorded did not have any investigative comments or actions documented.
- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Care Quality Commission (Registration) Regulations 2014. 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.
- We could not be assured that people who use services are told when they were affected by something that goes wrong, given an apology and informed of any actions taken as a result as staff we spoke with were unaware of the duty of candour and what it meant to their practice.

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Mandatory training

- Not all staff received effective mandatory training in the safety systems, processes and practices.
- We reviewed mandatory training data and found that not all modules met the trusts target attendance of 90%. Oxygen administration training had attendance rates of; 67.7% of ACAs and 77.7% of drivers, both infection control and mental capacity act (MCA) training had attendance rates of 53% of ACAs and 51.2% of drivers. 40% of non-operational staff had completed mandatory training.
- Mandatory training was provided in two formats, face to face in personal update (PU) training and via paper workbooks. For operational patient facing employees, all refresher mandatory training was delivered in both formats, for non-operational employees (such as those working in the control room) training was delivered via the workbook.
- PU training included topics such as basic life support (BLS), safeguarding, manual handling and infection prevention. We reviewed training materials from PU courses and found it to be in line with the most recent national and professional guidance.
- The mandatory training workbook covered topics such as information governance, equality and diversity, fire safety and safeguarding. In conjunction with reading the workbook staff were required to fill out an assessment booklet to demonstrate their understanding of the training material and subject.
- The trust had a policy on checking the driving license of staff which included an annual check. However senior staff told us that licenses were checked at recruitment and when a driving course was undertaken. Most PTS staff drove on their car licenses and did not require further training.

Safeguarding

- Safeguarding systems were in place however the process and practices that are essential to keep people safe were not communicated or clear to staff.

- Staff received level two safeguarding training for adult and children which was appropriate for their role and in line with intercollegiate guidance.
- The trust policy stated that safeguarding training should be conducted every two years for patient transport staff and this would be completed during their PU training and also within their workbook.

- Data provided by the trust showed that no staff group in PTS met the trust target of 95% attendance. During 2014/2015, 67.7% of ACAs, 77.8% of drivers and 14.3% of managers had received safeguarding training with their PU session. Workbooks had been completed by 32.15% of patient facing staff in 2013/2014 and by 52.4% of patient facing staff in 2014/2015.
- A single point of contact (SPOC) number was in place to allow staff to phone and report safeguarding concerns. Staff told us that they would report safeguarding incidents onto the electronic incident report system rather than calling the SPOC line dependant on what their manager told them to do. Staff PU training advises staff to report all safeguarding concerns through SPOC.
- We asked managers whether this was the correct process and they told us that staff could do either and that if it was noted on the electronic incident report system then a manager would report it to the safeguarding team.
- Managers told us that sometimes staff did not report safeguarding concerns directly but would write a note on their patient list sheet to suggest there was a concern; the manager would then report it as a safeguarding concern.
- The lack of consistent process and training across the PTS service meant there was an opportunity for some safeguarding concerns to be missed and be unreported.
- Within the majority of PTS vehicles there was a booklet containing information relating to safeguarding, to assist staff in recognising abuse and also advising them on the SPOC contact number. The majority of staff we spoke with were unaware of these booklets.

Cleanliness, infection control and hygiene

- We were not assured that reliable systems were in place to prevent and protect people from a healthcare-associated infection particularly in relation to dirty vehicles.
- During our inspection we found that eight out of 24 (33%) vehicles were visibly unclean, with four vehicles containing opened food and drinks containers.
- There was no deep clean process in place within PTS; managers told us that it was staff responsibility to clean the vehicle at the beginning of each shift.
- Within the daily vehicle checklist there was a box to state whether the crew had cleaned the vehicle, we found this was not consistently filled out. We reviewed

Patient transport services (PTS)

88 daily vehicle check records across PTS and found that 45 (51%) did not state they had been cleaned during their shift, with several of these not stating whether a vehicle had been cleaned on three consecutive days.

- Managers told us that the daily vehicle checklists were not audited and that they were unaware that daily vehicle cleans were not being completed.
- Staff we spoke with were able to describe the steps they would take if a vehicle became heavily contaminated or they had carried a patient with an infection disease.
- All equipment within vehicles was visibly clean. We witnessed staff cleaning items between patient uses.
- We found that baby carrying seats stored on station were unclean, these had fabric covers and staff told us that these were not washed in between uses. Two straps on different carriers had white dried stains that staff were unaware how long they had been there. Staff were unsure who was responsible for ensuring these seats were clean.
- All stations we visited were visibly clean and suitable for their purpose; most station had a domestic member of staff for daily cleaning.
- Cleaning facilities and products were available on each station for crews to utilise and each vehicle had a stock of decontamination wipes for surfaces and equipment cleaning.
- Infection control audits of premises and vehicles were completed within PTS. The stations audited were Martlesham and The Paddocks, with average compliance since October 2015 being 82.4%, we saw no action plans in place to improve months where compliance was low. Vehicle audits were consistently completed monthly across all areas, with an average of 99.2% compliance across 131 vehicles. However when comparing results to our findings they did not always correspond, some vehicles were given 100% compliance relating to equipment the week prior to our inspection, whilst we found equipment that had been out of date for over six months on the vehicles.
- We found that 10 out of the 24 (42%) vehicles checked lacked full PPE, with eight of these missing aprons and face masks.
- All staff we saw on stations adhered to the trusts infection control policy and regularly utilised hand washing facilities or alcohol gel where sinks were unavailable.

- 96% of all vehicles checked contained alcohol gel for staff, patients and visitors to utilise; most staff also carried individual bottles of alcohol gel with them.
- Hand hygiene audits were not conducted due to the nature of the role meaning that staff were not in one place for a long period of time; however managers told us that hand hygiene was covered during infection control training and we saw notices advising staff on correct hand hygiene across stations.
- Infection control training should be completed within the training workbook yearly; the 2014/2015 completion rates show that 53% of ACAs, 51.8% of drivers and 42.86% of management had completed this training section. This did not meet the trusts target of 90%.
- Stations did not have laundry facilities and staff took their uniforms home to wash. Information was visible on station notice boards to advise staff how to wash their uniforms appropriately.

Environment and equipment

- The design, maintenance and use of facilities, premises and equipment generally kept people safe, but some areas including safety restraints and disposable equipment were not safe for use.
- Most vehicles appeared to be in good condition, with those that were unsuitable for use having a notice in the windscreen to advise crews. Some of the vehicles at The Paddocks station had worn seats with tears in the material.
- Staff completed a daily vehicle check at the beginning of each shift, which was printed onto the back of the crews' daily job sheet. This checklist included inspections of electrical equipment for example lights and radios, non-electrical equipment such as lifting aids and chair restraints, and medical equipment including oxygen and first aid boxes. We reviewed 88 daily vehicle checklists and found that 19 were incomplete. Managers told us these sheets were not audited to establish if crews were completing them fully during each shift.
- Vehicle records indicated they were regularly serviced under manufacturer's warrantee at specialist dealerships. Records indicated that those vehicles requiring an MOT were up to date. The trust aimed to have all their vehicles less than five years old, however some had been in service for 10 years.
- There was a system for reporting defects. These were appropriately assessed and repairs organised in a timely

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manner. Staff told us they sometimes waited until the end of their shift to report defects as there were not always replacement vehicles, but this would generally be discussed with a manager to ensure it was safe to do so.

- Vehicles were fitted with a winch for use when assisting patients in wheelchairs onto a vehicle. We observed staff checking and using this equipment safely.
- Each vehicle checked during inspection had an automated external defibrillator (AED) available for use, one out of 24 AEDs had out of date defibrillator pads stored. All AEDs had been serviced and were stored securely on vehicles.
- We found out of date equipment including airway adjuncts, dressings and alcohol wipes in eight vehicles. Single use equipment was not always stored in sterile packaging as advised by the manufacturer. We raised these concerns with managers on individual station who made attempts to rectify them where able on the day of our inspection.
- Patient equipment such as walking aids could only be carried with prior arrangement due to limited space and the need to secure all items during travel. However, we did see staff showing flexibility when a patient's walking aid was secured and transported despite not being booked.
- Vehicles did not have the appropriate safety belts to transport children. Vehicles with trolleys only had an adult harness and no adaptor available for children. Staff told us that they had access to baby carrier seats if a small infant required transportation. We saw these on several stations however no one took responsibility for ensuring the safety or suitability of these seats, they had no checks completed or documentation as to when they had been acquired.
- Vehicles were fitted with appropriate moving and handling aids, which included slide sheets, banana boards, and lifting belts. Staff we spoke with were confident in the use of these moving and handling aids.
- Stations we visited had appropriate storage facilities and space for their use.
- Five of the stations we visited did not have appropriate fire safety advice in place. There was no congregation point displayed to advise staff and visitors where to go if there was a fire, and regular fire alarm tests had not been completed. However all stations had green arrow signs to direct people to the nearest fire exit.

- Appropriate arrangements for managing waste and clinical specimens keep people safe.
- Clinical waste was stored appropriately on all vehicles and each station had a clinical waste bin that had appropriate segregation of waste in line with national guidance.

Medicines

- Arrangements for managing medicines and medical gases kept people safe. However there was a lack of documented processes and practices in place to communicate to staff and monitoring of administration of medical gases was not audited or reviewed.
- PTS vehicles did not carry medication, other than oxygen. Oxygen cylinders were available on vehicles for those who required oxygen during transport, with most patients bringing their own if they were on oxygen regularly.
- Oxygen cylinders on the vehicles had a sticker indicating the delivery regulators had been checked and the oxygen was within date. Staff checked these during the routine morning vehicle checks. We looked at vehicle check books and found that oxygen was checked prior to the start of each shift. We found two oxygen cylinders out of service date and one large empty oxygen cylinder being stored on vehicles; staff rectified this immediately and obtained new cylinders.
- Replacement oxygen cylinders were stored on some stations, with staff knowing where to obtain a new cylinder if necessary.
- Staff told us they would either administer oxygen based on a medical professional's prescription or that they could make the decision to administer oxygen should they feel a patient would benefit from it. There was guidance and documentation available to all staff in the administration of oxygen. We discussed this with staff and the majority we spoke with were unable to give an appropriate example of when to administer oxygen or what the potential risks of administering oxygen inappropriately were. Administration of oxygen should be documented if given in an emergency situation but managers and staff we spoke with were not aware of the process involved.

Records

- PTS staff received printed daily job sheets at the start of a shift. These included collection times, addresses and

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patient specific information such as relevant medical conditions, mobility, and if an escort was travelling with the patient. Information was stored in the driver's cab out of sight, respecting patient confidentiality.

- PTS staff received information via mobile telephones, although staff told us these were unreliable at times due to network coverage and short battery life. Team leaders were assessing this issue although it was not on the risk register. Staff told us this was not a direct risk to patients as information was recorded on the daily job sheet and updates could be received through the radio system. However, they felt the mobile telephone system was better for patient confidentiality.

- Patient medical records were transported in an envelope and handed directly to a nurse or carer on arrival at the destination.

- Do not attempt cardiac pulmonary resuscitation (DNACPR) orders were communicated in advance of journeys to PTS crew. This would be on their job sheet or mobile telephone. All staff we spoke with knew the importance of the original DNACPR form travelling with the patient. The service had introduced small plastic cards to provide crews with a reminder to ensure all aspects of the patient DNACPR were valid, most staff we spoke with were aware of these cards.

- Within The Paddocks station patient information was not always stored securely; we found a box of historic daily job sheets containing patient identifiable information kept in an unlocked store room. We also found two daily job sheets containing patient information from 2013 stored within vehicles.

Assessing and responding to patient risk

- We were not assured that staff could identify and respond appropriately to changing risks to people who use services, including deteriorating health and wellbeing and medical emergencies. However staff demonstrated a good understanding of dealing with changes in behaviour.

- Information about patients' needs, collected at point of booking, was communicated to PTS staff on their printed daily job sheets. Many patients were regular users of the service and crews were familiar with their needs.

- Staff told us if a patient became unwell during a journey, they would stop their vehicle as soon as it was safe to do so. Staff were not always clear what action they would take should a patient deteriorate, some stated they

would call the facility they collected the patient from, others would call a manager and some would call 999. Senior staff told us that the procedure was to call 999 however most staff used their radios straight to the control centres. There was nosupporting policy or standard operating procedure (SOP) in place to advise staff what to do or what steps to take. Some staff said they did not feel confident in recognising a deteriorating patient due to gaps in training.

- All patient facing staff were required to attend basic life support training, data from 2014 to 2015 showed that only 67.7% of ACAs and 77.7% of drivers had received this training. However all staff we spoke were had a good knowledge of how to administer cardiopulmonary resuscitation (CPR) if required.

- Patients with complex needs were generally accompanied by a carer or relative. Staff told us they had good relationships with carers and relatives of regular patients, which helped them to cope with any concerns relating to the patients complex needs.

- During periods of high activity or difficulties due to adverse weather conditions patients with life threatening conditions were prioritised. This included patients requiring renal dialysis or chemotherapy.

Staffing

- Staffing levels and skill mix were planned and reviewed so that people received safe care and treatment the majority of the time.

- The overall vacancy rate across PTS was 15.4% (57 whole time equivalent). The staff group with the highest vacancy rate was managers and administrative at 58.8% (13 staff) and the lowest vacancy rate was ACAs (5.9%).

- Staff turnover for all staff groups increased from 2013-14 to 2014-15. Overall PTS turnaround in 2013-2014 was 7.5%, this increased to 17.58% in 2014-2015. The highest staff group turnover was drivers and liaison/control staff. Patient facing staff we spoke with told us that staff often left the service due to lack of progression opportunities and professional development.

- Sickness throughout PTS was generally below 7% between December 2014 and December 2015, there was a peak at 11.57% during June 2015 within the Great Yarmouth and Waveney team but this then decreased to below 7% for the remainder of the time period.

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- Staffing levels generally met planned levels at all times of the day when PTS were operational, when sickness increased other staff provided cover through overtime and bank staff were utilised.
- Staff generally finished shifts on time and most staff felt that control staff were considerate when allocating work close to finish times. From reviewing staff timesheets we saw that excessively late finishes did not often occur. Staff felt they had adequate breaks during shifts and were generally supported to take these within an appropriate time scale. Some staff did occasionally have late meal breaks, but told us that when this became excessive they would inform their manager.

Anticipated resource and capacity risks

- Senior staff that we spoke to told us that potential risks were taken into account when planning service provision. This included instances such as industrial action (internal or external), adverse weather and seasonal fluctuations.
- We saw Business Continuity Plans in some areas of PTS, these plans provide a step-by-step guide on how to recover services in all areas should there be disruption caused by any adverse incident impacting on service delivery or loss of infrastructure, this was not consistent across all areas.
- We saw evidence that changes made to service delivery were equality impact assessed. For example, plans to amalgamate control rooms had undergone a full risk assessment and included consultation periods with staff.
- If severe weather conditions occurred there were contingency plans in place to ensure services were provided to the most vulnerable and/or urgent patient, for examples those requiring chemotherapy.

Response to major incidents

- Whilst the trust had a credible emergency/ major incident response plan and policy there was not a thorough understanding of the direct role PTS would take.
- Some staff we spoke with believed that there was a section on major incidents covered within their induction but they could not remember details. Other staff that we spoke with had not received major incident training, they were able to describe what their actions might be if there was a major incident, but had not received formal training. Staff also told us that they were

aware that PTS was included in the trust's major incident policy and felt that their role would be to support emergency operations in the event of a major incident. Some managers had received training, but again this was not consistent across all areas.

Are patient transport services effective?

Requires improvement ●

We rated the service as requiring improvement for effective because:

- Staff were not always supported to participate in training and development opportunities.
- There were significant knowledge gaps in relation to consent, the Mental Capacity Act and how this is applicable to practice.
- There were no methods in place to monitor staff performance within the service.
- There were some delays in sharing information relating to patients and their transport needs due to communication devices being unreliable.

However

- Appropriate information was shared between multidisciplinary teams prior to the patients transport.
- Eligibility criteria reflected national guidance.
- Good relationships were in place with local healthcare providers.

Evidence-based care and treatment

- People have their needs assessed and their care planned and delivered in line with evidence-based, guidance, standards and best practice. Eligibility for patient transport reflected Department of Health guidelines and was monitored by the control centre staff at point of booking.
- There was guidance in place in relation to oxygen administration, with managers advising us that it would have been taught during each member of staff's first person on scene (FPOS) course. We reviewed the most recent training presentation dated 2012 which advised staff to consult the joint royal colleges ambulance liaison committee (JRCALC) guideline in relation to which levels of oxygen to administer, none of the staff we spoke with had access to these guidelines or had

previously seen them. Staff told us they did not feel confident in knowing when to administer oxygen and there was no guidance day to day to inform them of when this would be appropriate.

Assessment and planning of care

- Patient's care needs were assessed at point of contact by the PTS control staff and communicated to the ambulance staff on their job sheets and verbally via radio transmissions. Relevant patient information such as medical conditions, mental health conditions and patient's mobility was also collected by control staff and information relayed to the PTS crew.

- Bookings were received via a fax machine direct from referrers such as GPs and hospitals and also via the telephone. Staff in the control room told us that if they received a referral that they felt was not appropriate they would liaise with the referrer to clarify the patient's needs.

- Some staff told us that GPs and hospital staff who book transport sometimes underestimated patient requirements, mainly in terms of mobility. This meant PTS crews arriving with unsuitable vehicles or equipment to transport patients and the patient then would need to be rebooked, delaying transfer.

- Crew staff also told us that they would carry out their own informal assessments on arrival at a patient's pick-up location. For example, if they arrived at a patient's home address they would make an initial assessment of the environment, surroundings and patient's mobility before attempting to transport them.

Nutrition and hydration

- PTS staff 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. Staff told us that they would check with diabetic patients if they had some food or biscuits with them if the journey was extensive.

Patient outcomes

- Information about peoples care and treatment that used this service was routinely collected and monitored to establish if intended outcomes were being achieved in line with commissioners' requirements.

- Key performance indicators (KPIs) were used to establish whether intended outcomes were being achieved. KPIs were set by the various local commissioners in line with national guidelines and in agreement with the trust; this did mean that there were some variations in requirements by contract.

- Monthly performance figures showed that between April 2015 and November 2015 the trust performed well and met targets in all areas for KPIs relating to patient documentation and vehicle/transport suitability for the patient. There were also KPIs set in relation to the percentage of patients that arrived for their appointment times within specified timeframes, these varied slightly between contracts.

- In Great Yarmouth and Waveney targets included 98% of patients should arrive at their appointment on time or prior to their appointment and 90% of patients who were being discharged or transferred to another facility should be collected within 60 minutes of their 'booked ready' time. Between April 2015 and November 2015 the service average for arrival for appointment time was 92%, with achievement of the target in November 2015. During the same timeframe, the monthly average met the target of 90% of patients collected within 60 minutes of 'booked ready' time.

- In Suffolk, 90% of patients were required to arrive for their appointment time no more than 60 minutes before and no less than 10 minutes before their appointment time. Between April 2015 and November 2015, the service did not meet this target as the average monthly performance was 65%. The target for patients being collected post day surgery/treatment or transferred, was that 80% of patients should be collected no more than 30 minutes after their booked collection time, the service was working towards this and had achieved a monthly average of 79% (between July and November performance against this KPI had ranged from 86% and 91%, performance in April had been 58% which impacted on average).

- In West Essex, 90% of patients were required to arrive within 60 minutes before their appointment time. Between May 2015 and November 2015 the service did not meet the target as the monthly average was 66%. The target for collection time for day patients, transfers and post appointment had two separate KPIs. The first was that 90% of patients should be collected within 60 minutes of the 'patient ready' time and during the same

time period the service achieved an average of 74%. The second target was that all patients in the same category should be collected within 120 minutes of 'patient ready time'; the service achieved 95% during that period.

Competent staff

- Staff had the right qualifications, skills, knowledge and experience to do their job when they commenced their role.

- Appraisals were carried out yearly within PTS, data the trust provided to us showed that in 2014-2015 only 54.5% of all PTS staff had received an appraisal. Current progress for 2015-2016 appraisals varied throughout different areas of the trust. Managers within Martlesham had a good knowledge of who required appraisals and action plans were in place to ensure they were to be carried out in a timely way, other areas had not progressed this far within their appraisal plans. However the trust reported that 9.8% of staff in PTS had received an appraisal prior to the announcement of our inspection.

- We reviewed 15 staff appraisals; they were brief documents that allowed staff to comment what they had done well the previous year and what they wished to improve on. Some staff commented on progression and use of existing skills, whilst these were noted by the manager completing their appraisal we were not provided with any plans of how this would be acted upon. Staff we spoke with felt that appraisals were often rushed and felt like a 'tick box' exercise.

- We were not assured that learning needs of staff were always identified or acted upon. Staff were given limited opportunities or support to develop.

- The majority of staff we spoke with felt the lack of development and further training opportunities was one of the main negative aspects of their role. Many staff wished to look at joining the emergency care team, or have the opportunity to observe them but this was not supported by the management team.

- Staff we spoke with felt their induction into the trust was satisfactory and gave them the necessary knowledge and skills to carry out their role.

- All patient facing staff received driving assessments and training prior to commencing their roles, they also have refresher assessments if they had been on long term sick or not worked in a prolonged period of time. If an

accident occurred managers would assess whether the individual member of staff had previously had any accidents, and where necessary arrange a driving assessment to ensure their driving competence.

- Poor or variable staff performance was not identified or managed. Managers told us that they did not monitor staff performance within PTS; there were no methods to identify performance over time of individual staff. Key performance indicators (KPIs) were in place for the service as a whole but were not in place individually for administrative or control staff.

- PTS control staff told us that there was no specific training or development plan for them, however, we did see that a member of the control staff had started developing a programme of training for PTS control staff which was being supported by the ALO.

Coordination with other providers

- All PTS bookings were coordinated through control centres for each region where the most appropriate and available transport was selected for each booking. This could be single or double person crew or a volunteer driver.

- There were established relationships with local health care providers. We observed two-way communications between drivers and staff at their planned destination regarding traffic status, which had the potential to delay a patient's arrival.

- Hospital discharge lounges staff told us PTS staff responded to their requests for transport in a timely way. One control room was based at a local acute hospital site; this was co-located with the discharge lounge. Whilst visiting this area we saw there was minimal communication between PTS and hospital staff. When we spoke with the healthcare assistants working in the discharge lounge they told us they would not share service feedback with the PTS staff if a patient passed this along and would rely on them contacting them themselves. PTS and hospital staff told us they did not work together but as two separate services, which they felt could be improved upon.

Multidisciplinary working

- Staff generally felt that the information provided to them prior to transporting a patient was sufficient to ensure they knew what needs the patient may have,

including any mobility issues and existing medical complaints. This information was provided both by electronic communication and also verbally from where the crew collected the patient.

- Do not attempt cardiac pulmonary resuscitation (DNACPR) orders were communicated in advance of journeys to PTS crew. This information was gained by control staff whilst taking the booking. If a crew arrived and the patient had a DNACPR that was not advised during booking then the crew would contact their control so this information could be recorded and discuss if the transport was suitable.
- PTS staff were in regular contact with clinics and telephoned ahead if a patients was going to be late for an appointment.
- We observed PTS and care home staff sharing key information when collecting patients to attend hospital appointments. This was important for the patient's wellbeing and ensured they were prepared and adequately supported for their planned journey.
- We observed good working relationships between drivers and control staff. We felt this was important as the relationship between control staff; drivers and volunteer drivers enabled effective care and promoted good team working.

Access to information

- The availability of special notes varied throughout the service, some areas made these available to crews whilst others had to rely on carers/hospitals/medical facilities verbally informing them.
- If a patient has complex needs that may result in behavioural problems during transport staff told us they would be made aware as this information is passed during the booking process.
- Staff utilised mobile phones, radios and personal digital assistant (PDA) devices to obtain information and remain in contact with control staff. We witnessed occasions when PDA devices failed to obtain a signal which delayed information getting to the PTS crew. We saw an example of where a crew attended to the hospital to collect a patient, but another crew had already taken them, the PDA should have advised the crew of this but lack of signal meant the information did not get through. Plans were in place to start using newer tablet devices in some areas of the trust, which would allow the crews to access more patient information and to receive up to date, reliable daily job plans. A trial had

been conducted successfully within Cambridgeshire and managers were hopeful this would be a positive step for providing crews with the information they needed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We were not assured that PTS staff had sufficient knowledge to assess a person's mental capacity to consent to care or treatment.
- Patients were supported to make decision. We observed staff asking for patients' verbal consent for all interventions, including use of the winch to load wheelchairs and the use of restraints such as seatbelts and chair fixing equipment.
- The majority of staff we spoke with lacked a knowledge or understanding of the Mental Capacity Act (MCA) or Deprivation of Liberty Safeguards (DoLS). Staff told us they received very brief training in this area but did not feel it was sufficient to ensure they were fully confident in this topic.
- A knowledge booklet was on the majority of vehicles that contained information relating to MCA and DoLS but most crews were unaware of these or what information they contained.

Are patient transport services caring?

Good 🟢

We rated caring within the service as good because:

- People were treated with dignity, respect and kindness during all interaction with staff.
- Staff showed an awareness of the importance of providing emotional support to patients during difficult times, including developing positive relationships with regular patients who were undergoing major healthcare treatments.
- Feedback from people who use the service, and those close to them, was largely positive about the way staff treat people.
- Patients told us they felt supported and encouraged to be independent and make choices in relation to their care.

Compassionate care

Patient transport services (PTS)

- Staff showed an encouraging, sensitive and supportive attitude to people who use services and those close to them.
- Relatives and carers described the PTS staff as 'brilliant…absolutely fantastic. They have always been very nice', 'staff are always kind and friendly' and 'I always feel looked after, they ask about how I am and ask about my past and family, we have nice little chats'.
- The 'Friends and Family Test' (FFT) score was a CQUIN and quality priority for 2014/15 for EEAST and is also a national directive. Trusts are required to report the NHS England. The FFT is a response to the question 'How likely are you to recommend our service to friends and family if they needed similar care or treatment?'
- The trust created detailed FFT reports for each quarter of the financial year. Quarter 3 of 2014-2015 which was 1st October to 31st December showed that 94.9% of PTS patients would either be 'likely' or 'extremely likely' to recommend the service to friends and family. Many of the comments were very positive, with three negative comments relating to noise and comfort of the ambulance during their journey. Quarter 4 of 2014-2015 which was 1st January – 31st March showed that 95.3% of PTS patients would either be 'likely' or 'extremely likely' to recommend the service to friends and family with very similar comments on staff and vehicles to the previous quarter.
- We observed positive interactions between staff and patients as they prepared for their journey. Staff ensured patients had with them all that was required for the appointment as well as keys to get back into their home on return and snacks if necessary.
- We observed some exceptionally caring practice from patient facing crews, including stopping the vehicle to allow a patient to have a drink just before their allocated nil by mouth time began, and also a patient who was extremely anxious about her legs being on show and staff remembering this from previous journeys and taking the time prior to leave their address to ensure they were covered appropriately.
- During each patient contact crews introduced themselves by name and asked patient what they would like to be called.
- We observed patients being collected from their own homes, care homes and hospital settings. Every effort was made to ensure that they were comfortable, secure and warm during the journey. PTS staff requested extra clothing or blankets where indicated.

- Staff told us that wherever possible they picked up the same patients attending for regular appointments such as dialysis and got to know them well during their period of treatment.
- Staff understood and respected people's personal, cultural, social and religious needs. One crew we observed showed a thorough understanding of and respect of a patients religious beliefs and how they should be assisted onto and off of the vehicle.

Understanding and involvement of patients and those close to them

- Staff communicated with people so that they understand their care, treatment and condition, involving those close to them.
- Feedback from care homes and families was wholly positive in relation to the care that the PTS crews provide to their residents.
- Control staff explained to callers the rules about booking escorts for patients on journeys. We observed staff in the control centre taking time to explain eligibility criteria and service provision. Control staff directed callers to alternative transport if they did not meet the eligibility criteria. They were also able to advise where financial assistance could be sought if required.
- We observed conversations between patients and PTS staff during journeys. Patients were reassured about arrival times for their appointments and kept informed if there were any delays due to traffic conditions.
- Negative feedback from patients and those close to them was relating to delays and lack of communication.

Emotional support

- Staff showed a respectful understanding of the impact that a person's care, treatment or condition had on their wellbeing and on those close to them.
- Staff we spoke with and observed showed an excellent knowledge of using communication to support patients if they became distressed or upset.
- Staff regularly transported patients to chemotherapy appointments and demonstrated an understanding of how relapses effected patients and felt that allowing patients to talk about their emotions and feelings during transport helped them and allowed building of supportive relationships.

Supporting people to manage their own health

Patient transport services (PTS)

- Staff told us they felt it was important to empower those who used the service and support them with independence.
- Patients were encouraged wherever possible to use their own mobility aids when entering or leaving the vehicle.
- Staff asked each patient whether they required assistance with walking, sitting and standing at the beginning and end of each journey.

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

Requires improvement ●

We rated the service as requiring improvement for responsiveness because:

- There were shortfalls in assisting communication with people who did not speak English.
- There were not documented procedures in place to advise staff what to do if there would be a delay in someone's care.
- Complaints procedures were not directly available to patients and staff did not know where to signpost patients.
- Learning from complaints was not shared across the service.

However

- The booking system was easy for people to access, with flexibility and choice of services.
- People living with disabilities could easily access the service and have their needs accommodated.
- Staff showed a good awareness of people's needs in relation to disability, race, religion and age.

Service planning and delivery to meet the needs of local people

- 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.

- The service was meeting the demand for patient transport locally as reflected in the commissioning requirements.
- There were plans in place to redesign Suffolk day control operations, involving moving the base controllers worked from, the reasons for this move were to enable better control of workload, create better support function for control and enable better resource allocation and management. This change would also result in staffing adjustments and changes in working rotas to provide longer hours of cover. Senior staff told us that they had worked with local commissioners on the redesign to increase performance planning. The new design included the implementation of a new process of allocating journeys to crews; instead of crews receiving their journey plans a day ahead, with the new system journeys would be allocated on a daily basis to improve flexibility and management of resources to meet demand.
- Volunteer drivers supported the ambulance service transporting patients who did not need the facilities provided by an ambulance. A total of 157,565 journeys were carried out by volunteer drivers between April 2014 and March 2015, this equated to approximately 34% of all journeys carried out by PTS.
- There was demand within the EEAST region for bariatric PTS support. The service had use of two bariatric vehicles to transport patients who required this service. If a patient required a bariatric vehicle this would be communicated within the booking process to ensure the appropriate support and information was provided.

Meeting people's individual needs

- Reasonable adjustments were not in place to accommodate communication with people who did not speak English.
- Whilst there were communication aid booklets on the majority of the vehicles, staff told us these were new to the service and most staff were unclear how they should be used appropriately. These had been acquired and used following successful use in another ambulance service. The communication books contained pictured aids to enable those with complex needs to communicate with staff.
- A telephone translation service was available for staff throughout the trust. Knowledge of this service varied across areas, some control staff were aware of language line being available, some had previously experience

Patient transport services (PTS)

problems using this service and therefore it was rarely utilised, while some control staff were unaware of it being available. Patient facing staff were unaware of any translation services available to them should a patient not speak English, stating they would rely on carers or family to translate, or would contact their ALO if they required further assistance.

- The majority of patient facing staff we spoke with showed an understanding of cultural and religious beliefs and how they may have to alter their practice to meet individual needs.

- Staff told us that their awareness of patients' needs and how to appropriately meet them came from their own experiences and knowledge rather than from training by the trust.

- Vehicles were well equipped to transport those living with a disability and on booking the most appropriate vehicle could be requested, for example one with wheelchair capability to ensure needs of those unable to walk could be accommodated.

- Staff received training on how to communicate with and care for those living with dementia or other cognitive impairments. We reviewed the training material and whilst basic, provided information relating to conflict resolution and importance of using verbal and non-verbal communication. Staff we spoke with and observed showed an understanding of additional needs patients living with cognitive impairments and how to alter their manner and communication to ensure these patients were relaxed and comfortable.

Access and flow

- Where possible people could access care and transport at a time to suit them, in line with an appointment or clinic. Patients or their representatives booked the service by telephone through the control centre. Those asked about the booking process said that they found it easy but that they were asked the same questions every time.

- Some crews would contact patients prior to their pick up to make sure they still required transport, this ensured only correct journeys were completed, however this was not common practice across the PTS and no SOP in place to support this. Some planning assistants also stated they called patients the day before booked transport to ensure their journey was still required, but this was not supported with a policy or procedure, but seen as 'best practice.'

- Control and patient facing staff told us they tried where possible to communicate with patients if there would be a significant delay in their transport; however there was no policy or SOP to support this action.

- We observed control and patient facing staff sharing traffic information via radio systems to ensure that the quickest and most convenient routes were taken whilst transporting patients.

- Control staff were given training during their induction in relation to the process of taking patient bookings, however the service did not have an SOP or policy for staff to refer to in relation to creating bookings or the correct process that should be undertaken.

- The service did not collect information in relation to missed appointments following cancellation or delays in transport.

Learning from complaints and concerns

- Procedures were in place to allow patients to make complaints if necessary. Patients told us that they would make any complaints to the driver or the control centre if they had experience problems or had concerns relating to their care from PTS. We did not speak to any patients who had previously needed to make a complaint about the service.

- Most patient facing staff we spoke with were unsure what to do if a patient wished to make a complaint. There were no patient advice liaison service (PALS) leaflets available to give patients and only a small number of vehicles contained a sheet containing a contact number for the PALS service. Staff told us they would try to resolve the complaint immediately if possible, but if a patient, family member or care staff were unhappy they would contact their manager for advice on what to advise them.

Are patient transport services well-led?

Requires improvement ●

We rated the service as requiring improvement for well-led because:

- Governance arrangements within PTS were minimal, meaning a lack of guidance for staff to carry out their roles. Risks were not identified, addressed or reviewed often by leaders within PTS.

Patient transport services (PTS)

- The culture within PTS was poor, with staff feeling a divide between PTS and the rest of the ambulance service. Staff also felt unsupported by leadership teams and that there was a clear separation between them.
- Staff and managers did not understand the service's strategy or plans moving forward, due to uncertainty with contracts and due to lack of innovation or set objectives.
- There was a clear focus on meeting financial targets rather than on patient safety and quality.

However

- Staff took clear pride in their roles, and showed how important patient care was to them.
- There were pockets of enthusiastic and forward thinking line managers who wanted to improve the service.

Vision and strategy for this service

- The trust had a clear vision to 'deliver harm free care to every patient, every time, everywhere' and set of values which included safety, honesty and a supportive environment. Future plans for PTS services were centred on securing PTS contracts and developing staff opportunities.
- There was no PTS specific strategy in place.
- Senior staff told us that it had been challenging to effectively plan for PTS as it was dependent upon competitive tendering for contracts but there were still plans to develop staff and make improvements in some areas. We were told that the uncertainty of the PTS market had had an impact on the morale of staff and the ability to communicate the complete future strategy to staff; this was reflected on the PTS risk register.
- In some areas of PTS we saw that there were clear plans in place to improve service delivery. For example, there were plans to redesign the PTS control rooms.
- Most staff that we spoke to were not aware of the vision and values for the trust, or their role in the PTS going forward. Staff in the PTS control rooms were aware of the future plans to reconfigure their control rooms to improve service delivery and their roles in achieving it.

Governance, risk management and quality measurement

- The trust's governance framework included four groups who met regularly and provided assurances to the board in the separate areas. These groups were the Quality Governance Committee, Clinical Quality and Safety Group, Safeguarding Group and Infection Prevention and Control Group. These groups were attended by managers from each division including PTS. At a local level, LBMs and ALOs told us that they had regular meetings amongst themselves and any issues, concerns or ideas for improvements were then discussed at further meetings with the Head of PTS.
- There was an understanding of performance in terms of the financial implications and there were systems in place to monitor levels of activity and ability to meet KPIs set by commissioners.
- There were no clear systems in place to measure individual performance and identify areas of good practice or improvement in most areas. For example, in control rooms some staff told us that they were aware of target times and workloads so they would monitor the status of vehicles and plan their workload accordingly, this allowed flexibility to meet the demands of service. There was no system in place to measure if all staff were doing this or if this practice needed to be reviewed. We saw no evidence that individual performance for patient-facing staff was monitored or reviewed – this meant that leaders were not able to identify areas of good or poor performance effectively. Patient-facing and control staff told us that they worked for the patients and did what they thought was best based on their own commitment to quality patient care.
- Performance measurements were taken from the computer software systems and staff were unable to explain or demonstrate a quality assurance process that ensured that the information was accurate.
- There were no regular local audits or reviews undertaken to ensure that performance and patient care was being delivered safely.
- There were four risks on the PTS risk register, two of which related to securing future tenders. One of the risks related to recruitment and resources and the other related to a lack of resilience training for managers. This did not reflect all present risks within PTS including not compliance with training attendance, no compliance of stations with IPC guidance and appraisal targets not being met.
- Business Continuity Plans were not consistent across the service.

Patient transport services (PTS)

- There was not sufficient oversight of systems of safety in all areas, managers lacked knowledge of governance arrangements and the lack of policies in place, and also in terms of basic premises safety, for example fire alarm testing and congregation points.

Leadership of service

- Some staff felt they only heard what was going on throughout the service from other colleagues, and that their managers rarely communicated anything with them.
- Patient facing staff and control room staff felt that the service was succeeding due to their teamwork and supporting one another rather than through the correct management of the service.
- Feedback regarding ALOs was generally positive, but some of these were new in post and patient facing staff had received minimal contact with them since their appointment. Most staff felt that managers above this level were not visible, encouraging and did not understand the demands and responsibilities of patient facing roles.
- Some ALOs we spoke with had initiatives and improvements they wanted to make to the service to improve efficiency, however due to segregation between areas these were not developed and ALOs felt frustrated with this.
- Most patient facing staff were unaware of who the head of service was or any of the executive team, most were aware of the new chief executive but did not feel they had made any difference within the PTS service since their appointment.
- Whilst some managers knew of the chief executive, the majority of PTS did not have a knowledge of who the chief executive was or any member of the executive team. Control and patient facing staff felt there was a lack of visibility from senior executive.
- There was a lack of support mechanisms in place for PTS staff that may have been involved in a traumatic or upsetting incident. Staff who transported a patient in the late phases of a terminal illness felt that this had an emotional impact on them but that there was no forum or means to discuss their feelings relating to this. Some staff had previously come across serious car accidents whilst transporting a patient and were not provided with follow up support from a manager to ensure their wellbeing.

Culture within the service

- The vast majority of staff we spoke with told us they thoroughly enjoyed their work and valued their roles. However many stated that morale was not particularly good due to uncertainties about contracts in some areas and lack of support from managerial staff in terms of progression and empowering staff to improve the service.
- All PTS staff we spoke with felt there was an obvious divide between PTS services and frontline emergency services, many staff felt this was detrimental to the trust and that some PTS staff would like the opportunity to support the frontline emergency colleagues but this was not an option due to the segregation.
- Patient facing staff and control room staff felt that the service was succeeding due to their teamwork and supporting one another rather than through the correct management of the service.

Public and staff engagement

- Control and administrative staff were transitioning to wear full green ambulance uniform with the view of making all staff feel part of the ambulance service. However most staff we spoke with felt uncomfortable with this as it meant that members of the public may see them as clinical staff and expect them to respond to an unwell patient, which they would be unable to deal with and had not received training for. Staff did not feel they were engaged in relation to this change and their views and feelings were not considered.
- Staff generally received information via email, whilst staff generally found this useful because they did not always have time to look onto the computer system this meant that vital information could be missed.
- Staff meetings were varied across the service, some station had meetings and others did not. General staff meetings were not minuted and we were told attendance was not high at these meetings.
- 62 PTS staff took part in the trusts 2015 staff survey, which showed that 45% of all trust staff would recommend it as a place to work and 53% of all staff felt that care of patients was the trusts top priority.
- The trust used social media to engage with the public, however the main focus of this was on emergency care; however patients who posted on social media sites received a response to their query or concern relating to PTS.

Patient transport services (PTS)

- Patients could share views on the NHS choices website, these were usually directly responded to by the trust with further contact details made available.

Innovation, improvement and sustainability

- Due to uncertainty of the future of some areas of PTS there were limited innovations in place. However there were plans to introduce new tablet devices to enhance communications and ensure crews have the correct information when transporting a patient, this had been trialled successfully and was deemed to be sustainable across all areas.

Emergency operations centre

Safe	**Requires improvement**	🟠
Effective	**Good**	🟢
Caring	**Outstanding**	☆
Responsive	**Good**	🟢
Well-led	**Good**	🟢
Overall	**Good**	🟢

Information about the service

Between April 2014 and March 2015 the emergency operations centre (EOC) responded to and dispatched ambulance clinicians to 964,917 calls. Every day EOC receives approximately 2,600 calls from people dialling 999 including healthcare professionals making urgent transport requests.

The Emergency Operations Centre (EOC) receives and triages 999 calls from members of the public and other emergency services. It provides advice and dispatches ambulances to the scene as appropriate. The EOC provides assessment and treatment advice to callers who do not need an ambulance response, a service known as 'hear and treat'. This had been an under resourced service at the trust and was subject to a major redesign to improve the numbers pf patients being cared for in this way. Staff give callers advice on self-care, making an appointment for a general practitioner (GP) or directs them to other services.

The EOC also manages requests by health care professionals to convey people either between hospitals or from the community into hospital. The trust has three emergency operations centres (EOC) in Bedford, Chelmsford and Norwich. There are good communications between the three centres and all answer calls for the region in peak demand. The incident command desk (the coordinated response for major incidents) is based in Chelmsford.

We inspected all three EOC sites during our visit. We spoke to 63 staff across both sites including emergency medical dispatchers (EMD), dispatch officers, clinicians (including paramedics, nurses and GP's), team leaders, duty managers and senior managers. We listened to over 30 emergency calls and observed how patients were treated and responded to over the phone.

Emergency operations centre

Summary of findings

Overall we rated the emergency operations centre (EOC's) as Good.

Safety required improvement because incident reporting methods were inconsistent and not all staff received feedback about incidents. Mandatory training (professional updates) rates were low across the EOC's and safeguarding reporting methods were inconsistent and staff did not always know there was a safeguarding lead. Resource was limited for the EOC's because of delayed ambulance handover times which severely limited capacity to dispatch resources. Effectiveness was good because evidence based care and treatment was incorporated into systems used in the EOC's which followed national guidance and best practice and there was an ongoing programme of local and national clinical audit within the EOC's. Calls were answered promptly for almost all patients (greater than 99%) and staff were competent to carry out their roles and there were systems in place to support them. However, understand of the Mental Capacity Act 2005 was poor across the EOC's

Caring was outstanding. Staff consistently demonstrated compassionate care when dealing with patients and made extra efforts to protect their privacy and dignity, including dispatching additional resources. We saw several examples of staff acting with the utmost professionalism and supporting patients and the public in the most trying of circumstances to provide positive outcomes for patients. Staff always ensured that patients or the public understood what they were being told and kept communication open throughout calls.

Responsiveness was good because there were examples of service planning to meet local needs including the increase in provision of hear and treat services. The EOC's met individual needs including using a variety of communication tools for callers and there were systems in place to try and manage the access and flow of calls and patients. Complaints were investigated properly and the old computer system had been maintained so that older complaints could still be fully investigated. There was evidence of learning from complaints.

Well led was Good. There was a clear strategy and vision in place for the EOC's including the development of clinical hubs. All the staff we spoke with were aware of the direction of the service and plans for the future. The EOC's had undertaken a major infrastructure change, done in a short period of time with comparatively small number of incidents for such a large change. There was a clear governance structure in place for the EOC's and regular audit and measurement. However, we also found staff felt under pressure because of rising call volumes and the lack of resource to send to some calls and there had been a high turnover and sickness at the Norwich EOC and some allegations of bullying. A culture project had been undertaken to address these concerns and the allegations properly investigated.

Emergency operations centre

Is emergency operations centre safe?

Requires improvement ●

We rated safety in the emergency operations centre (EOC) as Requires Improvement because:

- Incident reporting methods were inconsistent and not all staff received feedback about incidents.
- Mandatory training (professional updates) rates were low across the EOC's.
- Safeguarding reporting methods were inconsistent and staff did not always know there was a safeguarding lead.
- Resource was limited for the EOC's because of delayed ambulance handover times which severely limited capacity to dispatch resources.

However, we also found:

- The environments were visibly clean and well maintained and were conducive to a good working environment.
- There were appropriate methods and processes to respond and manage risks to patients.
- There were systems in place to respond to internal and external major incidents and backup systems for contingency within the EOC's.

Incidents

- The trust reported a similar number of incidents to other ambulance services. The trust reported 1274 incidents between January 2015 and 2016 of which 180 were directly related to the emergency operations centre (EOC). A number of incidents crossed over boundaries of service provision and where investigated by the EOC as well as by operational clinical staff. The large majority of incidents were graded as no harm with smaller numbers of incidents resulting in moderate or severe harm. The largest number of incidents reported was in relation to delays in responding due to a variety of reasons including insufficient resources available, miss identification of address and miscommunication between the EOC and the ambulance crew.
- The trust used an incident reporting system called Datix to record and manage incidents that happened within the service. Managers told us that all incidents were recorded on this.

- There were inconsistent methods of reporting between the three centres. In the Bedford centre we were told by staff that they informed their team leader of any incident that required reporting and that they completed the incident report. In the two other centres in Chelmsford and Norwich we were told that each member of staff reported their own concerns. Trust policy states that individuals who initially have a reportable incident brought to their attention should report the incident.
- We reviewed five root cause analysis (RCA) and found them to be comprehensive. There was clear lessons learned and evidence of action plans to address the concerns as well as who was responsible for monitoring the actions. Three RCA we considered showed an over reliance on 'human error' rather than considering other issues including more detailed human factors.
- Serious incidents (SI) had resulted in a change in practice for example, SI's related to the triaging of children with a small number of conditions had identified that the triage software did not ask sufficient questions so formal work arounds were put in place of which all staff were aware.
- However, there was one SI in relation to a missing call that disappeared from the CAD. Five staff we spoke with were not aware of this incident despite it directly impacting on the care they provided.
- Prior to the inspection we saw jointly investigated serious incidents where EEAST had cooperated with other providers to manage the investigation.
- 26 staff told us about how they reported incidents and received feedback and learning from incidents. 17 staff said they did not always received feedback from incidents or any associated learning. This included serious incidents that were related to the EOC's. When managers discussed serious incidents they did so in relation to punitive measures taken against staff and less so regarding support to individuals to identify the concerns and take remedial action including training.
- 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. SI investigations showed that the duty was considered as part of the investigation and most managers were aware of the duty.

- 28 staff across the three centres had either not heard of duty of candour or if they had where aware of it in a vague way. 2 members of staff told us it meant being "open and honest" but could to describe the other responsibilities of the duty.

Mandatory training

- Data provided by the trust showed a poor uptake of mandatory training in the EOC's. Training was provided in a number of ways from face to face training to online/ televisual training. The update training was called professional update (PU) days.
- Managers and external providers provided the professional update days. They included focus on specific issues or concerns including any thematic concerns locally or the trust as a whole.
- For all staff on all mandatory training, the overall figure for compliance with mandatory training in 2015 was 12%.
- Compliance with individual items of mandatory raining varied widely. For example, Mental Capacity Act level 2 training had been completed by 20% of staff, business continuity by 63% of call handlers but only 23% of clinical support and infection control workbook level 2 completed by only 1.5% of call handlers and 25% of clinical support. There was 100% compliance with resilience training.
- 26 staff we spoke with told us that they did not always get their mandatory training due to the extreme demand on the EOC. Two members of staff said they had not had training since their corporate induction more than two years previously.

Safeguarding

- All staff had received safeguarding level 2 training as part of their induction. All staff we spoke with told us they had had no refresher training for safeguarding as part of professional updates. The trust told us that safeguarding was provided as part of professional updates and through mandatory workbooks.
- 14 staff we spoke with told us that they were confident to make a safeguarding referral and they could accurately describe what constituted a safeguarding concern. However, 7 call handlers we spoke with told us that they would escalate a safeguarding concern to their

manager on the understanding they would report it. They told us they were unlikely to follow this up to ensure this had been done as "there wasn't enough time".
- Most staff we spoke with did not know who the trust lead was for safeguarding, with 8 staff not knowing the trust had a lead at all. The safeguarding lead had been new in post a few months prior to our inspection.
- There were multiple arrangements in place to manage safeguarding referrals based on the six counties in which East of England Ambulance Service (EEAST) provides a service.
- Staff were aware of child protection concerns and arrangements thought they did not have direct access to child protection registers.

Cleanliness, infection control and hygiene

- The three EOC's appeared visibly clean at the time of inspection. There were hand gel dispensers and facilities for hand washing. Disinfectant wipes and cleaning equipment was available for work stations.
- Whilst the trust completed detailed infection control audits for stations and ambulances this was not completed in the same way at each station. Out of hours premises were included in the audit but it was not clear if the EOC's had been included in the audit and if they were, they were not broken down by individual centre.
- Infection prevention and control training was provided to all staff on induction and formed part of the ongoing training schedule.
- We observed on several occasions call handlers and dispatchers asking if there was an infection control risk while arranging the response to the caller.
- Staff we spoke with were aware of the potential for a major incident involving infection and public health measures involved with this.
- 11 staff told us they knew how to access the infection prevention and control team/ advisor within the trust.

Environment and equipment

- The environments in the three EOC's were spacious enough to accommodate equipment and large numbers of people.
- Work safety assessments had been completed for staff joining the EOC's. Some staff had additional equipment

provided to ensure their health and safety at work. This included specialist chairs and 'standing' desks with adjustable height. These desks were the only ones provided at the Norwich EOC.

- At Chelmsford and Norwich, there was additional equipment in currently unused areas of the EOC. This equipment was configured and ready for use. These additional desks could be opened in the event of equipment failure elsewhere, a major incident or the failure of one EOC which could relocate to the spare capacity.

- Other measures were in place for equipment failure. This included the use of a paper based system if there was a total failure of the system. Staff we spoke with clearly articulated how the system worked. The paperwork for the redundancy system was in close proximity to call handlers and dispatchers so a prompt switch over could occur.

- There had been a new computer assisted dispatch (CAD) system implemented between the end of 2015 and early 2016. This had been a large piece of work, fundamental to the running of the EOC's and the whole ambulance service. Staff said that they had received sufficient training and support to use the new system and many said it was an improvement on the old system. The CAD offered advantages over the old CAD including quicker accessing of records.

- There was a backup card system in place should a call handler have problems with their equipment. This allowed them to offer the some protocol based advice as was available on the system.

- We observed one occasion when a call handlers system froze during an emergency call. The call handler switched immediately to a backup card system that allowed him to continue the call, offer advice to the people attending the emergency. As this occurred, another member of staff used a nearby work station to support their colleague.

- Staff complained that the trackers, fitted on vehicles switched as soon as they were on scene. However if they were close to but not at a call such as passing over a bridge above the incident these would be automatically switched on. This meant that the data showed a vehicle was at scene when potentially it had not arrived at the actual scene of the incident.

Medicines

- The trust informed us that there were 'drugs bags' of medicines held in the EOC's though two members of staff we spoke with were unaware of this.
- Call handlers and clinical staff from the clinical hub offered advice to some callers to take simple analgesia or antihistamines based on clinical procedure and protocol.
- Clinical staff working in the clinical hub contacted patients GP's to ascertain what medicines they were taking and to ensure they did not advise patients to take any medicine such as paracetamol that was not appropriate.

Records

- All patient records were stored electronically on the system. All were easily accessible for staff that required access to the records but remained secure and confidential.
- All calls were recorded and monitored. This ensured any concerns; incidents or complaints could be followed up. Calls were audited as part of an ongoing audit plan.
- The EOC's used AMPDS to determine the acuity of the patient's condition and the priority of the assistance they required. The system was updated regularly and incorporated national guidance/ best practice. Other local providers used a different system – Pathways. Whilst a number of staff expressed the frustration of services that refer into them using another system, none could demonstrate the impact of this.
- The AMPDS system was used to prioritise calls based on patient acuity. Risk assessments for medical conditions were incorporated within the nationally approved system. Risk assessments and guidance were automatically updated to reflect best practice and national guidelines.
- Some patients had 'flags' on their records. This was to indicate a variety of issues such as known concerns, unusual medical conditions or access issues for the property. They also included flags for people receiving end of life care to ensure an appropriate response form the ambulance service.
- Patient names were not routinely obtained on emergency calls. This had caused problems with duplicate calls and accurately identifying which calls related to the same patient.

Assessing and responding to patient risk

Emergency operations centre

- EOC staff used a computer system to prioritise emergency calls. This is a nationally recognised system. Patient details are recorded and this determined the priority of response required which dispatch staff then arrange resources for. The system utilised a number of risk assessment tools for example in relation to cardiac arrest or breathing difficulties. The answers to this determined the coding and the speed of the response. It also allowed call handlers to give members of the public and others, advice on how to deal with an emergency before help arrived.

- Several call handlers told us that there was no place to record known safety issues relating to addresses within the databases. Managers we spoke with told us that it was possible to put 'flags' on individual patients but not addresses. Dispatchers were reliant on call handlers to put that information in separately.

- There was a clearly defined policy outlining what calls staff of different job roles, skills and abilities should attend calls. This ensured that staff of the required skill attended the correct calls. Dispatcher's displays showed the skill level of the staff in each vehicle and whether the vehicle was EEAST's own vehicle or a private provider sub contracted. We observed this process in operation and found it to be appropriately used. We followed up 10 previous calls and found they had been responded to correctly.

- In the event staff arrived at a call and found the concerns to be greater than their skill level, staff told us that they were sent additional resource as a priority though we did not see any examples of this.

- The clinical coordinators were able to upgrade responses if they were concerned that a patient's condition was more serious than they were reporting. They were also able to upgrade if there were delays in responding to the call due to lack of resources. Call handler team leaders in Chelmsford and Bedford told us they could upgrade the response when the response was delayed but team leaders at Norwich told us they were advised not to do this. Responses were never downgraded.

- Welfare calls were made to patients who had waited longer than the target time for a response. These calls were made regularly to the individual. During the inspection we saw numerous occasions of these being used to ensure patients remained safe and to check on

their condition. If there was concern about the patient's welfare or a long delay in sending resource, particularly for 'GP urgent' calls, then the patients were upgraded for a quicker response.

- The clinical coordinators also provided the clinical advice line. This was for ambulance staff to receive advice on managing lower acuity calls or where they required information about local care pathways both acute and community.

- Staff working in the clinical hub used different software and clinical judgement to triage and treat patients. They were able to reprioritise and upgrade calls for an emergency response if they considered that was required.

- Procedure stated that for some emergency calls, two resources were allocated to ensure an appropriate response. This included patients with chest pain, fitting, pregnancy and stroke.

- There were three grades of back up for calls if a rapid response vehicle (RRV) or technician crew were on scene. The highest priority back up were not divertible to other calls and so provided timely backup in the majority of incidents.

- For other defined calls such as cardiac arrest, allergic reaction or fitting amongst others, the call handler was required to stay on the line to offer support and monitor the patient's condition.

- If police or other authorities informed the EOC of a change to a patient's condition (before the arrival of an ambulance) this information is added to the original case notes. If it is passed to a clinical coordinator to consider upgrading the call, this is done on a piece of paper. This does not alert dispatchers to a change in condition and must be done manually. This created a risk of a patient's deterioration not being responded to.

Staffing

- The EOC's had a high turnover rate for some staff including call handlers. Data showed that the turnover for call handlers in 2015 was at 18% which was an increase on the previous year. A 3% increase to 10% turnover rate for dispatchers was recorded for the same period. For all staff the turnover rate was 11.7% up from 10% the previous year.

- Most recent data showed a fall in the turnover rate for call handlers but a further increase for dispatchers with a slight fall in the overall turnover rate.

Emergency operations centre

- The vacancy rate was 6.3% at Norwich EOC, 2.4% at Bedford EOC and -1.3% at Chelmsford meaning Chelmsford EOC had more staff than they were planned for in December 2015.
- The highest vacancies were for clinical staff for the clinical support desk and administrative staff. There had been a large number of vacancies recently created in the support desk as part of a wider strategic plan to increase the number of calls that could be treated as 'hear and treat'.
- The EOC's used bank staff and overtime to manage gaps in the rota. The nature of the role meant that agency staffing was not available or appropriate. Rota's showed that, on most occasions, staffing was maintained though this was reliant on occasion on bank staff.
- Norwich EOC had identified a high turnover of call handlers as a concern. Data showed turnover at the Norwich EOC at 17% to be more than double that of Bedford EOC and 5% higher than Chelmsford EOC. Turnover for the last full year (2014/ 15) showed all three EOC's having about the same turnover rate.
- The manager we spoke with told us that exit interviews showed that new staff did not fully understand the demands of the role before starting work. They have since introduced shadowing opportunities so that prospective staff can see what the role entails before applying or commencing the job.
- Rotas were produced to match the right number of staff to a predicted high volume of calls and peak demand. The frequency and acuity of calls was audited frequently. This allowed the trust and EOC's to use a rolling data set to manage their anticipated peak demand.
- There was a large recruitment drive to have clinical staff working in the EOC's to improve the volume of patients for 'hear and treat'. This was a new priority for the trust and a number of clinical staff had been recruited. At the time of the inspection, the trust was aiming to recruit another 40 clinical to work in the clinical hubs in the EOC's.

Anticipated resource and capacity risks

- Staff discussed anticipated resource needs and capacity risks on a daily basis and at shift changes. We observed a handover, a large part of which was to do with the predicted resource requirements for the following 24 hours.

- Resource planning also considered external factors including bad weather which would have an effect on what resources could be deployed and when – for example, the air ambulance.
- On numerous occasions throughout the inspection and from data provided, we observed ambulances queuing for over two hours to hand patients over to acute providers. This had a significant impact on the resource available for dispatch staff to send to emergency calls.
- There were backup systems which could be used in the event of a major incident. For example, a large area of the Norwich EOC was fully equipped for call handlers and dispatchers. His enabled a large amount of extra capacity in the event of a major incident or the failure of one of the other EOC's.
- In the EOC's training room at Chelmsford, the computers were set up with the 'live' system meaning they could be used in the event of extra capacity required or the failure of other systems.
- There was a comprehensive resilience action plan (REAP) to manage business continuity and EEAST's obligations under the Civil Contingency Act. It outlined the steps to take to effectively manage resource and demand dependent on the prevailing conditions. There were 6 levels of escalation form level 1 – normal service, to level 6 - service failure and was updated on a weekly basis as a minimum or when required as per national guidance. The policy provided indicated that it was due for review in September 2014 which did not appear to have been done. The trust informed us they had moved to national triggers and guidance and that their own policy had been put 'on hold' though the policy was not clear it had been superseded or put on hold.
- A 'surge' system was in place to manage incidences of high call volumes. Business as usual was surge green, 20 calls waiting locally or 20 within region was surge amber and more than 100 calls in the region was surge black. Surge black had happened shortly before our inspection.
- Each 'surge' had associated actions to address the call volume including escalating to senior managers or directors and increasing the number of call handlers available to take calls.

Response to major incidents

- Trust information showed that there had been a programme of exercises to test emergency

preparedness in a variety of situations including aircraft crash, major road accidents amongst others. The EOC's were involved in many of these exercises and the last one in October 2015.

- Staff we spoke with had been involved in major incident planning and exercises. These included multi-agency exercises and exercises related solely to the EOC. Some exercises were paper based only whilst others also included scenario situations.
- 30 EOC staff we spoke with were aware of their role in the event of a major incident.
- An Incident Command Desk (ICD) was based at Chelmsford EOC and would be responsible for a region wide response to a major incident. There was a clear chain of command for respond to major incidents and who was responsible for managing the ICD. They were also able to dispatch specialist resources including the HART team and liaised with other agencies to provide a coordinated response.
- Team leaders were aware of the REAP (Resourcing Escalatory Action Plan) level at the trust but were not aware what the individual level meant for their role or work.
- Staff were aware of the national terrorism threat level. Information and protocols were in place for staff and the actions they should take in the event of a terrorist incident.
- In the event of an internal major incident, other systems were in place to manage this. For example, a paper based system was in place if the CAD failed. All the paperwork for this was locate with the call handlers and dispatchers so there would be no delay in switching to the system. Although it had not been used, staff were aware of the system and how it would work in practice.
- A full business continuity plan was in place to manage failure of the EOC or the service more generally including mitigation and work around to provide an emergency service.

Is emergency operations centre effective?

Good 🟢

We rated effectiveness in the emergency operations centre (EOC) as Good because:

- Evidence based care and treatment was incorporated into systems used in the EOC's which followed national guidance and best practice.
- There was an ongoing programme of local and national clinical audit within the EOC's.
- Calls were answered promptly for almost all patients (greater than 99%).
- Staff were competent to carry out their roles and there were systems in place to support them.
- There was effective multidisciplinary working within the trust and cooperation with other providers including acute trusts.

However, we also found:

- Most staff we spoke with did not fully understand their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS).
- The number of patients treated over the telephone was lower than the England average though there were plans in place to address this.

Evidence-based care and treatment

- The EOC's used AMPDS to assess and prioritise emergency calls. The system was regularly updated including changes to national guidance or protocols and procedures in their management of emergency medical conditions. EEAST were using the most up-to-date version (12.2) of the protocols.
- Staff were aware that in a very small number of conditions, the software bid not always ask enough questions and there was a concern it may miss certain conditions such as meningitis and children. The trust had recognised this as a risk and had an additional work around in place to ensure the additional questions were asked. 19 call handlers we spoke with were aware of these concerns and the work around in place.
- The trust used Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidance for supporting clinical operations. This included when road crews called the clinical service desk for clinical or care pathway support. Clinical advice was available to call handlers and dispatchers from clinical staff within the EOC's.
- 3% of calls were audited as were all complaints. 1% of calls were audited at random, the others being made up of requested audits. Dedicated staff at each EOC who fed back the results to team leaders and the local senior manager completed audits. A pro forma for data collection ensured consistency of data and judgement.

Emergency operations centre

If a team leader was concerned about performance or other issues, they could request a targeted audit. Reflective practice was carried out by team leaders and call handlers in relation to finding of audit.

- Call handling staff had 20 of their calls audited each month. The results of the audits were discussed between their manager (team leader) and the member of staff. Good performance was acknowledged. Any concerns with specific calls were discussed and a reflective piece of work undertaken. Concerns about performance would lead to a member of staff being supported in the first instance by managers which could include working with a mentor. There was increased audit of calls for staff who were not meeting the required standard and a capability procedure was in place to support staff to carry out their role.
- For clinical staff, there was clinical debrief completed in conjunction with the call.
- Telephone advice provided by the clinical hub and other clinical staff was routinely audited for completion and quality advice.

Assessment and planning of care

- The clinical hub were a team of clinical staff working across the three EOC sites. The service was relatively new and was being dramatically increased to improve the number of patients who could be treated in this way. Clinicians conducted a detailed assessment of patient's needs and determine a level of care whether that was self-care, referring to a GP or other care pathway. At the time of our inspection 6% of calls were managed by the clinical hub. This was 4% lower than the England average but similar to other ambulance providers. The trust planned to double this by the end of 2016 and further improvements in 2017 to become a leading trust for hear and treat services.
- GPS were also available during peak periods for clinical staff in the EOC and on the road to gain further clinical advice.
- The AMPDS software included pain scoring and we regularly heard call handlers asking patients if they were in pain and recording the response.
- 111 services automatically transferred calls into the EOC. These calls were not re triaged and if the 111 service had determined an emergency response this

had to be sent without further review. All staff we spoke with told us that this had an impact on the planning of care and that they were unable to undertake further assessment of the calls.

- We observed compassionate care of people with mental health concerns particularly with anxiety. Whilst staff were aware of section 136 of the Mental Health Act (where a police officer can remove a person to a place of safety) and their role in facilitating this they had a limited knowledge of mental health are or the Mental Health Act. This was not included as training either on induction or as part of a professional update.
- Dispatchers had a variety of resources depending on the level of the emergency. This included community first responders who could start testament on scene before an ambulance arrived.

Response times

- The proportion of abandoned calls was lower than the England average until August 2015 when it went slightly above the England average. The proportion of abandoned calls was consistently below 1%.
- The proportion of patients who re-contacted the service following discharge of care, by telephone within 24 hours is higher than the England average by an average of 4% per month between July 2014 and December 2015.
- The proportion of calls from patients for whom a locally agreed frequent caller procedure is in place is lower than the England average between July 2014 and December 2015.
- The percentage of emergency calls resolved by telephone advice is lower than the England average at around 6% between July 2014 and December 2015. The England average for the same period was between 8% and 10% on an increasing trajectory.
- The trust was performing better than the average of all ambulance trusts for time to answer call using the median and 95th percentile.
- During our inspection we saw call answering times consistently below one second. If a call was not answered within a second then it would also be available to be answered in the other two EOC's. At the time of our inspection 100% of calls were answered in less than five seconds.
- Dispatch times did not always meet target as there was insufficient resource in some areas to meet the demands on the service.

Emergency operations centre

- We observed throughout the inspection emergency dispatchers struggling to find resource to attend calls. Whilst the highest risk category calls were always prioritised, we saw on numerous occasions, patients waiting for much longer periods on lower acuity calls.
- The use of portable defibrillators in the community helped to meet the 8 min target for red calls. Red calls are the most serious emergency calls and should be responded to in 8 minutes. If a working defibrillator was on scene with someone trained to use it then this could count against the 8 minute target. Trust data showed that less than 2% of red calls met target in this way.
- Community first responders (CFR) received automatic text messages to jobs that fell within their area. The CFR was then required to call the dispatchers and say they would be attending. The dispatch team could then advise if the call was not suitable for them (such as a high risk patient). We were told that of some instances of CFR's responding to inappropriate calls because they had not confirmed with dispatch but there were no recorded incidents of this occurring. The trust informed us that there was a full mobilisation process for CFR's including stand down.

Patient outcomes

- The trust collected data on patient outcomes and this was collected in board reports and disseminated through team meetings. This data included hear and treat rates for the trust.
- The hear and treat survey found that the trust performed in line with expectations for all measures except for the question of patients being aware of their call back time which was better than expectations.
- The trust managed to close only 6% of calls as hear and treat against an England performance of 10%. The trust had identified this as requiring significant work and investment including the creation of clinical hubs and ambitious performance expectations by the end of 2016.
- The trust took part in national clinical audit including heart attack and stroke. This data is reported under Urgent and Emergency Care.

Competent staff

- Staff we spoke with told us that they had received an appraisal in the preceding year through 18 members of staff told us that before this it had been many years since they had an appraisal.

- Data for 2015/16 showed that only 3% of staff in the EOC's had had an appraisal. The latest trust data provided immediately before inspection showed that 6.5% of EOC staff had had an appraisal. Managers at the sites told us there had been a push to improve appraisal rates and the Bedford EOC had an appraisal rate as greater than 80%. Managers at all 3 EOC's had planned dates to complete all appraisals with staff. Documentation seen on site showed that most staff had received an appraisal. 11 staff we spoke with told us they had received an appraisal, most very recently. 4 Dispatch staff told us they had not had an appraisal in more than a year. At the Norwich EOC, 92% had received an appraisal, and a similar proportion at the Chelmsford EOC.
- Call handlers received monthly one to one meetings to discuss performance and any other concerns or queries. Notes seen showed this to be the case though there was no standard template for this across the three EOC's.
- New call handler and dispatch staff had a comprehensive induction period. Call handlers had a week's training to ensure they could you the decision making software, a further two weeks training on computer assisted dispatch (CAD) and then a minimum of 12 mentored shifts before being signed off. This was deferred if a new member of staff had not met the required grade and they were given additional support. Dispatchers had two weeks of training on the CAD and related software and then a month with a mentor before being signed off. Ongoing one to one meetings between dispatchers and team leaders happened monthly.
- Several staff told us that if they returned form long term sick leave or maternity leave, they were expected to resume their role without preparation or plan and felt unsupported in this. The trust informed us there was a process in place for staff when they return from long term leave.
- Ongoing audit highlighted any concerns about performance which was followed up with a structured programme of support and further training. Positive performance in audit was recognised by the awarding of badges. Performance of call handlers was measured against Integrated Academy of Emergency Medical Dispatch performance standards.
- There were clear competency assessments at given time points and the ability to extend the induction period if required. There was a sampling of calls to ensure competence.

Emergency operations centre

- The EOC's were developing a Senior Call Handler role for staff who performed well on audits and who wanted further development. The role came with additional responsibility and as well as acting up to team leader of required. This was created in response to staff expressing the wish for opportunities for development.
- Staff who had had a difficult or traumatic call could access traumatic incident management (TRiM) debriefing. Other occupational health accessed counselling was also available as was cognitive behavioural therapy (CBT) if that was deemed required.

Coordination with other providers

- The EOC's coordinated with other hospitals to ensure that staff at receiving hospitals were aware of patients due to arrive. This was predominantly the case in the event of major incidents.
- Intelligent conveying was in use across Essex as part of a pilot scheme. This allowed ambulances to be redirected (subject to patient acuity) to other hospitals emergency departments to manage demand on services.
- We saw examples of working with neighbouring ambulance providers where calls were close to borders. Staff clearly had a good relationship with their counterparts in other providers and on one occasion we saw a patient received quicker treatment as a result of this joint working as a neighbouring trusts vehicle was closer than an EEAST vehicle.
- Prior to our inspection EEAST had written to acute providers saying that they would leave patients at hospital after 30 minutes if there was an emergency call in the community. EOC staff were aware of this procedure and said it would require a duty locality officer to make that decision.
- The critical care desk (CCD) at Chelmsford EOC monitor the whole trust for any major trauma. They were able to dispatch multiple resources including the air ambulance and the Hazardous area response team (HART) as well as liaising with other emergency services.
- The incident command desk (ICD) at Chelmsford had set criteria for the calls they managed and could take over trust wide to manage major incidents. The Gold commander would be responsible for the desk in the event of a major incident.
- The EOC's were unable to re-triage calls received from 111 services. If the service was under extreme pressure they were able to call the patient back but not re triage the call. The 111 services used different decision making software to the EOC which staff felt increased the number of high priority calls put through to the EOC's by the 111 services. 111 services could transfer calls directly from their system to the ambulance services CAD (dispatch) and bypassed the call handler/ triage. All staff we spoke with told us that 111 services had increased the number of emergency calls for a variety of reasons including not considering self-transfer options for patients such as by taxi, or triaging patients incorrectly.
- Prior to the inspection many front line road crews told us they regularly attended calls that did not require an emergency response.
- EEAST had started a programme of joint responding with the fire and rescue service across the trust to improve response times. There was a full procedure ion place and clear guidance with what the fire service could respond to.
- Some acute providers were not prompt in updating their Capacity Ambulance Management System (CAMS), one had not done so since February 2016. This made the management of ambulance conveying less responsive due to inaccurate information.

Multidisciplinary working

- There were daily meetings between managers of the three EOC's to determine capacity and anticipated demand.
- There was positive engagement between staff in the clinical hub and call handlers and dispatchers. Each recognised the skills of the other and worked together to provide positive patient engagement.
- We observed good handovers between road crews and dispatchers and within the EOC by call handlers and dispatchers.
- However, staff in the EOC and contacts received prior to the inspection told us that tensions had increased between EOC and road crew as increasing pressure had affected the relationships. Senior managers had investigated complaints by paramedics that they were given late jobs as they were about to finish. The investigations showed that the call was appropriately sent to each crew and was the result of high demand and limited resources.
- There were clear processes in place for dealing with other emergency services and agencies. We observed an incidence of this and that EOC staff worked well with the fire service to manage an appropriate response to a complex emergency.

Emergency operations centre

Access to information

- Frequent callers were identified and marked on the system with a 'flag'. There were specific care plans for these patients agreed by the clinical coordinator in the EOC and agreed with the GP. Care plans outlined what action should be taken and the frequency of the response (for example, only sending one ambulance per 24 hours). At 10 months a review would be triggered by the system. Staff said that the flags had not transferred well from the previous system onto the new system. A small number of frequent callers contacted the ambulance service in excess of 50 times per day.
- The EOC monitored the number of calls from a specific phone number as some frequent callers were anonymous. Evidence was gathered to pass onto the police if staff felt this appropriate.
- The decision not to send an ambulance in line with a care plan was always reviewed by a clinician to ensure it was the appropriate response.
- The clinical coordinator in the EOC's supported colleagues with clinical advice and monitored the triaged calls. They also had access to local GP's records system (SystmOne) which allowed them to review important clinical information relating to patients requiring an emergency response.
- Each call handler had a backup card system in the event of failure of the system. This ensured that they could still provide a safe service in the event of computer failure. We saw one of example of this in action during our inspection.
- All systems were integrated in the EOC so that all staff could see records of calls, dispatch status and medical and other notes. This ensured that all staff had access to the correct information.
- The EOC's had taken action to address the safety alert form NHS England in 2015 relating to delayed updates to ambulance dispatch systems and satellite navigation. The new CAD was updated frequently with latest information and issues relating to difficult addresses could be recorded within the system and also reported to the CAD manufacturer to incorporate into new updates.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Call handlers, clinicians and others who spoke with patients all gained verbal consent when talking to, treating or wishing to share information (for example with the GP) about individual patients. All the staff had an excellent knowledge of consent and when it may be necessary to share information without consent.
- Most staff had not had training on the Mental Capacity Act 2005 or Deprivation of Liberty Safeguards with only 20% of staff receiving this training in the last year.
- Almost all staff we spoke with were unsure of their responsibilities under the Mental Capacity Act 2005 (MCA) or the implications of Deprivation of Liberty Safeguards (DoLS). 15 staff told us that they had MCA training and could describe and though they had heard of DoLS, they had received no training and were unaware of any procedures about it.

Is emergency operations centre caring?

Outstanding ☆

We rated Caring in the Emergency Operations Centre as Outstanding because:

- Staff consistently demonstrated compassionate care when dealing with patients and made extra efforts to protect their privacy and dignity, including dispatching additional resources.
- Staff were highly motivated to provide the best patient care possible. We saw several examples of staff acting with the utmost professionalism and supporting patients and the public in the most trying of circumstances to provide positive outcomes for patients.
- On one occasion we saw a call prioritised to ensure that young children with an unwell patient were also cared for.
- Staff always ensured that patients or the public understood what they were being told and kept communication open throughout calls. Staff were committed to ensuring patients were involved with their care and understood the options available to them.
- Within limited resources at the time of the inspection, staff endeavoured to offer as much assistance for patients to manage their own care as possible.
- Feedback from people who used the service and those who are close to them was positive about the care they received.

Emergency operations centre

- Hear and treat survey results showed the trust performed in line with expectations other than one question where it exceeded expectations.

Compassionate care

- Last available information from the 'Hear and Treat' survey showed that East of England Ambulance Service (EEAST) were within expectations for all measures with the exception of the question 'Were you told when you would get a call back' which was better than expectations.
- We saw numerous occasions where an ambulance was sent to people in public places. Staff were clear that the reason for this was to help protect the patient's dignity and privacy and ensure they were properly cared for as promptly as possible.
- Staff consistently demonstrated excellent, compassionate care to patients and members of the public in extreme difficult or challenging circumstances including people in mental health crisis and people caring for patients collapsed in the street.
- In all of the 32 calls we listened to, staff were unfalteringly polite and respectful, even when on occasion they were verbally challenged by members of the public for delays in getting resources to the call.
- Healthwatch Suffolk provided feedback to us before the inspection. Almost all feedback about staff working for the ambulance service was extremely positive and remarked how kind and caring staff were from the EOC's through to the team who responded.
- Where responses were delayed due to insufficient resource, it was clear that the call handlers concern was for the safety and welfare of patients and those with them. On one occasion we observed a call escalated as a patient had small children with them who were vulnerable.

Understanding and involvement of patients and those close to them

- We observed many occasions when staff ensured the person they were talking to understood what was being said., they reported key information and let the person ask questions. They understood that people calling in an emergency don't like 'quiet calls' and as such, call handlers kept talking to people, giving them information and asking them if they were ok.

- For some conditions such as cardiac arrest, the call handlers could give information to the person making the call so they could commence treatment before paramedics arrived.
- Staff in the clinical hub took time to discuss a patients anxieties and concerns whilst offering them choices in how their condition was managed such as through a walk in centre or GP. This included consideration of the totality of patient needs both physical and mental. They were committed to ensuring patients were involved with their care and understood the options available to them.

Emotional support

- We observed and heard numerous examples of staff providing emotional support to patients, relatives and members of the public phoning on their behalf. We also heard two outstanding examples of emotional support during our inspection.
- On one occasion a member of the public called into to report a patient choking in the street who subsequently had a respiratory arrest. The call handlers system 'froze' and they reverted to a backup card system to support the member of the public. They delivered cardiopulmonary resuscitation advice in a calm and assertive manner whilst providing ongoing emotional support to the member of the public carrying out a difficult task. The resuscitation was successful and the call handler continued to provide emotional support to the member of the public until an ambulance arrived telling them they had done an excellent job and should be proud.
- On another occasion a patient was giving birth in a lay by on a very busy dual carriageway. The call handler stayed calm throughout whilst offering encouragement. At the same time the police were alerted due to the risk on the road. The call handler successfully talked the woman and her partner through the late stages of childbirth to a successful delivery. They did so with the utmost professionalism, care and compassion.
- One patient who rang for an ambulance had an anxiety disorder. They were constantly reassured by the call handler who liaised with the dispatcher so the crew who arrived were aware of the patient's condition. Staff consistently showed empathy for the patient in very difficult circumstances and remained professional

throughout. We heard the paramedic arrive and they tailored their behaviour following the call handlers and dispatchers advice and successfully engaged with the patient.

Supporting people to manage their own health

- One call the patient was unhappy with a call back despite appropriate triage. On occasions it was possible to transfer these patients directly to the clinicians as a 'warm transfer'. We were told that during busy periods this was not possible and the lack of clinicians (ahead of recruitment) made this difficult.
- There were a number of pathways in place that meant not all patients required transfer to hospital. For example, we saw occasions where the clinical service desk arranged a community nurse visit following a review by a paramedic and the clinical hub arranged GP appointment's for patients not requiring an ambulance. The trust had robust plans in place to increase the number of patients treated in this way.
- The software used by the clinical team also gave self-help advice when it was clinically safe to do so though staff used their clinical knowledge to ensure it was appropriate.

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

Good ●

We rated Responsive for the Emergency Operations Centre (EOC) as Good because:

- There were examples of service planning to meet local needs including the increase in provision of hear and treat services and the strategic placement of hazardous area response teams.
- The EOC's met individual needs including using a variety of communication tools for callers, having processes in place for frequent callers and silent calls and providing welfare calls to patients who had waited longer than target time for resource.

- There were systems in place to try and manage the access and flow of calls and patients including 'intelligent conveying' which highlighted demand in local hospitals and transferred patients to areas with lower demand.
- Complaints were investigated properly and the old computer system had been maintained so that older complaints could still be fully investigated. There was evidence of learning from complaints.

However, we also found:

- Throughout the inspection, access and flow was severely limited at times due to the lack of available resource.

Service planning and delivery to meet the needs of local people

- A secondary system (PSIAM) was in place to secondary triage lower acuity calls (Green 2, 3 and 4) and was only used by qualified clinical staff. PSIAM is computer software that allows trained clinical staff assess and manage patients medical conditions remotely. This allowed staff to manage more patients in the community ('Hear and Treat'). The number of clinical staff in the Clinical Hub was being significantly increased to increase the proportion of patients who could be treated in this way.
- At Chelmsford EOC staff told us that they believed the clinical hub managed to hear and treat approximately 40% of the calls they received though the trust only managed to transfer 6% of calls to hear and treat. The trust's ambition was to double this number by the end of 2016.
- The clinical hubs were being introduced across the EOC's with a large recruitment exercise underway. Clinical staff including nurses, paramedics and doctors would offer telephone triage for lower acuity calls to improve the performance of 'hear and treat' as well as ensuring patients were treated in the correct place. This reversed a decision taken two years ago which reduced the number of clinical staff in the EOC's.
- The trust had many Community First Responder schemes around the trust to attend calls and start treatment before the ambulance arrived. Staff told us they were valued, particularly in areas with historic slow response rates including parts of Norfolk and Cambridgeshire.

Emergency operations centre

- The Hazardous Area Response Team (HART) could be deployed to address specific incidents involving hazardous materials and environments. They were placed so as to get to the main risk areas promptly including Stansted Airport.

Meeting people's individual needs

- Translation services were available for patients requiring this assistance with communication. We observed two occasions then this was required and found the translation service to be easily accessible. All call handers we spoke with were aware how to access and use the service. However, one call handler did not utilise the service for a patient and instead dispatched an urgent ambulance. They told us that the process of calling for translation support took too long.
- The service could use type talk for members of the public who used this to communicate. The Norwich EOC had a frequent caller who used type talk and all the staff we spoke with were comfortable in using it.
- There were specific care plans for patients with complex needs. These were either built into the software or where person specific where the service knew of patients, particularly children, who had complex health and care needs. For example, we saw one care plan in place for a child who required ventilation at home and who was prone to respiratory infections.
- Staff told us they had received no specific training on patients living with dementia or those with a learning disability.
- There was a process in place for no voice contact calls. In these instances the call handler would ask the caller to tap the phone handset which was useful for some calls where, for example, a crime was happening or the caller was at risk and did not want to speak.. If they were still silent they were transferred to the police.
- The computer system allocated a Green 2 call whilst language line was being contacted. This ensured a response was underway even before the problem had been identified.
- Patients received welfare calls if the response to their call was slower than target. This included for GP Urgent calls (where an ambulance is requested by a GP within 1,2,3 or 4 hours). Patients for these calls were called back after an hour and if no vehicle assigned then they were upgraded to a Green 2 call which meant a prompt response was required (within 30 minutes). The clinical coordinators undertook this role.

- On one call a patient told the call handler that they were obese but there was no attempt to ask the patient their weight and whether a specialist vehicle would be required. Bariatric vehicles were available for patients requiring these vehicles.
- Each EOC had additional space for staff to take breaks and have meals.

Access and flow

- The EOC's were frequently challenged in matching resource to calls. Handover delays at hospitals were cited as a major barrier in providing a more timely response to calls.
- Calls into the EOC were monitored at all times. Staff could see the performance of theirs and other EOC's as the data was displayed on large screens around the room. If calls were not answered within a second at the EOC it was available region wide to be answered. During the inspection we saw all calls answered promptly with no delays.
- Dispatch team leaders used the status plan to ensure that priority standby points were covered in order of operational priority (where sufficient resource allowed).
- The clinical coordinators monitored the calls awaiting an emergency response and could upgrade the response time or resource if they felt the call was of a more serious nature or that the patient had been waiting too long. This was an active role and we saw examples of this in action.
- The regional operational support officer (ROSO) based at Chelmsford EOC followed up any crews that were either 'off grid' (unidentifiable) or were held up at acute hospitals. The ROSO liaised with hospital management to address delayed handovers and improve the amount of resource available.
- An intelligent conveying officer based at the Chelmsford EOC made decisions on which hospital ambulances should attend. So if one hospital is very busy and another is not so busy, depending on clinical priority, the ambulance may be diverted to the quieter hospital to attempt to relieve pressure on the acute trusts.
- GP triage was provided from EOC's and covered the entire trust. Most calls were from paramedics who had completed an assessment and wanted further advice on pathways or community services to avoid unnecessary admission though the GP's also undertook hear and treat with patients.

Emergency operations centre

Learning from complaints and concerns

- Staff told us it was rare that they would answer a call that was a complaint rather than an emergency call. In the event that this happened they passed the call to the team leader who spoke with the person and connected them to the team leader. They attempted to resolve the concern at a local level but if this was not possible they transferred the call to PALS.
- Complaints investigations held locally showed that complaints were properly investigated and learnings identified. Audit staff played a role in the investigation process and reviewed the calls which the complaint related to.
- Learning from complaints was clearly identified and changes made to service provision. For example, one complaint related to questions related to an eye problem. The investigation concluded that the questions were too generic and changes had been made to ensure more detailed questions were asked. Staff in the EOC were aware of the change pf procedure for this condition.
- Senior managers told us that on occasions that a serious incident (SI) may be identified from a complaint. In this instance, the complaint would be forwarded to the trust Patient Safety Officer and it would be considered at the SI panel.
- The old computer assisted dispatch (CAD) system was still available to staff. This was essential for the investigation of incidents, complaints ort queries that related to the service when the old CAD was in use.

Is emergency operations centre well-led?

Good 🟢

We rated Well led as for emergency operations centre (EOC) as Good because:

- There was a clear strategy and vision in place for the EOC's including the development of clinical hubs. All the staff we spoke with were aware of the direction of the service and plans for the future.
- The EOC's had undertaken a major infrastructure change with the implementation of a new computer system. This had been done in a short period of time with comparatively small number of incidents for such a large change.

- There was a clear governance structure in place for the EOC's and regular audit and measurement.
- Staff spoke highly of their immediate leaders and managers told us that the executive team were approachable.
- There was a supportive culture amongst colleagues within the EOC's.

However, we also found:

- Staff felt under pressure because of rising call volumes and the lack of resource to send to some calls.
- There had been a high turnover and sickness at the Norwich EOC and some allegations of bullying. A culture project had been undertaken to address these concerns.

Vision and strategy for this service

- Information provided by the trust prior to the inspection said that the EOC's did not have a distinct strategy or vision but that it was part of the wider strategy for the trust. However, during inspection we found that staff and managers were aware of a local vision to improve their part of the service for the benefits of patients,. Whilst this clearly fed in to the overall strategy for the service, there was a clear and distinct vision held by the staff and managers of the EOC's.
- The vision and future strategy for the service included the development of the clinical hubs to improve the number of patients who were treated without sending a resource or conveying them to hospital unnecessarily. All staff were aware of the service development and the impact it would have and all staff we spoke with were supportive of this model of care.
- Two managers we spoke with were extremely enthusiastic and positive about the new model of care.

Governance, risk management and quality measurement

- There was a clear governance structure within the EOC's with defined roles and responsibilities. There had been some changes including the creation of some management posts to effectively manage the new clinical hubs. Staff were aware of the management structure and who was responsible for different parts of the EOC.
- Communication between the three EOC's was a challenge given the distances between the facilities and the idiosyncrasies of each one. Some key staff including

senior managers had to routinely travel large distances between the three centres. This had been a requirement of certain roes for some time but a number of staff raised the question how sustainable this commitment was in the future.

- A comprehensive plan of audit was in place for both local measurement as well as national clinical audit. There was a clear feedback loop for the audit data which was sent to senior managers and then cascaded for one to one conversations with individual members of staff. The Board Assurance Framework clearly picked up audit data and performance data from the EOC's and reported it at board level. Quality assurance was discussed locally and there were examples of improvement based on audit including the improvement of data collection during calls.

- There was a comprehensive risk register in place which identified the risks and mitigation. Managers at all three centres and the overall service manager had a clear view of the risks faced by the EOC's and what plans were in place to address them. Managers told us they were able to add items to the risk register if they had concerns.
- Quality audits and rounds were carried out by staff from outside of the EOC to measure quality and performance.
- Senior managers at the three EOC's had daily calls to review demand and capacity and manage it regionally where required.

Leadership of service

- Staff spoke highly of the EOC manager and felt them to be approachable. Staff told us they had seen the new chief executive on occasion in the EOC's and had found the executive team to be approachable.
- Staff told us they would be confident in raising concerns and that their concerns would be taken seriously and acted upon.
- A new computer aided dispatch (CAD) system had been introduced to the three EOC's shortly before our inspection. This had been a large piece of work, fundamental to the running of the EOC's and the whole ambulance service. There had been some 'teething troubles' with the new system though incidents reported in relation to it were small (approximately 25 directly related to the CAD). Staff said that they had received sufficient training and support to use the new system and many said it was an improvement on the

old system. A dedicated email address was available for staff to report concerns. The CAD had been implemented within 4 months of procurement and offered advantages over the old CAD.
- We saw on several occasions, senior managers supporting call handlers after difficult calls or congratulating them for what they had done well.
- Leaders and managers within the service had commenced the Edward Jenner leadership programme designed to improve their leadership skills.

Culture within the service

- Prior to the inspection we received many contacts from members of staff. Seven staff alleged bullying at the EOC's and we found on inspection that two episode's had been appropriately dealt with. 5 further allegations had been identified/ reported at the Norwich EOC and investigated. Senior managers told us they believe there had been a bullying culture in the past but were working hard to address this at the EOC's, Norwich in particular. This had included work on culture and work behaviours.
- 22 staff spoke highly of the chief executive who had visited their EOC and felt him to be approachable.
- There was a very supportive culture in the service amongst colleagues and managers. On several occasions a member of staff was supported emotionally following a difficult or challenging call and given time out to reflect.
- 8 staff told us that it was not always easy to take leave as only two members of staff could be off at once. The staff felt this had impacted negatively on their morale and work/ life balance. The trust informed us that this had been a limited period when the CAD had been implemented and was lifted following this.
- A number of staff told us that they were under increasing pressure because of the year on year increase in call volumes. They were proud of the work they did and the value of their work but were concerned that morale would suffer with the high demand on the service.
- Sickness rates were variable across the EOC's with Bedford at 6% (against trust average of 7%). IN Norwich EOC, sickness had been at 20% for 2014/15 but this had been reduced to 4%. Managers had identified bullying as an issue in the past and recognised this by running dignity at work workshops which they felt had improved the morale and lowered the sickness rate.

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- There was an employee assistance programme where staff could self-refer or be referred by occupational health regarding any matters at work or personally related.

Public and staff engagement

- There had been increased efforts to engage with staff to improve the service provided and work/ life balance issues. There had been listening events for staff to attend which had been attended by an executive to answer questions.
- Team leaders in Chelmsford told us that they attended meetings every four to six weeks and that information from the meetings were shared with staff at their 1 to1 meetings. Team leaders had a 1 to 1 with the senior manager every 2 months though we were not provided with any paperwork to conform these meetings took place however we did see records of meetings between team leaders and call handlers/ dispatchers.
- Due to shift patterns, team meetings were not held frequently. There was a reliance on meeting with team

leader's hand having information cascaded to other staff. Some staff said they did not always fell kept up to date with changes and that communication between managers and the teams could be better.

- A reward and recognition form had been created by the EOC manager to recognise good and outstanding performance. This was retained in the member of staffs file.
- The trust carried out roadshows to engage with other stakeholders and members of the public through the EEAST area, to gather their views and ensure the service met their needs.

Innovation, improvement and sustainability

- The EOC's have been involved with developing enhanced care tools including in stroke care to improve the performance and identification of stroke in the community.
- There was a clear plan to substantially increase hear and treat services to ensure a more appropriate response for patients. There were ambitious targets for this part of the service that staff felt would 'revolutionise' the way care is provided for many patients.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve
Action the trust MUST take to improve

- Improve performance and response times for emergency calls.
- Ensure that there are adequate numbers of suitable skilled and qualified staff to provide safe care and treatment
- Ensure staff are appropriately mentored and supported to carry out their role including appraisals.
- Ensure staff complete mandatory training (professional updates).
- Ensure that incidents are reported consistently and learning fed back to staff.
- Ensure that all staff are aware of safeguarding procedures and there is a consistent approach to reporting safeguarding.

- Ensure that medicines management is consistent across the trust and that controlled medicines are stored and managed according to regulation and legislation.
- Ensure that all vehicles and equipment are appropriately cleaned and maintained.
- Ensure all staff are aware of their responsibilities under legislation including the Mental Capacity Act 2005.
- Ensure all staff are aware of their responsibility under Duty of Candour requirements.
- Ensure records are stored securely on vehicles.

Action the hospital SHOULD take to improve

- The trust should consider how all risks associated with PTS can be captured and reviewed on the risk register.
- The trust should improve the numbers of patients offered hear and treat services.

Requirement notices

This section is primarily information for the provider

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
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider was not ensuring the use of effective audit to assess, monitor and improve the quality of the service. Care records were not always stored securely.

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider was failing to ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced persons to meet the needs of people using the service. The provider was failing to ensure all staff received annual appraisals. The provider was failing to ensure that all staff received mandatory training (professional updates).

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider was failing to ensure that all staff were aware of their responsibilities and acted in accordance with the Mental Capacity Act 2005.

Requirement notices

The provider was not ensuring medicines were always stored safely and securely and audited effectively nor ensuring staff followed trust policy relating to controlled drugs.

The provider did not consistently report safety incidents or feedback actions and learning to staff.

The provider was failing to meet the needs of all patients by ensuring a timely emergency response.

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The provider was failing to ensure that all staff were aware of their responsibilities and acted in accordance with safeguarding procedures.

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The provider was failing to ensure that patient transport service vehicles were properly cleaned.