Report Detailing the responses to the CQC Consultation on How to Regulate Ambulance Services

March 2015

Contents

1. Introduction

About the consultation

CQC ran a consultation between 28 November 2014 to 23 January 2015, where they asked members of the public, stakeholders and providers, about their plans to change the way we regulate the following services:

- Ambulance services
- Primary care dental services
- Independent acute healthcare services.

About Quality Health

Quality Health is an independent healthcare consultancy, commissioned by the Care Quality Commission to support this consultation process. The consultation documents and the various processes for collecting feedback were designed and organised by the Care Quality Commission.

Quality Health has collected all the response data from all aspects of the process and captured it in this document.

Any conclusions reached in this report are therefore the conclusions of Quality Health based solely on the responses provided to the consultation; they do not necessarily represent our own views or the views of the Care Quality Commission.

You can read the full consultation response on the CQC's website here – www.cqc.org.uk.

2. Key numbers

1. 33 respondents replied to the 11 consultation questions.

   30 of these responded via the webform:

   - 9 Providers of Service
   - 7 Healthcare Professional
   - 6 Members of the Public
   - 4 Stakeholders
   - 2 Commissioners of Services
   - 1 CQC Staff Member
   - 1 Voluntary and Community Services Representative

   3 responded via a written submission:

   - Commissioners of Services
   - 2 Providers of Services

2. 4 Respondents submitted general written comments about the consultation via email and letter:

   - 1 ex Implementation Manager (and current Independent Consultant for MCA and MHA)
   - 1 Professional Body
   - Unknown respondent
   - A National Disability Forum

In addition, this report contains:

3. A summary of issues about ambulance services from a number of SpeakOut groups including:
   - Binoh (Othodox Jewish)
   - Disability Equality North West (People with disabilities)

- Windrush Initiatves (BME)
- Lesbian and Gay Foundation
- My Life, My Choice (Learning disability)

4. A summary of Children and Young People's Advisory Group Discussion regarding ambulance services.

3. Responses to Consultation Questions

1. We have identified the core services that we will check during our inspections of ambulance services (see appendix A). These questions are for both NHS and independent ambulance services.

Do you agree that these are the right core services to look at?

33 respondents replied to this question

30 agreed that these are the right services to look at:

- 7 Healthcare Professionals
- 9 Providers of Services
- 6 Members of the Public
- 3 Stakeholders
- 3 Commissioners of Services
- 1 CQC Staff Member
- 1 Voluntary and Community Services Representative

3 respondents did not agree that these are the right services to look at:

- 2 Providers of Services
- 1 Stakeholder

If you don't agree, please tell us why:

<u>Providers of Services</u>

- Yes to some degree. It defines Emergency and PTS areas, but does not seem to get to include any intermediate tier elements, sometimes undertaken by higher trained PTS or lower skilled Emergency Ops.
- We agree that Emergency Operations Centres, Emergency and Urgent Care Services and Patient Transport Services should be core services however we consider that Resilience Planning is not necessarily a core service, but could be integrated within the other three areas. If resilience planning is amalgamated it could be considered to identify Trust Governance, as a core function. However if scope is not available for alteration we recommend that Resilience Planning should include Business Continuity.

Stakeholder

- We get information about booking service for patients not being flexible or at times accessible, you include PTS but the access and booking needs to be a key focus

Do you understand what we mean by these core services?

4 of the 31 respondents didn't understand what is meant by core services. The reasons were as follows:

Healthcare Professional

- You have said you will class HDU with Emergency/ Urgent Care Services - Will there be guidance or specification as to what defines a HDU Ambulance e.g. Crew Qualification Kit List etc. At present there are a lot of firms that run a PTS service - stick a 12 Lead ECG on a PTS Ambulance and class it as a HDU. Causing unfair competition and putting lives at risk. This category needs to be defined by Patient and Vehicle Classification - happy to explain more in detail

Provider of Services

- In the main yes, however the mention of 111 in the EOC core service appears confusing. Referring to Appendix A, Core service definitions we would seek clarity on whether this is intended to include 111 services in your approach to regulating ˜primary care services", and not within the ambulance inspection regime (even where they are provided by ambulance services). However, ˜Inspecting a combination of services" in section 5, Inspection, (p24), muddies the waters, so clarification would be helpful.
- We believe there is an area of overlap between the definitions of the core services 'Resilience planning' and 'Emergency and urgent care services'. Ambulance provision at events is a business as normal service and should not fall into the same categorisation as resilience planning. Business continuity is a core part of effective governance and planning of services. Therefore we do not feel that it should be specifically covered under Resilience planning as it will being all providers into this core service. The focus of this core service should be category 1 response under the Civil Contingencies Act 2004. We would also like to raise some issues to be considered when finalising your approach to the inspection of ambulance services at events. If this approach is poorly managed from the perspective of the event organiser then it could be have an impact on the provider's relationship with the event organiser. Ultimately it could lead to loss of

business. We feel that it is important that the inspection team contacts the event organiser prior to any inspection and gives them an introduction to the CQC: purpose, aims, powers and methodology. Some event organisers may have concerns at having a statutory regulator on site as inspectors cannot 'un-see' what they have observed. The introduction should address how the CQC would deal with event management issues and what agreements it has in place with the HSE. If this introduction is not made would the CQC's Power of Entry enable your inspectors to gain entry to event sites which could have a range of access and security controls? For example our first aiders and ambulance crew are unable to access the London Marathon sites unless they have a pre-allocated ID badge. It is also important that the approach considers how events will be inspected, judged and reported where there are multiple providers at the event. At some events the event organisers may have contracted these providers directly, in other cases the event organisers may have only contacted one provider which has in turned subcontracted part(s) of the provision to another provider(s). Multiple providers may be engaged but actually cover separate days or provide separate services. For example one provider may be delivering first aid and the second provider will be providing the ambulance service. They could also be delivering the same services on the same day at separate sites. In addition, some contracts are for multiple events delivered throughout England and therefore consideration needs to be given on how the outcomes of these inspections would be managed in terms of service and Location ratings.

<u>Member of the Public</u>

- As a Trust we have separated Emergency Services and Urgent care. Emergency/Ambulance services for the Trust involves three main types of services; 999 A&E services, Hazardous Area Response and Patient Transport Service. 999 A7E services is where the Trust provides emergency and urgent responses to ˜Red" or ˜Green" categorised injuries and illnesses, which are likely to require treatment and possible transport to a hospital or other facility. While for the Trust, urgent care involves three main types of service; Out of Hours service, NHS 111 and the provision of a Single Point of Access service. As a provider who provides urgent care in the forms of Out-of-Hours, NHS111 and Urgent Care Centres will these all be inspected under the Emergency and Urgent Care services core services? As the appendices doesn't not cover urgent care in these setting. The definition only covers the different types of transportation (specialist, air ambulance) and the different types of emergency responses (community first responder). So we are unclear as to where/when Out-Of Hours, NHS111 and Urgent Care Centres will be assessed.

We believe weighting core services equally is in line with our commitment to promote equality in the services we regulate and to uphold Equality Act legislation. Everyone who receives care and treatment should expect to receive the same good quality care, irrespective of the type of service that they are using.
An exception might be where an ambulance service provides a core service to a smaller population than another core service; for example where an ambulance service provides patient transport services to 10% of the population they provide emergency and urgent services to. In this situation the inspection team would use their professional judgement to determine what weight to give the core service when aggregating ratings.
Do you agree that, in general, core services should be weighted equally with the above exception?

32 respondents replied to this question

24 respondents agreed that core services should be weighted equally with the one exception:

- 8 Providers of Services
- 5 Members of the Public
- 4 Healthcare Professionals
- 3 Stakeholders
- 2 Commissioner of Services
- 1 CQC Staff Member
- 1 Voluntary and Community Services Representative

The 8 respondents did not agree gave the following reasons:

<u>Healthcare Professionals</u>

- No matter what type of service is being delivered all aspects should be inspected to the full extent. For Example a company might provide 85% PTS as a core service and only 10% as Emergency - If they were rated based on the PTS and get a good report it might miss the fact that life's are at risk on the Emergency Side. Ambulance Services should be inspected on all services provided - it may be that Company A gets a Outstanding for PTS as a core but fails the Emergency side - this should be set out clear for people to see.
- If the principle is that you provide this service and it matters what quality you provide and therefore it requires equal weighting, why then does it matter what size the service being delivered is? If its dependent on size of service

then all NHS Ambulance Services would have EOC,E&U and Resilience as core and not PTS. No PTS contract covers the whole of an NHS Ambulance Service.

- Agree everyone who receives care and treatment should expect to receive the same good quality care, irrespective of the type of service that they are using, however it may take time and resources to equalise services, is this national picture? Disagree with the exception as this appears to support the theory that PTS is a secondary service. Volume should not matter, quality of service should.

Providers of Services

- Yes, however please note the following. I think that weighting them in this way gives much more fairness to the overall patient experience. However demographics of patient population, geographical area and placement of specialist treatment centres should be noted if comparisons are being made regarding patient outcomes if ACQIs are used as part of the weighting process. It should also be noted that some patient outcomes for which ambulance services are assessed such as Discharge from Hospital for pre-hospital Cardiac Arrest patients are also dependent on hospital care/treatment not just ambulance services. This consideration should also be included to ensure ambulance services are not penalised for poor hospital outcomes.
- In general yes, however it should also be considered that weighting core services equally may not produce a fair reflection of a Trusts services. We do agree with the exception cited, however we would also consider that there may be further factors and would suggest there is scope for this to be a non-exhaustive list that any developments submitted to yourselves can be assessed during initial information gathering.

Stakeholder

- NHS Providers considers consistency and transparency to be critical to the credibility and sustainability of the inspection regime.. Patients should be confident that the regime ensures agreed quality standards are met irrespective of the type of service they are receiving and how often a provider is required to deliver that service. We therefore concur with CQC's view that weighting core services equally is in line with the commitment to promote equality in the services it regulates. We would however encourage CQC to maintain an ongoing dialogue and consultation with providers to understand how factors such as relative demand on a core service influence resource distribution and care quality outcomes.

Commissioner of Services

- EPRR is a smaller function for most ambulances services and standards are closely monitored by peer review and national standard setting. It would be better to have greater weighting for the contact centre, PTS and emergency services

Member of the Public

- Some core services have more impact on patient outcomes, individually and as a group. I would consider Emergency and Urgent Care and Emergency Care Planning to have more impact on people's clinical outcomes and therefore given more weighting, compared with Patient Transport and Resilience Planning.

2. Do you feel confident that the key lines of enquiry and the list of prompts will help our inspectors judge how safe, effective, caring, responsive and well-led NHS and independent ambulance services are?

32 respondents replied to this question,

28 respondents feel confident that the key lines of enquiry and the list of prompts will help inspectors judge how safe, effective, caring, responsive and well-led NHS and independent ambulance services are.

- 6 Providers of Services
- 7 Healthcare Professionals
- 6 Members of the Public
- 4 Stakeholders
- 3 Commissioners of Services
- 1 CQC Staff Member
- 1 Voluntary and Community Services Representative

4 respondents, all Providers of Services, don't feel confident that the key lines of enquiry and the list of prompts will help inspectors judge how safe, effective, caring, responsive and well-led NHS and independent ambulance services are.

Is there anything missing?

15 Respondents replied to this question:

Providers of Services

- We have not identified anything that is missing, however we have a number of points that you may wish to note; how are you measuring safety? It states you are looking at a track record. Is this number of incidents/Sis/complaints/never events or what you have done with that information? The prompts do not really answer this, particularly the first one of safety performance over time (S1). Given the recent demand on the NHS for example, there have been periods where we may not have been safe due to ambulances being stuck outside A&E departments. Outcome data is extremely difficult to get. Hospitals and GPs are very reluctant to give any information out which does not enable full learning to always occur.E2, point 6 Staff may get a better chance of feedback locally than the Trust can regionally. E5, point 1; how will this be measured as the ambulance service will not have any control over the patient information provided to us, this will be the responsibility of the relevant healthcare provider to ensure that care plans etc. are available when we attend. We will be required to ensure that we provide our clinicians with the all the information we hold so it may just be that the examples provided require amending to suit the ambulance service as the ones given don't. E6, point 6; is deprivation of liberty really an ambulance service request? I am not sure it is. C3, points 2 and 3;a As long as you understand that in an emergency situation this would not routinely happen due to the nature of the work. Point 3 particularly is difficult if you don;t know what is available within the communities.
- Comment - 1. Refer to comment to Q1 above and note that this is an essential consideration during review of KLOEs.2. Providers are naturally restricted through contractual/commissioning arrangements. It is unclear as to how this will be taken into account in the proposed approach.3. Could not see explicit reference to provider arrangements for Duty of Candour?
- In principle we consider that the key lines of enquiry offer structured guidance that would enable effective inspections though some may be viewed as quite long. We would query, regarding the prompts that some may not be relevant to ambulance services and would believe there is benefit in clarification between the CQC and appropriate clinicians from the ambulance services to include the correct criteria in the prompts.
- This trust has had considerable input into the development of ambulance specific KLOEs at several stages and welcomes the new set. The questions and prompts are appropriate to ambulance services.
- Little is known about whether patient preferences are adhered to, especially those which are legally binding under the Mental Capacity Act. Whilst there are a handful of policy and guidance documents in circulation which refer to the importance of Advance Decisions, LPAs and Advance Care Planning

(ACP), our understanding is that the NICE Quality Standard for End of Life Care for Adults is one of the few which sets out exactly what needs to be measured in order to get a picture of adherence to patient preferences. Of relevance to the regulation of ambulance services in this Quality Standard are 'People approaching the end of life are identified' (0301), 'Individuals' preferences and choices are documented and communicated and available at all times of day to all relevant professionals' (0304) and 'Proportion of ambulance transfers for people approaching the end of life where the GP is informed' (0407). We strongly recommend that this Quality Standard is used to inform the development of CQC regulations. The Government's response to the House of Lords Select Committee Report on the Mental Capacity Act 2005 (1) stressed the urgency to: address the low level of awareness among the general public of Advance Decisions to refuse treatment; promote better understanding among health care staff of Advance Decisions, in order to ensure that they are followed when valid and applicable; promote early engagement between health care staff and patients about Advance Decisions to ensure that such decisions can meet the test of being valid and applicable when the need arises; promote the inclusion of advance decisions in electronic medical records to meet the need for better recording, storage and communication of such decisions. With this in mind it is timely that the CQC should specifically measure the uptake of Advance Decisions, LPAs and ACPs (which should, where possible, include an Advance Decision to Refuse Treatment) and the extent to which they have been adhered to. Whilst we acknowledge that the use of Advance Decisions can be difficult in emergency situations where the patient is not on a defined care pathway, it is manageable for patients who are recognisably approaching the end of life (e.g. those on their GP practice's register of patients who might be expected to die within a year). In 2013/14 Compassion in Dying conducted a Freedom of Information Request of Ambulance Trusts in England, which reported that only half had a formal electronic system in place to record the treatment wishes of patients at the end of life(2). In addition, three Trusts reported having a formal system in place for recording the wishes of individuals who are not nearing the end of their life. This clearly shows a gap in the provision of best practice, which needs further and more rigorous audit through the CQC. Similarly, Public Health England recently carried out an analysis of the end-of-life care delivered by two Ambulance Trusts (3). The report identified that ambulance staff may not have access to key information such as the individual's medical history or advance decisions to refuse cardiopulmonary resuscitation and recommended that an end-of-life care decision support tool needs to be developed to help enable safer and appropriate care decisions•

being made by ambulance clinicians. These principles should inform the inspection of ambulance services. The provider handbook on ambulance services that goes with this consultation sets out that â€˜During our inspections, we will assess how well providers are using the MCA to promote and protect the rights of people using their services. We will also look at staff understanding of advance decisions to refuse treatment and lasting powers of attorney for health and welfare decisions, which relates to E3 and E4. This is to be commended; however we are concerned that the CQC inspectors may misunderstand how Advance Decisions should be used in practice, as evidence by a CQC report on Longwood Lodge Care Home which wrongly stated that a photocopy of an Advance Decision was not fit for purpose as only the original document would suffice to allow others to act in accordance with the person's wishes (4). Compassion in Dying is currently in correspondence with Rachel Griffiths (Mental Capacity Act Policy Manager) at the CQC in relation to this issue. As evidence in a recent BMJ paper (5) the portability of DNACPR decisions between organisations and healthcare settings is inconsistent, with limited guidance arising from the national guidelines. DNACPR decisions were portable in 13 out of 26 acute Trusts and 8 out of 12 community Trusts surveyed. An additional six acute Trusts' DNACPR decisions extended to include ambulance. It is essential that DNACPR policies are inspected and reported on.

- More work should be done around the way that ambulance services work with other emergency services. Data should be examined in relation to the number of calls cancelled by ambulance vs. police, the number of calls that are made by police etc. The CQC should encourage collection of relevant, accurate data and encourage data-sharing and joint working. The work that Ambulance Trusts do on vulnerable people, repeat callers, and repeat places of note should be examined. The work in the control rooms should be examined - triaging of calls, initiatives such as clinicians being available to give advice Whether the Ambulance trust are an active participant in Local Resilience Forums, Health and Wellbeing Boards, Mental Health Transport Concordat work. Emergency services within the trust area should be more formally consulted on the way the services work together. Rather than anecdotal evidence from police officers that inspectors happen across when carrying out their work Force representatives should be identified and consulted.
- We wondered if the KLOEs should provide a prompt regarding compliance with contractual requirements to demonstrate when a provider is meeting its contractual obligation and providing the service that has been commissioned.
- What is missing is any reference to information gathered from patient groups. This is particularly important in the pre-inspection phase as such information

could help inspectors include or focus upon elements which may not be gathered from elsewhere.

Healthcare Professionals

- There are a lot of questions around the patient, but not the company or equipment i feel a line of inquiry should be is the Ambulance Equipment inspected by an appropriate company and documented? Are the Ambulances Serviced regularly? is there an audit trail of defects and repairs?
- Having discussed the comprehensive lists, and reflected on our recent experiences as a pilot, would offer the following for further consideration: Under safety;S3 Safety briefings S3- safely discharged if not conveyedS5(1)- multi-casualty situations Under Effective;E3(5)- Pastoral support for staff Under Responsive; R4(5)- Compliments

Commissioners of Services

- I think there should be an element of evaluation of the clinical effectiveness of care. In particular for children as this is often a neglected area
- The CQC needs to assure itself it is comparing like with like, which may need ambulance services to be aligned in respect of definitions that cover their reporting. For example, some providers only report emergency responses on in their see and convey rates. Others include urgent HCP requests for example. There is also, we understand, some variation in AQI reporting too. Should there be something under caring about how an organisation cares for its staff?
- Should there be something under caring about how an organisation cares for their staff?

Member of the Public

- We believe the Key Lines of Enquiry will be thorough in helping inspectors judge how safe, caring, responsive and well-led NHS and independent ambulance services are. There are some prompts which would be difficult to evidence with documentation. Where prompts are difficult to evidence with documentation, will evidence be gathered and recorded through other sources e.g. interviews, observations? No, we believe the Key Lines of Enquiry and prompts would provide thorough and overarching prompts in order to help the inspectors to judge how safe, effective, caring, responsive and well-led the services are.

Stakeholder

- NHS Providers welcomes the iterative and consultative approach that CQC has taken to involve providers comprehensively in all areas of its new regulatory approach, including the detail of developing the Key Lines of Enquiry (KLOEs) and prompts that flow from the five domains of the inspection framework, the tailoring of the KLOEs to reflect the particular aspects of each sector, the data indicators for intelligent monitoring in acute and mental health care, and the criteria for the performance ratings that underpin the new regulatory model for care quality. The effective use of the KLOEs by inspectors in practice will be essential in ensuring that judgements are objective, comparable and robust. It will be essential for CQC to ensure its inspectors are fully trained on their usage and to adopt a robust quality assurance process to verify judgements and inspection reports before they become public â€“ feedback from trusts in other sectors already subject to new-style inspections suggests there is still some way to go before CQC has fully achieved this. We also note that the provider handbook consultation document makes reference to the need for inspection teams to use their discretion and professional judgement in light of the available evidence and complexity of services offered by an ambulance provider, which could be misinterpreted as a license for inspectors not to apply particular KLOEs and prompts in making judgements. We would therefore be keen to ensure that CQC has capacity to offer training on the KLOEs to all of its inspection teams, and focuses on evaluating the effective implementation of the KLOE framework within the handbooks on an ongoing basis and in consultation with trusts, including before final judgments on quality of services from an inspection are determined and published.

3. Questions for both NHS and independent ambulance services

Do you agree that the characteristics of 'outstanding' (in appendix C) are what you would expect to see in an outstanding NHS and independent ambulance service?

32 respondents replied to this question

28 agreed that the characteristics of outstanding are what you would expect to see in an outstanding NHS and independent ambulance service:

- 8 Providers of Services
- 6 Healthcare Professionals
- 5 Members of the Public
- 4 Stakeholders
- 3 Commissioners of Services
- 1 CQC Staff Member
- 1 Voluntary and Community Services Representative

4 respondents made additional comments:

Provider of Services

- Comment - The overall quality of services will be dependent upon the combined effect of the individual core services. It is unclear in the proposed approach as to how the consequences of actions taken within other parts of a 'whole system' will be considered in the assessment of individual providers. Specifically, an organisation may deliver outstanding care for their particular core service but the overall patient/service user experience may be very poor. An example would be one where the quality of care provided by the provider of A&E services is undermined by poor Emergency Operations Centre practice or by other care pathway components outside of their control (e.g. delayed handover at receiving hospitals).

Healthcare Professional

- In principle characteristics are ok - but there is no mention about equipment, Ambulances

Member of the Public

- A qualified yes. I think an outstanding ambulance service must be "outstanding" in its core services for "Emergency and Urgent Care" and "Emergency Care Planning", and not any less. They are non-negotiable.

Stakeholder

- We recognise and welcome that CQC has developed the characteristics of the ratings in consultation with the sector, and we encourage CQC to maintain the consultation and feedback from providers to ensure that inspection observations and the judgments that flow from them do fairly, accurately and consistently reflect the characteristics under each rating. We would also

encourage CQC to ensure the benchmarks for ambulance services are as comparable as possible with other types of service, be that in the acute, community or mental health sector, to ensure parity of approach and expectation. We have not received any specific feedback from our ambulance members to indicate that they would not be happy with the proposed characteristics for each rating.

4 respondents didn't agree that the characteristics of outstanding are what you would expect to see in an outstanding NHS and independent ambulance service and gave the following reasons:

Provider of Services

- We do not consider that the structure and meaning of outstanding offers sufficient clarity to providers. We offer the following for consideration which may assist providers in understanding this rating; Outstanding: The Trust can demonstrate embedding and innovation of practice.
- Whilst recognising that outstanding has been designed to be the exception not the rule due to the limited control that most independent providers have over service design and development, we did not feel that the requirements around innovation were attainable. In addition, often independent ambulance providers have limited access to data and they are not engaged in national audit programmes. This will also impede the ability to drive forward innovation and undertake activities such as benchmarking. For some providers, given the range of services they provider, there also may not be a natural peer organisation with which to benchmark themselves against.

Member of the Public

- Safety - The majority of the characteristics are what we would expect to see in an outstanding NHS and independent ambulance service. It might be worth noting that Zero-harm cultures are very hard to instil. Zero-harm can lead to organisations not placing enough focus on managing significant hazards. If organisations are focused on trying to stop all injuries, then they are not likely to take risk based approaches, especially when hazards and risks cannot be completely eliminated. Effective - There is a holistic approach to planning people's discharge, transfer or transition to other services, which is done at the earliest possible stage. Arrangements fully reflect individual circumstances and preferences. With regards to this being an Ambulance handbook we suggest the characteristic would be better worded as: There is a holistic approach to providing people who make contact with the 999 service with the most appropriate care. Care that meets the clinical need, is delivered by the

most appropriate clinician and is provided at a location that is most suitable to the needs of the person and of the wider healthcare community. Caring: We think it is difficult to say that relationships between people who use the service, those close to them and staff are strong, as some patients or next of kin will only be in the care of staff for a short period of time. Where patients are with staff for a short period of time strong relationships are difficult to form. There are some cases where patients use the service frequently and staff and patients do develop strong relationships, however basing this as Outstanding may be unachievable. Responsive: Services that are tailored to meet the needs of individual people and are delivered in a way to ensure flexibility, choice and continuity of care can be difficult for independent ambulance service and non-foundation trust NHS services. Foundation Trusts have the advantage that they have Council of Governors which provides regular stakeholder engagement and ensures stakeholders receive a more tailor made service. Well-led: We agree with Rigorous and constructive challenge from people who use services, the public and stakeholders is welcomed and seen as a vital way of holding services to account. This should produce a robust process, as does leadership driving continuous improvement.

<u>Healthcare Professional</u>

- Effective outcomes would need to be measured and compared. This may prove difficult. Could be triangulated with NCPIs and discharge/recall figures?

Do you agree that the characteristics of 'good' (in appendices B and C) are what you would expect to see in a good NHS and independent ambulance service?

31 respondents replied to this question

29 agreed that the characteristics of outstanding are what you would expect to see in a good NHS and independent ambulance service:

- 9 Providers of Services
- 7 Healthcare Professionals
  4 Members of the Public
- 4 Stakeholders
- 3 Commissioners of Services
- 1 CQC Staff Member
- 1 Voluntary and Community Services Representative

2 of these respondents added additional comments:

Healthcare Professional

- In principle characteristics are ok - but there is no mention about equipment, Ambulances

Stakeholder

- We recognise and welcome that CQC has developed the characteristics of the ratings in consultation with the sector, and we encourage CQC to maintain the consultation and feedback from providers to ensure that inspection observations and the judgments that flow from them do fairly, accurately and consistently reflect the characteristics under each rating. We would also encourage CQC to ensure the benchmarks for ambulance services are as comparable as possible with other types of service â€“ be that in the acute, community or mental health sector, to ensure parity of approach and expectation. We have not received any specific feedback from our ambulance members to indicate that they would not be happy with the proposed characteristics for each rating.

2 respondents did not agree that the characteristics of outstanding are what you would expect to see in a good NHS and independent ambulance service and gave the following reasons:

Provider of Services

- We do not consider that the structure and meaning of good offers sufficient clarity to providers. We offer the following for consideration which may assist providers in understanding this rating; Good“ The Trust can demonstrate support and promotion of practice

Member of the Public

- Safety: We would have expected the characteristics to highlight when the service responses to unexpected changing circumstances in the service and its response to expected changing circumstances in the service. Effective: The deprivation of liberty characteristic isn't really relevant with regards to ambulance providers. Transporting a person who lacks capacity from their home, or another location, to a hospital will not usually amount to a deprivation of liberty. Even where there is an expectation that the person will be deprived of liberty within a hospital, it is unlikely that the journey itself will constitute a deprivation of liberty. In almost all cases, it is likely that a person can be lawfully taken to a hospital under the wider provisions of the Mental

Health Act, as long as it is considered that being in the hospital will be in their best interests. Caring: The characteristics “good” outline what we would expect to see in a good NHS and independent ambulance service. Responsive: Booking systems within an Ambulance service excluding PTS is not accessible to members of the public for emergency care, which means members of the public are unable to make bookings. Waiting times and delays depend on the telephone triaging and also the service pressures at the time of the call. With the Urgent care provided by Ambulance services, through Out-of-Hours, Treatment centres and Minor Injuries Units booking systems are more readily available. Well-led: We believe the knowledge and understanding of the provider’s vision, values and strategic goals are an important characteristic for “Good”• . With regards Well-led governance processes should be understood and effective for all staff. We believe providers rated as “good”• should have proactive and effective processes with regards to identifying and monitoring future risks and use clinical and internal audits to identify gaps in controls. Succession planning and processes are an important factor with leadership, management and governance of an organisation. We believe a culture of collective responsibility ensures and promotes responsible, safe innovation. Instead of a strong focus on continuous learning, we would prefer the encouragement of employees to view learning as a shared experience.

Do you agree that the characteristics of 'requires improvement' (in appendix C) are what you would expect to see in an NHS and independent ambulance service that requires improvement?

31 respondents replied to this question

29 agreed that the characteristics of ‘requires improvement’ are what you would expect to see in an NHS and independent ambulance service that requires improvement:

- 9 Providers of Services
- 7 Healthcare Professionals
- 4 Members of the Public
- 4 Stakeholders
- 3 Commissioners of Services
- 1 CQC Staff Member
- 1 Voluntary and Community Services Representative

1 of these respondents made additional comments:

Stakeholder

- We recognise and welcome that CQC has developed the characteristics of the ratings in consultation with the sector, and we encourage CQC to maintain the consultation and feedback from providers to ensure that inspection observations and the judgments that flow from them do fairly, accurately and consistently reflect the characteristics under each rating. We would also encourage CQC to ensure the benchmarks for ambulance services are as comparable as possible with other types of service; be that in the acute, community or mental health sector, to ensure parity of approach and expectation. We have not received any specific feedback from our ambulance members to indicate that they would not be happy with the proposed characteristics for each rating.

2 respondents did not agree that the characteristics of 'requires improvement' are what you would expect to see in an NHS and independent ambulance service that requires improvement and gave the following reasons:

Provider of Services

- We do not consider that the structure and meaning of requires improvement offers sufficient clarity to providers. We offer the following for consideration which may assist providers in understanding this rating; Requires Improvement: The Trust is unable to fully demonstrate support and/or promotion of practice.

Member of the Public

- Safety: Overall the characteristic is what we would expect to see if a provider requires improvement. We think it might be worth adding in about shared learning from risks and incidents whether is only shared with managers or only shared with managers and the staff involved. Effective: Once again the deprivation of liberty is not really relevant to the ambulance service, as this would be more relevant to Hospitals, primary care and Adult Social care. Caring: Overall these are the characteristics we would expect to see from a NHS and independent ambulance service which requires improvement. The only concern is the sources data for the kindness and respect to patients. Patient expectations of how they should be treated and how staff may actually need to treat them may be very different. Where patients expect to go to hospital but can be treated at home, can cause patients to believe they are not being cared for properly. Responsive: The long waiting time, delays or

cancellations will also need to reflect the individual service pressures (e.g. major incident, bank holiday) and the need to reallocate resources for more urgent patients. Well-led: Overall these are the characteristics we would expect to see from a NHS and independent ambulance service which requires improvement. We believe a “required improvement” provider would have a reactive approach to service delivery and improvements rather than proactive and would be more focused on dealing with short term issues.

Do you agree that the characteristics of 'inadequate' (in appendix C) are what you would expect to see in an NHS and independent ambulance service that was inadequate?

31 respondents replied to this question

29 agreed that the characteristics of inadequate are what you would expect to see in an NHS and independent ambulance service that was inadequate:

- 9 Providers of Services
- 6 Healthcare Professionals
- 5 Members of the Public
- 4 Stakeholders
- 3 Commissioners of Services
- 1 CQC Staff Member
- 1 Voluntary and Community Services Representative

1 of these respondents commented further

<u>Stakeholder</u>

- We recognise and welcome that CQC has developed the characteristics of the ratings in consultation with the sector, and we encourage CQC to maintain the consultation and feedback from providers to ensure that inspection observations and the judgments that flow from them do fairly, accurately and consistently reflect the characteristics under each rating. We would also encourage CQC to ensure the benchmarks for ambulance services are as comparable as possible with other types of service, be that in the acute, community or mental health sector, to ensure parity of approach and expectation. We have not received any specific feedback from our ambulance members to indicate that they would not be happy with the proposed characteristics for each rating.

2 respondents did not agree that the characteristics of inadequate are what you would expect to see in an NHS and independent ambulance service that was inadequate and gave the following reasons:

Provider of Services

- We do not consider that the structure and meaning of inadequate offers sufficient clarity to providers. We offer the following for consideration which may assist providers in understanding this rating; Inadequate - The Trust is unable to demonstrate support and/or promotion of practice, nor sufficient efforts for embedding.

Member of the Public

- Safety: Where it says “There are unacceptable levels of serious incidents and never events” will there be guidance as to what constitutes unacceptable levels, as clarification. We would change the word wilful to deliberate, as this ensures there aren’t any interpretations to the word. Effective : We would agree that the characteristics of “inadequate” are what we would expect to see in an NHS and Independent ambulance service. It would be worth seeing something about inappropriate conveyancing to hospital A&E departments mentioned. As this would tackle not only ensuring providers are finding the most appropriate setting for providing care to a patient but it would also ensure A&E departments are not being clogged. Caring: The characteristics described are what we would expect from an inadequate NHS and Independent ambulance service. Responsive: The characteristics described are what we would expect from an inadequate NHS and Independent ambulance service. Well-led: Overall the characteristics described are what we would expect from an inadequate NHS and Independent ambulance service. As an NHS ambulance service however, and with regards to high levels of stress and work overload characteristic we disagree with this characteristic. Nationally, there’s a paramedic shortage. There are insufficient numbers coming out of university and Paramedics are finding other positions within the NHS, positions that are better paid and that do not always require weekend and night working. The majority of those who are leaving ambulance services are saying the work is becoming more and more difficult and busier. It’s becoming a very stressful and tiring job. We have seen an increase in workload year on year and that’s not been matched by an increase in ambulance resources.

Do you agree that rating all ambulances will achieve the purposes described in the Nuffield report?

30 respondents replied to this question

23 respondents agreed that rating all ambulances would achieve the purposes described in the Nuffield report:

- 4 Providers of Services
- 6 Healthcare Professionals
- 5 Members of the Public
- 3 Stakeholders
- 3 Commissioners of Services
- 1 CQC Staff Member
- 1 Voluntary and Community Services Representative

5 of these respondents added additional comments:

Healthcare Professional

- Though all services do need to more closely align their quality data collections.

CQC Staff Member

- I do agree, but having been involved in registering over 25 independent ambulance providers this consultation feels predominantly about NHS services. Most IAS providers are very small scale so much of the inspection methodology would be completely irrelevant or unwieldy. Also I believe all IAS inspections should be unannounced or at least only announced with very short notice.

Commissioner of Services

- We believe it will contribute to the purposes

Stakeholder

- NHS Providers has always been clear that the primary audience for ratings should be the public, and that other interested parties, such as commissioners, would require more in depth information on a provider's performance to inform their decision making. It is therefore important that ratings remain accessible and clear for a public audience. We appreciate that the independent ambulance sector presents unique challenges to a consistent approach to inspections due to the wide amount of variation and complexity in size of organisation and services provided. However we remain convinced

that applying the principles and procedures of the inspection regime, including the ratings system, in a consistent and equitable way to all ambulance providers is the most appropriate means of achieving a transparent system of quality assurance in ambulance services that enables benchmarking, peer review and provider-led improvement. While public choice is less of an option for people using either NHS or independent ambulance services, it is also usually not an option for people who are in need of the accident and emergency services provided in the acute sector. Parity of inspection approach will be crucial to the consistency and therefore the credibility of the regime as well as for maxing quality improvement opportunities, so we encourage CQC to apply ratings to all ambulance providers.

<u>Provider of Services</u>

- Consideration needs to be given to all requirements placed on providers. For example providers which have charitable status have to comply with other regulatory requirements including appropriate expenditure of charitable funds, achieving its charitable purpose and possibly the delivery of services by volunteers. Non NHS providers may also be in a situation where the provision of regulated ambulance services is not their main service offer and so their governance, policies and procedures, systems of work and infrastructure are designed to meet other service area requirements. This would have to be achieved whilst also ensuring that clinical services are delivered safely and in a manner that meets the needs of its service user and commissioners. Inspection team training and guidance needs to highlight these challenges to ensure that judgement is applied appropriately whilst ensuring that patients receive a quality service.

7 respondents did not agree that rating all ambulances would achieve the purposes described in the Nuffield report:

- 4 Providers of Services
- 1 Stakeholder
- 1 Healthcare Professional
- 1 Member of the Public

If you don't agree, please tell us why.

<u>Providers of Services</u>

- Different Ambulance Trusts use a different way of producing statistical information. If they all used the same then this would not be an issue,

however different processes and measurement will affect credibility of outcome data

- We do not agree with the final bullet point as not all of the points from the Nuffield report may be appropriate and/or practical. Our specific concerns regard: Choice: facilitating choice of provider by individuals seeking care (as an end in itself) or by commissioners (for example, the NHS Commissioning Board, clinical commissioning groups (CCGs) local government)The public currently have no choice of ambulance provider, so the purpose of facilitating choice for the public could not be achieved. Performance: helping to improve performance of providers. As was seen with the ˜star ratings", any rating below that of ˜good" will likely have an adverse impact, in terms of an organisation's reputation (leading to a loss of confidence and potentially a loss of contracts), and on staff morale, which is already believed to be low in ambulance services. Unless adequate funding and support is provided to facilitate improvement where performance is found to be lacking, improvement is unlikely to be achievable. Failure: identifying or preventing failure. Reassurance: overall security/reassurance. The public would only be reassured if their ambulance service was awarded a rating of ˜good" or ˜outstanding". If an ambulance service was found to be ˜requiring improvement" or ˜inadequate", the public would lose confidence and likely become anxious and concerned, particularly as they have no alternative. This lack of confidence may potentially lead to reluctance in some people to dial 999 if needed.
- The characteristics identified for each of the four ratings appear reasonable. It is not yet clear to what extent rating ambulance services will be successful as no ratings have yet been applied. While we are satisfied that the methodologies appear reasonable, the challenge will be in the way that they are applied. The ten English ambulance trusts vary considerably in organisational structures and operational models, and it will be a challenge to make informed and fair comparisons.
- Only if the ratings are meaningful and the issue is not looked at in isolation - e.g. A&Es and handover times also need to be considered.

<u>Stakeholder</u>

- Have seen examples of other large NHS Trusts struggling to improve and believe NHS Ambulance services will be able to address the improvements effectively in all areas

<u>Healthcare Professional</u>

- It will help but the nature of the service is such that events themselves can upset the best made plans, so much depends on individuals acting with quick decisions in difficult conditions.

Member of the Public

- At best rating an ambulance service is a snap shot exercise. Evidence of commitment to continuous quality improvement, backed up by action plans, is more important in forming a relatively reliable profile of the organisation.

4. Do you think observing care in or from an ambulance is an appropriate way to gather evidence to inform the inspection?

32 Respondents replied to this question

29 thought that observing care in or from an ambulance is an appropriate way to gather evident to inform inspection:

- 10 Providers of Services
- 5 Healthcare Professionals
- 5 Members of the Public
- 4 Stakeholders
- 3 Commissioners of Services
- 1 CQC Staff Member
- 1 Voluntary and Community Services Representative

3 respondents did not think that observing care in or from an ambulance is an appropriate way to gather evident to inform inspection:

- 1 Healthcare Professional
- 1 Provider of Services
- 1 Member of the Public

If you have anything to add to your answer, please explain here.

16 respondents replied to this question:

Healthcare Professionals

- A company can show an inspector all the paperwork under the sun but only true reflection can be shown by hands on evidence. Ideally a secret shopper would be a better solution.
- I think that the inspector would have to be a paramedic with in-depth knowledge of that organisations local policy and procedures and that even then the crew would act differently with an observer on board.
- It is needed but is only appropriate if exercised with great care.
- Undoubtedly, however those that do this (and observe in EOC's) need to be adequately selected and prepared.

Providers of Services

- This provides a snap shot of activity and performance but it needs to be balanced with the overall service delivery indices including complaints, incidents, KPI performance, staffing indices
- Practical application of this approach requires clarification. This should include consideration of; 1. The impact of direct observation on patients and care providers.2. The potential for compromise of specialist advisors.3. how consistency of approach and objective interpretation of observations will be achieved.
- We would though highlight two areas of caution. The first is that Trust Governance processes for observing are followed and that patient consent has been gained. The second element is that inspectors should be aware of the potential to be left at the roadside/incident location where there is insufficient space to provide care and transport patient(s)/relatives as well as the inspectors.
- Experience from the pilot inspection in August 2014 shows this to be an essential method for learning about the care provided through first hand observation of patients receiving care. It is preferable that inspection personnel have some experience of ambulance work, particularly for the emergency & urgent care element. This is because the experience of 999 work can be very challenging to the unfamiliar, and sometimes observers will witness difficult and potentially upsetting scenes. It is challenging to apply judgements fairly and effectively if you only have experience of a relatively safe and structured environment. Those observing will also need to be physically active and properly equipped.
- Observation by inspectors must include audit of the uptake, recording and use of patient medical treatment preferences. This could be done by examining medical records and comparing outcomes with recorded preferences or the LPA's wishes. As a matter of urgency, research is needed to explore how ambulance and paramedics experience issues associated with patient

preferences (although I understand this falls outside of the remit of the CQC, it is something that could be suggested to other bodies via the CQC).

- With additional work on data held etc. as above.
- Subject to the following issues being effectively managed by the CQC: Clinical accountability for patient care (especially in circumstances where the inspector may be the only registered healthcare professional). Vehicle weight restrictions. Patient consent. Terminology: The handbook states specifically 'observing care provided to people by paramedics and emergency care assistants'. These roles will not always exist in non NHS providers and so it may be useful to change the wording to something less specific.

Member of the Public

- We believe the most efficient way of observing care from an ambulance service would be from seeing care in or from an ambulance. However there are a number of variable that would need to be accounted if the CQC intended to do this. Our service holds a third manning policy which CQC staff would have to adhere too while out with staff. The policy outlines responsibilities of the observer, and Staff and patients will need to agree with the presents of the CQC while on shift/being treated. If space is needed for a patient's next of kin or carer, the CQC will need to accommodate for this.

Commissioner of Services

- However, we think some people may feel obliged to say yes given the potential situations. There could be something more included on consent.
- It is thought that some people may feel obliged to say yes given the potential situations. There could be something more included on consent.

Stakeholders

- but I am unclear about evidence will be fully gathered in the context of PTS
- At the most recent Ambulance Advisory Group meeting hosted by CQC on 02 December, feedback from the representatives of the pilot inspection teams and reflections from CQC staff on the outcome of the pilot studies suggests that this was a useful first-hand way for inspectors to observe care quality and talk to staff and patients. In undertaking observation in such high-pressure environments as ambulances and the matters to which they attend, we would encourage the CQC to ensure that inspection team members are fully trained and compliant with the need to respect the operational pressures on ambulance services staff, and that the prioritisation of care delivery must remain of paramount importance, with the presence of inspectors at the discretion and permission of the senior responsible clinician, and suspended

optionally if deemed unmanageable or presenting risk to safety, clinical effectiveness or patient experience and privacy.

5. Do you think that 30 days is an appropriate period of time to complete an unannounced visit of an NHS ambulance service?

33 respondents to this question

28 respondents thought 30 days was an appropriate period of time to complete an unannounced visit of an NHS ambulance service:

- 10 Providers of Services
- 6 Healthcare Professionals
- 3 Members of the Public
- 4 Stakeholders
- 3 Commissioners of Services
- 1 CQC Staff Member
- 1 Voluntary and Community Services Representative

5 respondents did not think 30 days was an appropriate period of time to complete an unannounced visit of an NHS ambulance service:

- 3 Members of the Public
- 1 Healthcare Professional
- 1 Provider of Services

If you have anything to add to your answer, please explain here.

9 respondents replied to this question:

<u>Healthcare Professionals</u>

- While some notice should be given the less time the better so that the normal staffing pattern can be observed. With too much notice there might be some selection of the most experienced staff.
- 30 days felt right for the unannounced follow up inspection, but wouldn't wish to see it any longer than this.

Providers of Services

- As long as this is mirrored when inspecting independent ambulance providers.
- Yes, as long as the visit does not compromise performance of the service
- The statement that unannounced inspection will be completed within 30 days of the announced inspection may be unnecessarily limiting. It may be more practical to state that this will normally be completed within 30 days.
- Clarity is requested on this area as to whether this refers to unannounced follow-up visits following the planned inspection or the unannounced focussed inspections and whether this is 30 working days or 30 days actual. Two alternative proposals for consideration are cited below;1. Linking to the level of concerns, i.e. if major concerns identified, revisit within 7 days (actual) and a further follow up 30 days (actual) after the inspection. If minor/none 30 days (actual).2. Alternatively considering the level of work undertaken by both providers and inspectors we would suggest a shorter timeframe of 15 days (actual) may be more appropriate.

Members of the Public

- I do not think that visits should be announced at all at any time. From my experience of working in the NHS at senior management level, announced visits do not give a true picture of what is actually happening on a day to day basis
- We believe 30 day is a slightly inappropriate period of time for the CQC to complete an unannounced visit of an NHS ambulance service. After the initial inspection and the disruption to the service during this time, the possibility of having to wait up to 30 days for the CQC to complete an unannounced visit may cause an unsettled feeling amongst Front Line staff. We would suggest 15 days following the end of the announced visit would be an appropriate period of time for the inspection team to complete unannounced visits.

Stakeholder

- NHS Providers recognises that a comprehensive inspection of an ambulance service is a necessarily complex and time-intensive process given the geographic spread and size of NHS ambulance trusts. Our primary and ongoing concern is about the administrative and resource load the inspections place on trusts at a time when they are already extremely stretched. We encourage CQC to restrict its use of unannounced inspections to the most necessary cases and to work with trusts collaboratively to make the inspection as manageable as possible in the context of the service demand that trusts are facing. We appreciate that CQC is already revising its pre-inspection processes and inspection team structures and deployment in light of the pilot

inspections of ambulance trusts and we encourage further refinement and close consultation with the remaining trusts to be inspected to minimise the additional load. We appreciate the work CQC is undertaking to evaluate the cost and benefits of its overall regulatory approach.

6. Do you agree that we should report on and rate core services at trust level?

28 respondents replied to this question

27 respondents agreed that CQC should report on and rate core services at trust level:

- 6 Providers of Services
- 7 Healthcare Professionals
- 6 Members of the Public
- 3 Stakeholders
- 3 Commissioners of Services
- 1 CQC Staff Member
- 1 Voluntary and Community Services Representative

1 respondent, a stakeholder, did not agree that CQC should report on and rate core services at trust level:

Please explain your answer:

Healthcare Professional

- Management structure and efficiency is essential.

Providers of Services

- There can be differing standards achieved across multiple Trusts
- Yes, but consideration should be given if areas are generally performing well and one area may not be doing so well. That should not affect an overall rating if the service can be given an action plan and revisited. For example, if all services are doing well, say “good” and one area “requires improvement”, the whole service should not take on the lower rating; a small pocket of underperformance should not ˜roll-up” if the rest of the Trust is high performing in other areas’ actions should be implemented and monitored

- We consider reporting and rating at Trust level is appropriate to view the organisation as a whole and provide consistency of reporting and will enable providers to identify areas requiring improvement, not previously identified.
- Ratings of core services are now an established requirement for NHS trusts. There is no reason why this should not also apply to ambulance trusts.
- Agree with reporting on core services but rating issue subject to comment above.

Members of the Public

- Core services are rated at trust level to ensure corporate accountability. However, the actual areas of weakness must be clearly identified to direct attention. The inspection report must avoid averaging to the middle, but seek to unmask and signpost areas requiring improvement.
- We believe that the CQC should report and rate on core services at trust level. With the view that transparency must be at the heart of everything we do, reporting and rating core services at trust level provides the public and the trust with a key understanding of how the service is working. If the report was given in a more generalised approach member of the public might not gain the confidence they are looking for from the reports, and the service may not identify areas for improvements.

Stakeholders

- helpful to be able to see an inspection within its overall Trust context - particularly in relation to 'well led'
- size of most NHS ambulance Trusts makes it difficult to determine how services work for local people
- Yes, as core services are provided by all NHS ambulance trusts we recommend that a consistent approach to rating at trust level is undertaken, as is the case for the other sectors, to provide clarity, consistency and to meet the objectives of transparency to incentivise provider-led improvement.

7. Due to the large geographical areas covered by NHS ambulance services, do you think we should rate core services at area level within an NHS ambulance service?

29 respondents replied to this question

22 respondents thought CQC should rate core services at area level within an NHS ambulance service:

- 7 Providers of Services
- 5 Healthcare Professionals
- 5 Members of the Public
- 3 Stakeholders
- 1 Commissioners of Services
- 1 Voluntary and Community Services Representative

7 respondents didn't think CQC should rate core services at area level within an NHS ambulance service:

- 2 Healthcare Professionals
- 1 Provider of Services
- 1 Commissioner of Services
- 1 Stakeholder
- 1 Member of the Public
- 1 CQC Staff Member

If so, how would we identify the areas, and what criteria could we use?

20 Respondents replied to this question:

<u>Healthcare professionals</u>

- Each locality within the Trust.
- Areas should be based around local management teams/departments using the same criteria for the whole trust
- by county and call grades
- This would be very difficult as we are not commissioned by area
- This should be discussed with the Core management and from the public point of view possibly local Healthwatch groups and CCGs.
- Ideally no, the trust should be rated by core service only; to apply consistency between ambulance trusts. Understand that where a trust normally operates in geographical areas, rating by area may identify areas of weakness, which may assist in targeted improvement work, but there may also be un-intended outcomes? Feel that this kind of intelligence should be available within the content of the report.

Providers of Services

- Defined areas should be available from the NHS Ambulance Service and could be based around the location of major/minor bases.
- I think that could be a very good idea and the identification should be via the structure of the organisation Area Teams or localities for example. Yes, this could take into account the different patient demography within a Trust and different pathways in place that ensure we work with local populations. What may be appropriate for patients in Locality A may not be appropriate for patients in Locality B. Yes this would be beneficial as well as the overall Trust rating for example Emergency Ops could get an overall rating for the Trust and also a rating per locality as there are differences between how each locality is run and managed
- No we do not consider that the core services should be rated at area level, they should be rated at Trust level. A Trust would be commissioned to provide care for their entire operational area however many geographical regions are covered. The Trust is one service and should be governed and operate consistently across all areas and so should be inspected as one service.
- The original draft report for NWAS was provided at trust level, supported by reports for each of our operational areas. NWAS found this very helpful, and we were disappointed that legislation required that the final report was at trust level with sections relating to areas where possible. We felt that this diminished the effectiveness of the report and made it harder to read. Stakeholders would also have valued a report that gave some granularity by geography. This particularly applies in a trust as large as NWAS, and in particular one that has such a wide variation in geography and demographics. The definition of area is best agreed in advance to reflect the operational managerial structures in use within the service. In the case of NWAS this was simple in that we have three operational areas for the emergency service: Greater Manchester; Cumbria & Lancashire; Cheshire & Mersey. It would have been very helpful for the trust in following up the report if there had been the three area reports as originally intended.
- Identified areas: How patient preferences are used across geographical settings - between ambulance, care homes, hospices, hospitals etc.(e.g. some DNACPR forms are restricted to particular settings and can be time-bound).
- In line with Local Authority boundaries perhaps...

Members of the public

- Areas to be defined by patients' residence so that natural geographical areas can be found.

- In theory covering core services at area level within an NHS ambulance service is a beneficial way for members of the public to view the service within their area. However, there are some NHS ambulance services which do not operate the all core services identified in their service area. For providers like ourselves we provided a variety of services for different service areas (for example we only provide a Patient Transport Service for one of our Service areas). By applying each of the five key questions to each of the four core services (assuming that the trust delivers the four core services) CQC inspectors will be breaking their inspection down and reporting on 20 assessment of the service. When including the core services at area level the CQC will then be breaking down their inspection further with between 20- 140 assessments of a service. We believe this may be too exhaustive and repetitive for members of the public to read and gain assurance from.

Stakeholders

- our Healthwatch area is a part of a very large Ambulance Trust, which is geographically and demographically very diverse. We believe service ratings must be at an area level (and also that all sampling of services when undertaking an inspection, takes this diversity into account) we are aware that response rates for example are negatively influenced by the rural nature of large parts of our area and poor (or heavily congested) transport routes. we believe that ratings should be to Clinical Commissioning Group areas at least, but would prefer an approach that went below this - district council areas would be ideal
- large areas mask performance issues you should look for a locality methodology at least in areas like performance on response and waiting times where there is a wide variation
- We appreciate CQC's recognition that NHS ambulance service providers have a service specification that, owing to geography and variation between and across local health economies, is very complex. While rating services at an area level might provide a more complex and detailed understanding of variations in quality of services provided by a trust, there are â€“ as the CQC's inspection reports for providers in other sectors, as well as the State of Care 2014 noted â€“ many complex reasons for this including factors that sit outside the control of a trust. Trusts frequently emphasize to us that they can only provide the care services that they are commissioned to provide and that patients' experience is heavily influenced by the interfaces with services often provided by partners in the locality. Rating at area level would only be fair

and helpful in driving improvement if it is informed by inspections that can fully understand, explain and take account of such extraneous influences a both an area and trust level. We would expect any geographical ratings to be as closely comparable to ˜site ratings" for other sectors to ensure an equitable approach across the sectors.

Commissioners of Services

- Services should be provided equitably to all patients. However, where performance against the 8 minute target is included allowance should be made for rural areas
- Most ambulance trusts are formed around divisions/clinical business units/counties (titles may differ) which cover specific counties across the region.
- Clinical Business Unit areas could be used; for example, West Yorkshire, South Yorkshire, and East Riding/North Yorkshire and York.

8. If we rated independent ambulance services, what would be useful – a rating at location level or at core service level?

27 respondents replied to this question

14 thought it would be useful to rate independent ambulance services at a location level:

- 4 Members of the Public
- 3 Stakeholders
- 3 Providers of Services
- 1 Healthcare Professionals
- 1 Commissioner of Services
- 1 CQC Staff Member
- 1 Voluntary and Community Services Representative

12 thought it would be useful to rate independent ambulance services at a core service level:

- 5 Providers of Services
- 4 Healthcare Professionals
- 2 Members of the Public
- 1 Commissioner of Services

1 respondent, a Provider of Services, replied “both”

9. Do you think we should rate independent providers at corporate level?

26 respondents replied to this question

18 respondents thought that CQC should rate independent providers at corporate level:

- 5 Healthcare Professionals
- 4 Members of the Public
- 4 Providers of Services
- 2 Stakeholders
- 2 Commissioner of Services
- 1 Voluntary and Community Sector Representative

8 respondents did not think that CQC should rate independent providers at corporate level:

- 2 Stakeholders
- 3 Providers of Services
- 1 CQC Staff Member
- 1 Commissioner
- 1 Member of the Public

If so, how should we do this?

10 Respondents replied to this question:

<u>Providers of Services</u>

- We can appreciate that this would be difficult to manage as once an inspection is completed at each regulated provider location the overall corporate rating has the potential to be altered. The benefit and relevance would be limited.
- Consideration should be given into how they ensure these organisations are governed e.g. appropriate staff. NHS organisations have very rigorous

recruitment processes; do independent providers have the same assurances. Some of the problems can occur when inexperienced people are at a corporate level, but this would be part of your “well led” criteria.

- We would consider that independent providers should be rated at corporate level and should be treated the same as NHS Ambulance Services. However we would also accept that there may be a requirement for tailoring to accurately encompass the service being provided.

Members of the Public

- In much the same way as teachers are monitored and rated, by being watched in action and even questioned after to address any issues.
- This question is slightly confusing, as we would assume that when rating independent providers the Well-led question would cover the corporate level of the provider. When assessing Well-led the CQC have already stated that: “By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture”.• We also believe that if NHS ambulance services are looked at from Board to staff levels that independent providers should also be looked at as thoroughly and assessed at their corporate level down through to their frontline staff.

Commissioners of Services

- as a commissioner I commission independent ambulance services differently across my geographical area and so it would be better to assess these services at geographical level
- What you do for NHS ambulance services should be replicated for independent ambulance providers
- It is thought that what is done for NHS ambulance services should be replicated.

Healthcare Professionals

- I feel that it is important to know if a certain area/ station is failing but this needs to reflect in the company's overall score. This would stop Company A having Outstanding but yet Location C has failed due to one reason - this would not prevent the company from trading.
- Approach the managing company directly.

Stakeholder

- We concur with CQC’s view that rating independent ambulance providers at corporate level would promote a fair system of terms of public accountability

and an equitable emphasis on the importance of a provider being ˜well-led", particularly given the recognised relationship between quality of leadership and safe care. Even if a provider level rating proves of less interest to the public, it may still be an informative tool for trusts and commissioners who contract independent ambulance services. We encourage CQC to maintain as consistent an approach to inspecting and rating across NHS and independent providers and continue to close consultative dialogue it has established with the sector to ensure continual improvement of the regime.

10. Do you think we should introduce special measures for independent ambulances?

29 respondents answered this question

24 respondents thought CQC should introduce special measures for independent ambulances:

- 8 Providers of Services
- 4 Healthcare Professionals
- 4 Members of the Public
- 4 Stakeholders
- 3 Commissioners of Services
- 1 Voluntary and Community Services Representative

5 respondents didn't think CQC should introduce special measures for independent ambulances:

- 2 Members of the Public
- 1 Provider of Services
- 1 Healthcare Professional
- 1 CQC Staff Member

What do you think this should involve?

17 Respondents answered this question:

Providers of Services

- It should include involvement from commissioners and local NHS Trusts as these organisations will impact the success of achieving improvement following special measures.
- The range of measures should encompass anything from ceasing a particular arm of their service to consideration of cessation of business until proof of compliance. It is so easy to set up another private business that you may find this happening if the consequences are not clear.
- Timed opportunity to make a required improvement then suspension from delivering the service until evidence is received that standards have been met. It has become an unfair market where service providers are having to compete with other services who are able to make significant savings by clearly not investing in process to meet CQC standards. Although this is always reported in inspection reports it makes very little difference to them commercially - this is unfair.
- Preferred option would be defined period for improvement in first instance including, or followed by as appropriate, the provision of specialist impartial support that is unaffected by the commercial and competitive environment within which independent services operate.
- Yes we would consider special measures for independent providers appropriate including follow up inspections. Examples may include whether the provider is financially and/or reputationally viable and cover monitoring of compliance. We also consider that it would be beneficial for a review body with appropriate powers be established for independent providers to be referred to with the potential for further sanctions.
- There is no overt reason for using different criteria from those for NHS ambulance services. If, however, it means that a different set of criteria ought to be used, the CQC might be interested in the LAS Patients' Forum document attached, which has been circulated to some hospitals, for example, and which have been well received

Stakeholders

- your standard approach including a published improvement plan
- NHS Providers has encouraged CQC to take a consistent approach to encourage a transparent and fair playing field for all providers.. The special measures regime has helped some struggling NHS providers to improve, however it is an inevitably expensive, complex and resource intensive process. We have engaged comprehensively with trusts which have been subject to special measures, gaining an understanding of the benefits and

challenges of the process, and we continue to work closely with CQC about these and to work collaboratively and constructively to drive improvement. We recognise the need for a special administration regime for non-NHS funded services given the potential risks to patients of poor standards of care, and of the potential costs to the NHS of having to compensate or step in to cover independent services that present quality and continuity of service risks. However, we would recommend that CQC adopts a proportionate approach to the development of a ˜special measures" approach for the independent ambulance sector, given the need to prioritise the use of the regulator's own funds and resources which we would not wish to see invested in supporting non-essential services. . If NHS services are involved in the process of support they should be adequately resourced and compensated for their assistance. We suggest that this is a matter that requires wider consultation with other stakeholders involved in the special measures process including Monitor as the sector regulator, local health economies and the providers that service them, and commissioners.

- in the same way as for acute hospitals, this would help to bring poor services to account and for the public to be aware

Members of the Public

- Measures should perhaps be dependent on the degree of fitness for purpose, which could range from setting out an action plan with completion dates, re-inspection, to closing down the service.
- A recommendation as to how they could improve if necessary and what sanctions are in place if they do not
- We believe special measure should be applied to independent ambulance providers. According to the draft provider handbook special measures consists of a set of specific interventions designed to support and to improve rapidly the quality of care, this can easily be applied to independent ambulances as well as NHS Ambulance providers. By introducing special measures for independent ambulances the CQC can ensure services provide people with safe, effective, compassionate, good quality care. It would be practical and provide an aligned approach that if an independent ambulance was found to need significant improvements in quality, it was re-inspected 12 months from the first inspection to ensure changes and improvements are made. This would also provide the independent ambulance providers with a time-limited period to take the necessary action to make improvements and ensure the safety of members of the public.

Healthcare Professionals

- The same standards as for public services.
- This should prevent the company closing down and re-opening under a new name (marks against the key people) A CQC or NHS person allocated to take control whilst the company sort out the problems. 41 Day notice to comply or lose registration.

Commissioners of Services

- Not clear on specifics, but perhaps it should replicate NHS ambulance providers as much as possible.
- options for closing services down
- Unsure, however, it is thought that it should replicate the NHS Trust process as much as possible.

11. As part of this consultation we have published a regulatory impact assessment and an equality and human rights duties impact analysis. We would also like your comments on these.

8 respondents replied to this question:

Providers of Services

- A lot of the statistics cited are related to acute services, it should be noted that not all patients attending these are presented by ambulance and a high percentage of patients are left at home following ambulance attendance/care. It would be beneficial to see this updated once ambulance specific intelligence has been gathered (as per the action plan)
- Agree that move to ratings will drive improvements across the ambulance service sector. Agree that inspection and rating will provide opportunities for improved credibility of independent providers and that highly rated organisations will potentially gain competitive advantage. Consistent assessment of providers and transparent and robust regulation will help to increase confidence in independent sector.
- i) What costs have you experienced in terms of time and one-off expenditures relating to individual CQC inspection in the past? Response: Under the previous inspection regime we did not incur any one-off expenditures as external inspections sat within existing remits. In terms of time, the lead Director was available for the inspection, senior managers were on stand-by in the event of an interview request; and other staff, including operational staff, were interviewed at times and locations which fell naturally within their

work pattern. Time related costs were therefore at a minimum. ii) How do you envisage the costs of inspection to change for your provider as a result of our new inspection model? Response: It is acknowledged that the new model will result in an increase in fees (proposed at 9%) and subsequent incremental increases. Our costs will increase due in part and relative to the size and structure of our organisation and services. We have over 3,661 staff working across 110 sites. We provide services across a large geographical area, with urban, semi-rural and rural populations. There are areas of high density populations, some of which are amongst the most deprived in the country. We also have some of the busiest stretches of motorway in the country. Time-related costs will increase in terms of preparation, facilitation, the level and nature of staff participation. Four examples in which time-related costs have been impacted are:(1) Preparation: Any inspection or assessment regime is considered part of our core business and supportive of our vision and values. The new CQC inspection regime has required Executives, Senior Managers, team leaders and process administrators to be fully briefed and engaged with the new inspection process, with regular review, reporting and feedback relating to the CQC inspection. A sub-group of the Compliance Working Group has been created and tasked with overseeing the preparations for the inspection across the Trust. This includes addressing logistical and procedural elements. It also includes facilitating the collation and maintenance of a more extensive, readily accessible evidence library to improve timeliness and efficiency for CQC information requests, supporting information and data. The sub-group is mainly comprised of senior managers who have become CQC Leads for different work areas. It currently meets for two hours every two months with ongoing work and liaison between meetings. As the inspection nears, the group will meet more frequently. Another example of increased time-related costs is the commitment given to realigning the new Core Service Area requirements and KLOEs and the provision of evidence against them. (2) Facilitation: This includes, for example, tailoring training for inspectors to become Observers; arranging site and system access in line with our relevant policies and procedures; preparation and maintenance of Core Service Area portfolios; self-assessment against KLOEs.(3) Staff involvement: We envisage additional costs will be incurred for staff, including operational staff, to participate in the inspection process, due to the changes in the inspection itself and the increase in the size of the inspection team. More staff are likely to be involved in demonstrating systems and processes; hosting inspection teams across site visits; participating in interviews, completing surveys, etc. (4) Administration / Project Co-ordination: Historically administrative arrangements, such as arranging focus

group sessions, meetings, etc. have been captured within existing remits and were not considered an additional cost. The new inspection regime coupled with the pre-existing volume of work, has necessitated the recruitment of an additional (contracted) member of staff for the Compliance team to assist with co-ordination and facilitation. Some of time-related costs will reduce over time and be less impactful going forward. It is not possible to determine the actual costs and the Trust has opted not to do this because it believes outcomes will prove beneficial for both patients and staff. One-off expenditures: We have engaged an external management consultancy to assess our preparedness for the new style of inspection, something we would not have felt necessary under the old regime, and therefore a significant additional cost has been incurred. All other costs one-off expenditures are being kept to a minimum .iii) What benefits to your organisation do you feel will be experienced as a result of these proposed changes? Response: At an organisational level we agree that the changes can only help us in our mission of continuous improvement and credibility. We also welcome the fact that it will better help us to improve how performance is gauged and enable effective national benchmarking. From a public and patient perspective, including those with protected characteristics or from disadvantaged communities, we believe the outcomes will provide assurances and, where necessary, demonstrate that improvements will be implemented. In support of the mechanisms we have in place to capture and address staff concerns, feedback and opinions, we believe the inspection outcomes will demonstrate to our staff that the organisation is open, honest and transparent and that their views and experiences are of utmost importance to us. This will be further demonstrated by the actions taken in response to inspection outcomes, promoting a safe and secure environment in which staff can raise any concerns they may have. Our staff are proactive and encouraged to identify and develop best practice and we believe this will be promoted through the outcomes of the CQC inspection. We are accountable to 22 CCGs and in terms of influencing our commissioners to retain a focus on outcomes for people who use our services, rather than activity and cost, we recognise the inspection and its outcomes may enable us to influence our dialogue with them. iv) Have we missed out any other costs and benefits that you feel should be included in the analysis? Response: We believe the outcomes will be beneficial in terms of bringing about a greater public and patient understanding of how ambulance services are structured, how they operate and their interaction with other healthcare providers and community partners, as well as their relationships with our Commissioners / CCGs (i.e., the provision of services we are commissioned to provide). We also believe that it will help raise

awareness as to why our patients are taken to centres of excellence which may not be their nearest healthcare facility. Innovation and improvement will demonstrate that the service is not a static organisation, but also focusses on providing the best care and treatment possible through research and development.

- We do not feel this fits ambulance services very well. Ambulance services deal both with adults and children, most frequently with urgent medical problems, but also including patient transport. The quality and effectiveness of the service most often depends on how a patient is dealt with in a very short period, e.g. transporting to hospital, referral, or treatment and advice on the spot.

Healthcare Professionals

- It appears appropriate
- I doubt if impact assessments have much relevance to acute situations.

Commissioners of Services

- They appear to be comprehensive
- The approach seems to be thorough. It does not seem to take account of how to involve protected groups in inspection or how to increase their involvements in feedback. Limited reference to existing data around concerns patients/providers have already voiced about meeting equality needs within ambulance provision. There could be a lot more consideration given to the reporting approach.

Member of the Public

- An expected component of all public services. To be monitored via user feedback.

4. Summary of Discussion from SpeakOut Groups

- Binoh (Othodox Jewish)
- Disability Equality North West (People with disabilities)
- Windrush Initiatves (BME)
- Lesbian and Gay Foundation
- My Life, My Choice (Learning disability)

Issues with ambulance services identified by these groups were

- Having to wait for ambulances on discharge Ambulances on discharge.
- Co-ordination and bureaucracy, for example, having to give the same information to the hospital transport office every week
- Difficulties getting through to book hospital transport
- Complaints that hospital transport services are arranged around the needs of the transport service, not the patient (e.g. early pick up times, late drop off's,
- Concerns about the refusal of the ambulance service to let wheelchair users take their wheelchairs in to the ambulance. This was reported by several participants in one area who also reflected that this had an adverse impact in several ways.
- It restricted their own independence
- It cost the NHS in terms of additional resources as they either had to provide another wheelchair or provide additional support to patients who otherwise would not have needed it

5. Summary of Children and Young People's Advisory Group Discussion

The Group Consisted of:

- 12 young people aged 10-23
- 5 Family and carers
- 2 Support workers

Anything else you would like to tell us?

10-12 Year olds

- Ambulances are bad if they are rushing but good if they care

12-23 year olds

Have you used ambulance services? If yes, how did it go?

- Some are **good** – ambulances come quickly. Make jokes and calm you down. Accommodate you; for example, ask what music you like and play the music you like.
- My experience in an ambulance- when I had swine flu I remember saying I'm fine I didn't want to go to hospital but I didn't realise how bad I was. I couldn't breathe or hear properly then I fell asleep and don't remember what happened next! My mother told me the ambulance came and the paramedics were fantastic and saved my life. Also when I was little I have been in an ambulance many times but don't remember."
- Ambulances came quickly.
- I use an ambulance perhaps once per year. They're fairly OK. I have mild epilepsy. They can keep me waiting for up to an hour. I've had first aid training and I know what to do, so I can tell them.
- When the ambulance people come to my dad they know he is a priority. Having that knowledge of his medication and his condition helps. If I was to drop outside somewhere and nobody knows me how would they know what is wrong?
- They won't leave unless they are sure that you are OK – and they will never doubt you either. They will take you to get checked out just to be on the safe side.

- Ambulance people have a lot of medical knowledge themselves now. Important that ambulance staff have training to pick up on signs like someone has diabetes etc.
- Some are **bad** – too fast / rushed don't take your views, i.e. my left side was really weak when I was under seizures so I was not able to move on that side. Forget what you like, Not quick and efficient.
- Couldn't choose who came with me, I wanted my carer but my mum had to come with me
- When there are emergencies at one time I WAS IN SEIGURE FOR 25 MINS because it took so long
- When I got to the hospital they took my mum and dad. They wouldn't let my Mum come in the room with me and I was disappointed about that.
- When I arrived I had to go to the adult ward. I felt I was in a place of absolute nowhere.
- Even if people are younger than 18 they should still listen to them – most of these people would have had these needs their whole lives. The PA should take it from the person who has the most experience.
- Every ambulance person has a blood monitoring kit – I don't remember them doing that a few years ago. They carry the hypo kit with them – when you go hypo it's difficult to get out of it.
- To help ambulances to get to the people who needed most, we need to raise awareness about reducing self- inflicted injuries such as alcohol abuse. We need to educate people about when to call ambulances, for example, in serious situations like xxx, so we can help the services to be more efficient.
- Before making a decision on one you have to visit a few hospitals to get an overall picture.
- I live very close to the hospital but it took the ambulance 25 minutes to get there. They would rather speak to my Mum than me.
- Sometimes a professional feel to a person can be a bit intimidating. I could look at it from the young people's eyes. You know that person's been in your shoes.
- I think you (the patient) have to be honest because (otherwise) how are you going to really change something? If you speak to the staff in a polite way it puts them at ease.
- The best (staff) can be is both honest and positive. Staff need to give the people who are supporting (family and friends) a better picture what is going on.
- For small children it's a good experience if they want to have a ride in the air ambulance – if it was possible to give them a choice.

- Some situations are more complicated. Say the police have got some disturbance in one of the quiet streets, there's been like an incident where there's been some kind of fight that's got out of hand. One person might have been gashed somewhere by a bottle or a glass and they are losing a lot of blood and may be going into shock. While the police are still trying to stop the bleeding – the ambulance may be going (fast) but may still not be there fast enough to stop that person from going into shock. May not be their fault that they can't get there in time.

If you were a CQC inspector, what are the best ways to find other young people's views and experiences?

- How long did it take to get there? Did they feel safe coming with the ambulance service? Do they have a good bedside manner? I've always found that ambulance people are much nicer than the people working in the hospital.
- If I was an inspector I would borrow one of the paramedics to tell me what all the equipment is for. Make sure everything is in good condition and in working order. Make sure nothing is damaged and everything is clean.
- After every patient the ambulance van should be clean. You don't want to see other people's blood.
- You can ask certain things to the staff but it's better to get the opinion of the patients. as long as the patients are OK with that.
- I'd rather speak to a CQC inspector because they know more than someone my own age.

How could CQC find out more?

- Nothing's ever going to be perfect. Could send out surveys. If I have to fill in forms I can't physically do it myself. Easier to do it online or over the phone. If it's got too many words you don't understand it.
- On social media, younger people need to watch what they say. And you'd have to draw their interest in.
- Let young inspectors to speak to other young people who may not want to speak to an adult.

Parents and carers

- Cultural issue - A Muslim parent said a lady from her community went into labour unexpectedly. She was not offered choices and all the ambulance crew were male staff. She had no choice at that point.
- Language issue – The same parent also talked about the language issue. A man from the community was in huge pain due to his kidney stone problems. The ambulance crew had to ask his children for interpretation. But the dad did not want to tell his children that he was in such a pain because he did not want to worry his children.
- Timing – in general parents were happy with the ambulance response time. “Every time the ambulance arrived really quickly.”
- Pass on relevant information in a timely and efficient manner. A parent’s advice was not listened and acted properly and promptly. A parent’s disabled son used ambulance services a lot. He used to have lots of seizures in mid night or early morning. Parents told the ambulance staff about his weak side and how to handle / carry him sensibly. But this advice was not followed and the young person got lots of bruises on his weak side. When they reached the hospital, the information about this was not passed on to the hospital staff, so the parents had to tell everyone again. The parents said the information form that the ambulance staff filled in should include the important information like this from parents, and then acted on by all the medical staff, without parents having to tell everyone again and again.
- Another example was a young person was given a letter from his consultant about all the basic information and all the details about him when he goes to A&E in the same local hospital. But the hospital staff always asked the same questions again and again when all the information was already in the letter.
- Another parent agreed with the point of repeating the same information with medical staff. His daughter got skin cancer. Every time they had to see different doctors and repeat answering the same questions again and again. Sometimes he did not know the answers and expect the information such as dosage in the file. After 6 months, one doctor said he was not able to read the previous doctor’s notes!
- A parent told a story about his mum who fell on the pavement and an ambulance was called. She did not speak much English and kept telling the staff about her twin sons who lived nearby but she did not know the house number. This parent happened to be outside his house at that moment and was shocked when the ambulance pulled up and an ambulance person was calling out his name on the street. He then was explained what happened and asked to go in the ambulance and go to the hospital to make sure his mum was ok. The group thought the ambulance service was very resourceful on

this occasion. But the parent was wondering what would happen if he was not at home that day at that point.

- A parent said she always asked the ambulance what hospital they were going to. This was to make sure they would go to x Hospital, where her son was seen by consultants there.
- Parents said CQC must make sure talking to families and different communities to get people's views so have a better picture of the service

6. Written Submissions Regarding the Consultation

1. Response from an ex Implementation Manager and current Independent Consultant for MCA and MHA,

- In my view it would be very helpful for ambulance services to have mandatory MH awareness, assessment, signposting and suicide risk training as well as more input on the nature of S246 and alternatives to this legal option. My contact with ambulance services has usually been very positive and I think their staff wold welcome more input along these lines.

2. Response from a Professional Body

- Section 1 of the Consultation is on the proposed framework. In relation to core services, it would seem sensible to include 111 services as part of the core services as they often work hand in hand and Ambulance trusts will transfer calls to 111 desks where calls are deemed not urgent. Also, we note that high dependency and specialist transport are included as part of emergency and urgent care services and it might be better to separate these out as the care provision in these cases is different. Potentially, core services could be split into:

    - 111 provision
    - Emergency operations centre
    - Emergency and urgent care services
    - Resilience planning and response
    - Acute transport services
    - Non acute transport services

- In Section 3, 'How we work with others', in figure 4 it would be useful to reference the Health and Care Professions Council, which regulates paramedics.

- Section 7 of the Consultation asks for views on observing care in or from an ambulance. We agree with the suggested approach of observing care in, or from, an ambulance so that there is consistency across all CQC inspection modalities and because it is a useful tool to supplement issues that may be emerging during data review and interviews.

- In section 9, ‘Reporting’, we agree that reporting and rating should occur at trust level but also think that the specific issues in relation to locality should be identified in sufficient detail. It might be that detail is lost when consolidated from a locality basis and so consideration should be given to reporting and rating core services at a locality level, or in a meaningful unit articulated by the trust.

3. Unknown respondent

Consultation Document (Ambulance Services) – Additional Observations

Page 7 Section – Bullet point list regarding services that fall within NHS ambulance sector

Bullet point 1 refers to “emergency and operation callers handling 999 calls”. For clarity we would suggest that “callers” be replaced with ‘centres’ or ‘call takers’.

Page 7 Section – Next stages of development for NHS Ambulances

Regarding the title we consider that this should state NHS Ambulance services or providers not just ambulances.

In addition and on the third line we have noted that wave 2 inspections were cited for January 2014, we believe this should state 2015. Again we believe the same typo has occurred in the next paragraph at the bottom of the page.

Page 8 Section – Next stages of development for independent Ambulances

Regarding the title we consider that this should state independent Ambulance services or providers not just ambulances.

Page 15 Section – Consultation questions

In bullet point two regarding the characteristics of ‘good’ the point refers to appendices B and C. Having read these we can only find reference to this in Appendix B.

In the last bullet point regarding rating all ambulances, we believe this should instead read rating all ambulance services/providers.

Page 19 Section – Final bullet point

Regarding this point we consider that this should state Ambulance services or providers not just ambulances.

Page 23 Section – 4. Intelligent Monitoring

In the final sentence, where the document refers to the development of a set of indicators, we would be grateful for clarity regarding how, with whom, and will we be told what they are?

Page 24 Section – Inspecting a combination of services
We feel this section is unclear and would be helpful if this was expanded with further clarity.
Page 28 Section – Inspection Team
The document calls operational staff various names which might confuse/offend some. For example here Emergency Care Support Workers (ECSWs) and specialist paramedics are not mentioned, perhaps if the term "patient facing staff" was used it would cover all clinical staff.
Page 32 Section – second bullet point list regarding peer to peer focus groups
Having specifically mentioned most categories of operational staff, we consider it is important that 'Technicians' should also be specified to avoid feelings of exclusion and isolation. There is a difference between Technicians, ECSWs/Emergency Care Assistants (ECAs) and this should be acknowledged; and bearing in mind inspectors will be speaking to staff we consider it will be important to raise awareness of the various grades of staff and to understand the differences and even, perhaps, the sensitivities.
Page 32 Section - Other inspection methods/information gathering
Other than ambulance vehicles we are not aware of any other care environments that would relate to an ambulance service and so we would be grateful on further clarity of this point.
Page 34 Section – Title "Unannounced Inspection Visits"
We consider the title is confusing and suggest including the word "follow-up" in the title to provide clarity. The title would then read "Unannounced follow-up inspection visits".
Page 37-39 Section – Entire section
With regard to the matrix we would seek further clarity, as we are unable to understand the purpose of levels 5 and 6. Is this further amalgamated analysis/scoring for NHS providers or would the content mirror that which would be found in levels 3 and 4?
With regard to the appendices that support this section and offer guidance on scoring we consider that the structure presents a more negative approach. As an example, if we consider "robust investigations when things go wrong" we would not expect this to be near the top of the list for consideration as 'outstanding'; expecting instead that primarily the Trust would be taking active steps to innovate and prevent incidents (though this may feature lower on the list for when things do occasionally happen). If we apply this to 'good' we may expect to see this higher on the list of considerations as more incidents may occur as potentially a lack of innovation. Likewise with 'requires improvement' this may be near the top as perhaps there are robust investigations but a lack

of effect action from these. We accept 'inadequate' may be more complex as potentially there may not be robust investigations.
Therefore we would expect to see more positive factors at the top for the more positive gradings and more negative factors at the top for the more negative gradings.

Page 43 Section - Quality control

As there are only 11 English NHS ambulance services (including Isle of Wight), we would consider benefit of a quality control panel to be established specifically for ambulance services, comprising the same members, as far as is possible, or at least with a core membership.
For the same reason, we would suggest it would be best to keep to a national panel rather than regional panels for such a small number of services.

Page 48 Section – Factual accuracy check

On the fifth line reference is made to section 7 regarding providers having 10 days to review the draft report however we are unable to find reference to this in section 7?

4. <u>A National Disability Forum Response to the Equality and human rights duties impact analysis for provider handbook on ambulance services</u>

We welcome the principle of the CQC to promote equality and diversity and human rights in developing your regulation of ambulance services and appreciate the opportunity to respond to your consultation on your plans.

Under section 3. What we know about equality and human rights in the ambulance sector and what you know about equality for people using ambulance services, we would like make the following points in relation to the protected characteristics:

<u>Age</u>

- There is mention of the need to consider issues for children and younger people using hospital services. In addition Childrens Rights should be considered.

<u>Disability</u>

- Access issues for people who are Deaf/hearing impaired, without speech or have a learning disability. Whilst there is a 999 text facility people may struggle to get a full triaged assessment and users have to

pre-register for this service. For ambulance services that deliver the 111 service, there is no text option.

- Patients may be further disabled as ambulance services often struggle with the transportation of wheelchairs, scooters etc.
- Access for people with learning disabilities, communication difficulties and people who are Deaf can be challenging and delay getting the right care at the right time. Visual communication materials are available to aid communication in some services and can help avoid patients being taken directly to A&E rather than being treated on scent or referral to care in the community
- We would be interested to understand the type of questions inspectors might ask around disability, and how will they might challenge evidence provided to them.

Race

- It would be helpful to include details of % of people who are BAME, data on White British and Gypsy/Travellers are provided, but no other ethnicities.
- Health inequalities are a significant consideration for Ambulance Services and we would expect inspectors to seek assurance that services understand their local health inequalities data and have plans to tackle such inequalities. Ambulance Services have an excellent opportunity to contribute to Health prevention and reduce health inequalities.
- Although most services have a field to collect ethnicity data on patient record forms, the nature of our work and the circumstances of the patient can be difficult to record. It is therefore difficult to identify groups that may be experiencing barriers to accessing the service.
- Language for diverse ethnic minority communities can be a huge barrier, not only when they call 999 but also when they face to face with Ambulance Crews. We would expect inspectors to ensure that necessary translation services are in place and staff are using them appropriately, rather than relying on family members to translate. This can affect clinical outcomes and preclude the patient from disclosing relevant information.
- With the Introduction of the Workforce Race Equality Standard to be introduced in April 2015 we would like to understand how inspectors will ensure that Trusts comply with this and secondly and ensure it produces positive outcomes for the Trust.

Sexual Orientation

Stonewalls Older LGB People Study found some interesting facts that might help improve this section. Older LGBT people are:

- more likely to live alone, less likely to have family or keep contact with family, therefore support networks can be reduced
- more likely to have a history of mental health/depression and anxiety
- 1 in 6 are not confident that health services are able to understand or meet their needs

Gender Identity

- There is a high risk of suicide, side effects of testosterone treatment is cardiovascular disease and liver function issues which can result in greater health needs – See Age concern report attached.

Under section 5. Conclusions and actions required we would like to make the following comments.

- It is difficult to understand how human rights principles will be mainstreamed into your five key questions in developing lines of enquiry that cover human rights topics.
- We would expect inspectors to assess organisations by taking account of their Equality and Diversity arrangements and how the NHS Equality Delivery System 2 (EDS2) is implemented. For organisations that have not yet adopted EDS2 we would expect that further enquiries are undertaken in order to assess how Trusts are compliant with the Equality Act 2010 and the Public Sector Equality Duty, including the specific duties.
- We would recommend that assessors request patient experience, diversity monitoring information to understand how Trusts capture information via their patient surveys and patient experience teams. Furthermore, how are they using the information and analysing their data to improve access and experience?
- It is acknowledged that CQC are not experts and to understand how they might challenge using a human rights based approach. Therefore, we propose that guidance/prompts/questions are given to assist them with appropriate enquiries around Equality, Diversity, Inclusion and health inequalities, specifically seeking to understand the outcomes of such work.