South Western Ambulance Service NHS Foundation Trust

Evidence appendix
Trust Headquarters, Abbey Court
Eagle Way, Sowton Industrial Estate
Exeter
Devon
EX2 7HY

Date of inspection visit: 26 June to 18 July 2018
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This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

Facts and data about this trust

Background information
South Western Ambulance Service NHS Foundation Trust was established on 1 July 2006, and was the first ambulance trust to be authorised as a Foundation Trust on 1 March 2011. The trust acquired Great Western Ambulance Service in 2013.

The geographical area served by the trust covers 10,000 square miles, a fifth of England, and includes Cornwall, the Isles of Scilly, Devon, Dorset, Somerset, North Somerset, Bristol, Bath and North-East Somerset, South Gloucestershire, Gloucestershire and Wiltshire. The area has a large rural population, but also large cities including Bristol, Bath, Plymouth, Exeter, Swindon, Gloucester, Bournemouth and Poole.

The trust operates from a headquarters in Exeter close to the M5 motorway, where senior staff are based, and most of the management, support and administration functions operate from.

There are two emergency operations centres primarily taking the 999 calls and despatching resources, including the helicopter teams. One is co-located within HQ Exeter, and the other in Bristol close to the M5 motorway. The emergency operations centres are staffed by around 450 personnel including:

- Emergency medical advisors taking calls from the public or healthcare professionals.
- Emergency medical despatchers managing the movement of the ambulances and personnel.
• Special operations teams supporting the deployment of HART team, helicopters, and other specialist response vehicles.
• Teams of clinicians supporting patients with advice and guidance, and colleagues with frontline operational support and expertise. The clinician teams include nurses, doctors, paramedics and midwives.

There are 94 ambulance stations for over three thousand frontline staff of paramedics, some with specialist skills, and emergency care assistants. The trust has six ambulance air bases, and two hazardous area response teams (HART). The HART teams work alongside the fire and rescue services in very difficult circumstances, including in the presence of hazardous materials, working at height or in confined spaces, water rescues, and any situation involving firearms or explosives.

The trust has a team of community first responders. These are drawn from a range of volunteers and other professional organisations to provide support often in rural or hard-to-access areas.

The trust provides an emergency response to 999 injuries and illnesses, which are likely to require treatment and immediate transport to a hospital or other facility. This service includes:

• Call handling and triage of 999 calls from the public and other calls and requests from healthcare professionals and other emergency services.
• Prioritisation of calls, using an approved triage system.
• Identification and onward referral to alternative care pathways.
• The provision of frontline and rapid response vehicles with suitably qualified staff, to provide treatment, and meet the needs of patients.

The urgent care service provides a range of non-emergency responses to people who require, or perceive the need for, urgent (but not emergency) advice, care, treatment or diagnosis. Provision covers the following activities:

• NHS 111 call handling, call triage (clinical assessment), clinical advice and dispatch for Dorset.
• Out of hours service for GP services in Dorset.
• Tiverton (Devon) Urgent Care Centre.

From 2014, South Western Ambulance Service was one of two NHS ambulance services to take part in the various strands of the pilot testing for the proposed Ambulance Response Programme (ARP). The final section of the trial commenced in October 2016, with the trust piloting the new call categories and definitions. This new model and standards for responding to patients came into force for all ambulance trusts in November 2017. The primary reason for introducing ARP was to move away from the approach of any resource that was available attending a patient (and that stopped the clock on the response standard) to the right resource attending the patient in the right time. A new approach to how call handlers respond to patients had been designed into the triage system to provide an earlier recognition to life-threatening conditions, particularly cardiac arrest.

Data
The trust employs around 4,500 staff.

In the year 2017/18, the trust attended just under 921,000 emergency (999) incidents. The highest month was December 2017 with 86,500 incidents. The total for the year was an increase of 2.5% over the previous year, with all months but two having higher numbers of incidents recorded. Of all incidents attended, 6% were category 1, the most urgent priority. Category 2 incidents were 45% of the total, with the rest from the lower categories and less urgent priorities.
The trust transported around 450,000 patients to acute hospitals in 2017/18. Just under 40% of these had handover delays of more than 15 minutes. This resulted in around 75 minutes per day, or a total of more than 27,000 hours of resources lost to delays in the year.

In 2017/18, just over half of all incidents were resolved without taking the patient to accident and emergency. Data showed:

- 11.6% were treated over the telephone (called Hear and Treat).
- 35.8% were treated at the scene and not taken to hospital (called See and Treat).
- 5.9% were seen and conveyed for treatment, but not to an accident and emergency department.

**Financial position**
The financial position at the trust improved in the year 2017/18. In 2016/17 the trust saw a small deficit of £0.4m against a budget to breakeven. Income during that year was £240.4m. In 2017/18, the trust produced a small surplus of £0.3m against a budget to breakeven. Income during that year fell to £233.6m. The trust plans for 2018/19 are to breakeven with a further reduced budget of £227.6m.

*Source: NHS Improvement*

**Locations at the trust**
The trust’s main headquarters is in Exeter. It has three regional divisional headquarters:

- North division headquarters, Bristol
- East division headquarters, Yeovil
- West division headquarters, Bodmin

The ambulance stations are located as follows:

<table>
<thead>
<tr>
<th>Area</th>
<th>Ambulance Stations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bath and North-East Somerset</td>
<td>2</td>
</tr>
<tr>
<td>Bristol</td>
<td>7</td>
</tr>
<tr>
<td>East Cornwall</td>
<td>9</td>
</tr>
<tr>
<td>West Cornwall</td>
<td>8</td>
</tr>
<tr>
<td><strong>Cornwall total</strong></td>
<td><strong>17</strong></td>
</tr>
<tr>
<td>North Devon</td>
<td>7</td>
</tr>
<tr>
<td>South Devon</td>
<td>9</td>
</tr>
<tr>
<td>East Devon</td>
<td>7</td>
</tr>
<tr>
<td>West Devon</td>
<td>2</td>
</tr>
<tr>
<td><strong>Devon total</strong></td>
<td><strong>25</strong></td>
</tr>
<tr>
<td>East Dorset</td>
<td>3</td>
</tr>
<tr>
<td>West Dorset</td>
<td>7</td>
</tr>
<tr>
<td>North Dorset</td>
<td>2</td>
</tr>
<tr>
<td>Region</td>
<td>Count</td>
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<td>----------------------</td>
<td>-------</td>
</tr>
<tr>
<td>Dorset total</td>
<td>12</td>
</tr>
<tr>
<td>North Gloucestershire</td>
<td>3</td>
</tr>
<tr>
<td>South Gloucestershire</td>
<td>6</td>
</tr>
<tr>
<td>North Somerset</td>
<td>5</td>
</tr>
<tr>
<td>East Somerset</td>
<td>4</td>
</tr>
<tr>
<td>West Somerset</td>
<td>4</td>
</tr>
<tr>
<td>Somerset total</td>
<td>13</td>
</tr>
<tr>
<td>North Wiltshire</td>
<td>5</td>
</tr>
<tr>
<td>South Wiltshire</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>94</td>
</tr>
</tbody>
</table>

The trust also has the following internal services:

- Fourteen vehicle workshops distributed around the region.
- An integrated logistics site in Exeter, including stores.
- A medical device unit located at Ferndown.

### Is this organisation well-led?

#### Leadership

To write this well-led report, and rate the organisation, we interviewed the members of the board, both the executive and non-executive directors, and a range of senior staff across the trust. We met and talked with a wide range of all members of trust staff to ask their views on the leadership, performance, and governance of the trust. We looked at a range of performance and quality reports, audits and action plans, board meeting minutes, and papers to the board. We reviewed investigations, and feedback from patients, local people and stakeholders. Our colleagues from NHS Improvement gave us their views on the financial governance at the trust.

#### Leadership skills

The leaders had the skills, knowledge and integrity needed to run the organisation. The trust board members we met were a group of individuals with a range of different but complementary experience, knowledge and skills. Some of the trust board were new or relatively new in their posts, while others had a long service in senior management and were clinical professionals. Some had a long history of working in an NHS ambulance trust.

There was evidence from our conversations with senior people, including the non-executive directors, of an environment of constructive support and challenge among the leadership team. We found the senior team to be open, honest and committed to patients, their trust and its objectives. They had enough of the operational detail of the trust to be familiar with all the current strengths, areas of success or improvement, issues, challenges, and performance. Alongside this, they provided their teams with sufficient levels of trust and responsibility to effectively run the organisation.

There were development programmes for senior leaders, although the areas highlighted as the weaker areas had not been included in the first of these programmes then rolled out. Development
centres had been designed and provided from January 2016 to February 2017 for all managers of band 8a and above. This was a total of 91 staff and aligned with the trust’s Leadership Golden Thread initiative. This initiative was to ensure a consistent and common approach to how the trust was managed by its senior staff. The five key areas or Golden Threads were:

- Strategic and corporate thinking.
- Problem solving and analysis.
- Emotional intelligence and resilience.
- Personal impact and gravitas.
- Ownership.

Once staff had completed the development centre process, they were enabled to join the Aspire Leadership Programme. This was a skills-based course designed by a local leadership academy to deliver practical insights and applications for leadership and management.

A formal review of the development centre was undertaken by the human resources team in May 2017. This determined which subjects raised the need for further attention, which were strong, and which more specific subjects were topics for improvement. The area the review found the senior leadership were strong in among the five key initiatives were personal impact and gravitas, followed by emotional intelligence and resilience. The area for improvement was strategic and corporate thinking. An update to the development programme was presented to the trust’s people and culture committee in April 2018. Although several courses had been run and attended since the review the previous year, none of these related to the area of strategic and corporate thinking – the area said to be requiring improvement.

The trust board and senior executive team
There was a board of individuals with different strengths and skills, providing collective leadership. Ken Wenman, the chief executive officer at the trust, understood and could articulate the qualities of his team and where he looked for development in the future. He spoke highly of the team and recognised them as individuals with complementary qualities and skills.

The seven non-executive directors and one associate non-executive director had joined the trust at a variety of dates from 2013 to 2017. The chair, Tony Fox, had joined the trust as a non-executive director from the Great Western Ambulance Trust board in 2013. He was appointed as chair in March 2017.

We met and talked with three of the non-executive directors at our inspection, and with the trust chair. There was a range of skills in the non-executive directors from varied backgrounds in public and private sectors. From our conversations with them, we were assured of their significant skills, ability to support the organisation, and valid experience. It was possible to see their influence as part of the overall effective leadership of the trust. They all, and particularly the chair, spoke candidly and with insight about the pressures facing the trust, and they were committed and spoke intelligently about the service.

As with the senior executive team, the chair and non-executive directors did not seek to articulate excuses for poor performance around response times. This was despite some significant snowfall over the winter and a serious operational situation in Wiltshire. They gave a clear opinion that delays for a patient in the arrival of an ambulance and crew was something they found morally unacceptable. They also had collective views on how performance issues around response times needed to be improved and what were the solutions to this improvement happening.
The non-executive directors had a wide-ranging portfolio of work in the trust. Where possible, these linked with their professional expertise or areas of interest and experience. Each non-executive director (and the associate non-executive director) had a south-west county with which they linked and were expected to support. Within this regional role, they were linked also with the trust’s county and deputy county commanders. The non-executive directors had also been aligned with workstreams for operational productivity improvements. This included looking at the fleet and use of fuel; the trust’s estates and facilities; and individual-topic case studies. This work had been aligned to the Lord Carter of Coles review of NHS ambulance trusts which was due to report later this year.

The trust board had relevant financial expertise within the executives and non-executives. Executives had a sound understanding of the trust’s financial position and areas of opportunity and challenge. A review of board minutes suggested appropriate time was spent covering finance and resourcing, and there was a separate finance committee. The audit committee and finance committee were chaired by appropriately qualified and experienced non-executive directors. The trust operated bi-monthly full board meetings with seminars in the intervening months where specific topics were covered. This was to ensure that board members (both executive and non-executive) had the required competencies to fulfil their role.

There was a clear, straightforward and articulate document setting out the expectations for the trust board. This document, entitled “New Ways of Working” both set out those expectations and the changes being brought into the structure and governance of the board. There was a broad but comprehensive range of trust board committees, although with one possible exception. This was in the crucial area of information management and technology, which is covered in more detail in our section below on Governance. The document described each committee with its named members, the frequency of its meetings, and the range of personnel expected to attend meetings.

There was some cultural diversity among the board members. Of the seven executive board members at the trust, none were British Minority Ethnic. Four were female. Of the seven non-executive board members, two were British Minority Ethnic, and three were female.

Our conversations with senior people, including the non-executive directors, heard evidence of constructive challenge and collective responsibility among the leadership team. We observed a recent board meeting in May 2018. The board was conducted professionally but also welcoming and interesting for members of the public. The meeting was well run and organised by the chair of the trust.

Understanding the challenges
The leaders understood the challenges to quality and sustainability. They could identify the actions needed to address them. Our interviews with the senior leadership team brought out common themes around challenges to the organisation. This was centred without exception among the leadership on response times and getting the right resource to the patient at the right time. Patient care related to all the priorities for the leadership and could be seen throughout trust documents.

The operational leadership team were committed to providing safe and effective care with the right outcomes, and understood the challenges they faced to do this. Our conversations with them were focused on being able to structure a service that did not lose sight within the operational pressures of delivering the right outcomes. The senior operational team from the executive director, through the deputy director of operations, and the programme and resource managers had a tireless commitment to getting the service right. They worked to a new set of principles which were being
tested and implemented to support both staff workload (recognised as not always supporting wellbeing) and providing a safe service. This included a restructure of boundaries within the organisation to go back to a county-based structure with county commanders.

There had been a pilot programme with most good results to respond to staff on wellbeing. This included staff getting their meal-breaks and ending their shifts on time whenever possible. It was recognised by senior operational staff how this was important alongside the balance of delivering a safe and responsive service, but this was not being carried out by staff who had not had a proper break or were being overworked.

In the 2017 NHS Staff Survey, 59% of staff (the same as the national average for ambulance trusts) has said “yes” to the question asking whether care of patients was the organisation’s top priority. However, this indicator had deteriorated from the previous year’s results when 67% of staff said the care of patients was the top priority. Also, above (better than) the 62% national average for ambulance trusts, 66% of trust staff had said the organisation acted on concerns raised by patients.

Visible and approachable leadership
The leaders were visible and approachable. Many staff we spoke with said they knew some of the leadership team, and most had met several of them over the years. Most told us they thought they were approachable and would make time to talk with staff. The chief executive had visited around 40 different trust locations in the 2017/18 year. The chair had visited around 16. Other members of the board and the non-executive directors had also made numerous visits. However, the evidence as presented to us did not demonstrate whether all sites had been visited over, say, a year, or when the last time they were visited was, or by whom.

The NHS staff survey does not specifically ask staff about the visibility of senior management, but does ask about communication between senior management and staff. In the 2017 survey, two of the three indicators associated with management had deteriorated since 2016, and one was marginally better. Nevertheless, they were all above (better than) the national average for ambulance trusts. However, just 24% of trust staff reported good communication between senior management and staff, and this was down from 28% in 2016. However, this was above the national average for ambulance trusts of 20%. The best score for this question for ambulance trusts was 26%, so this trust was just slightly below the best scoring. The national average for acute NHS trusts for this question was 33%, so this aspect of the staff survey was a national issue for NHS ambulance trusts.

When staff were asked in the 2017 survey if they know who the senior managers were, 79% said they did (although this was down from 83% the previous year). The national average was 75%.

In other questions relating to leadership, the staff satisfaction score with recognition and value by managers and the organisation, was 3.12 out of five (down from 3.17 in 2016). The national average was 3.01. Support from immediate managers was scored at 3.59 out of five (up marginally from 3.58 in 2016). The national average was 3.44 so both indicators were above the national average for ambulance trusts. Other indicators around relationships with managers included:

- 75% of staff said their immediate manager was supportive in a personal crisis – 5% better than the national average.
- 64% of staff said their immediate manager valued their work – 6% better than the national average.
• 68% said their immediate manager can be relied upon to help them with a difficult task at work – 6% better than the national average.
• 26% of staff said senior managers try to involve staff in important decisions – 7% above the national average.
• 55% of staff said their immediate manager gave them clear feedback on their work – 5% above the national average.

Fit and proper persons
The directors were fit and proper persons, although there was one piece of information missing for two recently appointed staff. The trust was satisfied that staff with director level responsibilities, including the non-executive directors, were fit and proper persons in accordance with Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. However, there was a piece of information missing from the files of two executive directors which constituted a breach of the regulations.

To assure the trust of its directors meeting the test, the trust had taken assurance from each director completing a self-declaration form, although this had not been counter-signed by another appropriate director or ratified on the form by the trust chair. The trust policy on fit and proper persons recorded it was the trust chair’s responsibility and accountability for ensuring and declaring all directors met the requirements at appointment. However, there was no evidence as to how this was achieved or declared, and the policy did not say what evidence should be provided.

We examined the records and files of 10 of the directors and non-executive directors to check whether the information required had been obtained from these staff. The records held electronically for the non-executive directors were all in order, easy to navigate, and well managed by the trust board secretary. These files included documents required such as Companies’ House declarations, qualifications, insolvency checks, Disclosure and Barring Service (DBS) checks, and proof of identification.

The records held for the executive directors were less easy to navigate, and the information we needed to see was not straightforward to locate. If the trust chair had wanted to see evidence behind the executive directors fit and proper person declaration, this would not have been easily provided. In the following 24 hours, senior staff from the trust organised the files to bring some structure and order, and we could see the required information. All this information had been either in the files or obtained at the right time, but was not organised.

However, two of the documents for recently appointed directors had not yet been obtained and checked. The DBS checks had been applied for, but this was around two months after the staff had been appointed. The trust policy required all directors to have a valid DBS check at the time of their employment. We made the trust aware also that it was retaining some information from the DBS which it was required to return to the applicant once it had been seen. This did not meet the trust’s policy which was to limit retention of documents unless there were exceptional circumstances. We were told this would be addressed and all information kept be only that which the trust was entitled to have or needed.

Vision and strategy
Quality and sustainability in the vision and strategy
The trust had a vision and strategy which was linked to its mission and strategic goals. Quality and sustainability were the top priorities. These were as follows:
• Mission – to respond quickly and safely to patients’ emergency and urgent care needs, at every stage of life, to reduce anxiety, pain and suffering.
• Vision – exceptional patient care delivered by exceptional people.
• Values – respect and dignity; commitment to quality of care: improving lives; working together for patients; everyone counts.
• Strategic goals – every patient matters; every team-member matters; every pound counts.

The trust had undertaken to refresh the current strategy as described above a year before it was due for review in 2019. The mission, vision, values and strategic goals would remain, but the principle headlines would now be:
• Delivery of 999 emergency ambulance services.
• Retain the urgent care contracts.
• The financial plan continuing to focus on maintaining the financial sustainability of the organisation.
• Not to look to diversify core business further over the life of the strategy.

The document described how the trust would engage with the Ambulance Sector Operational Productivity review to identify, implement and embed cost efficiencies.

Involving others
The revised strategy was developed from conversations with stakeholders, the clinical commissioning groups, and members of staff. It extended to leaders across the organisation, Healthwatch, and trust board and committee meetings. These staff, stakeholders and organisations were invited to say what was important to them and what their priorities were. The mission statement was developed at a team away day with a cross-section of the trust’s managers involved.

Staff knew and understood the vision, values and strategy, or had the opportunity to do so. We had varied responses from staff about the strategy – some detailed, others vague. However, most described it in terms of getting to patients on time, ensuring they gave the right response to the patient, and the need to keep costs under control. We met a couple of staff who had been involved with the latest refreshed strategy, and they said they had been given the chance to get views from their colleagues to share. They told us most colleagues had said they wanted more resources to get to patients on time, and this included more staff and more stability in the staff groups.

Connected strategies
Most, but not all strategies were aligned with the overarching strategy. There were other connected strategies within divisions and roles, and in those we saw, some reflected the strategic goals as described above. For example, the human resources and organisational development three-year strategy (2018-2021) was based on delivering the strategic goals of “every patient matters, every team-member matters, and every pound matters.” This was to be achieved by having the objectives of “the right people with the right skills and right values.” The three-year strategy had yearly goals based on each of these objectives. The mental health strategy (in draft when we saw it) described being based upon the three strategic goals, and recognised support for the patient, staff, and funding. However, the medicines optimisation strategy did not obviously align to the strategy, but did seek improved patient outcomes and recognised the need for value for money.

Alignment with local plans and priorities
The strategy was somewhat aligned to local plans (and we recognise the trust was dealing with a far wider range than most NHS trusts), but this was not clearly explained or set out. The trust worked across seven counties in the south west and 12 clinical commission groups. It needed to align with seven Sustainability and Transformation Partnership (STP) plans. The STP is an extensive project as part of NHS England’s drive to design health and social care systems to meet the needs of an area, and not the individual organisations operating within it.

The trust had recognised from within the STP plans some key areas for its own focus, although it had not explicitly described this in the new strategic document. Nevertheless, we recognised these included caring for an ageing population, people becoming frailer and at risk from falls, a growing demand from patients with mental ill health, and over-reliance on the 999 services and admissions to hospital when other services were more appropriate.

We were unsure as to how the new strategy, the STP’s aims, and the trust’s objectives were all underpinned by the trust’s most recent Quality Account priorities (2017/18). These areas were listed as:

- Awareness and improving the management of the older patient.
- Improving the quality and timeliness for responses to patients (although this was around complaints).
- Impact of delays on patient safety (although we believe this should have been written as “understanding the impact… and identifying possible improvements.”)

The first priority on frailty aligned with improving care for older people. The second priority was not aligned with other priorities and was something the trust had been failing on in terms of complaint response times. The trust had a responsibility to investigate complaints in a timely and comprehensive way. It was meeting the requirement to give quality responses to people (see the section on Learning, continuous improvement and innovation below) but due to staffing pressures, had been not meeting its internal deadlines – and yet numbers of complaints had fallen.

It was therefore difficult to see, given the other pressures and priorities for the trust, why this was one of three key areas for quality improvement. The third priority was more aligned to known issues, but the quality account did not describe how any outcome was to be measured, and what improvements would be expected. The results of this set of priorities were unpublished at the time of our inspection.

Not all the 2016/17 quality priorities were achieved, and one of these did not align to strategic, regional (STP) or national priorities. The 2016/17 quality account was published on the trust’s website. The priorities in that year were:

- Cardiac arrest – improve how the national guidelines are being applied.
- Accessible information – improving access for people in accordance with the Accessible Information Standards.
- Human Factors – addressing how errors from human factors can be reduced.

The trust reported it had achieved or partially achieved these three priorities and described how it had done so. The cardiac arrest priority was achieved and had included 95% of frontline staff being updated in their training and assessed for their competence. New checklists had been produced based on the latest guidance from the UK Resuscitation Council.

The accessible information priority was partly achieved. This priority was based upon the new Accessible Information Standard (AIS), introduced by the government in 2016 to support people to
have information in a way they can understand it. During the 2016/17 year, the trust had engaged with groups who supported patients with various disabilities, such as sensory loss and met with the local Healthwatch groups. The trust’s website was also reviewed by an independent organisation which represented people with sensory loss. The website was found to be accessible as it was, but some suggestions were made for improvements to both the website and other opportunities for engagement. Otherwise, the trust had asked NHS England to consider how the AIS might be made more applicable for ambulance trusts.

The third priority was partly achieved. The work undertaken to determine where human factors influenced behaviour for a poorer outcome for the patient, unfortunately, did not reveal any patterns or clear areas to address. The study of the results seemed to conclude that the investigation of the human factors element of incidents was not adequate, although this is not clear in the report. It was not clear to us why this priority was chosen, and whether, given there were only three priorities, this had sufficient importance to be selected.

**Cost improvement strategies**

Cost improvement was a significant focus for the organisation. The trust had an outline financial plan based on business as usual for 2019/20 and 2020/21. This included anticipated levels of cost improvements and issues around the implementation of the joint plan towards achieving response times (in the new Ambulance Response Programme). To identify cost improvements, the trust had established an annual process whereby representatives from across the trust, including executives and managers from several directorates, were involved in the development of saving schemes as part of the financial planning process. This included an annual review of expenditure. Once schemes were identified they were developed into detailed cost improvement plans and quality impact assessments were undertaken.

Directorates also held fortnightly meetings to investigate and look for further schemes. Additional schemes were developed throughout the year from ongoing conversations reviewing the organisations services.

The cost improvement programme (CIP) reporting structures were clear. Anticipated savings from agreed CIP initiatives were removed from budgets and expenditure was tracked monthly against the revised budget. As an example of a successful programme, the trust had recently undertaken an in-depth rota analysis for frontline staff. This resulted in rota changes at 95 ambulance stations and delivered £12m- £13m of cost-saving efficiencies.

**Culture**

**Supporting and valuing staff**

Most staff felt valued and supported. Many of the staff we met and talked with were committed to their roles and proud of the work they delivered. The trust, overall, had a good 2017 NHS Staff Survey with many of the key indicators being above the national average for ambulance trusts (see below for detail). However, in the question of staff recommending the organisation as a place to work or receive treatment, the score had deteriorated since 2016. It was, nevertheless, slightly above (better than) the national average. Staff motivation had also fallen since 2016 and was now the same as the national average. Staff satisfaction with the quality of work and care they could deliver had also deteriorated since 2016. This indicator was below (worse than) the national average. There was a deterioration also in the number of staff who agreed their role made a difference to patients. This was 86% in 2017 and 89% in 2016. The 2017 national average was 88%.
The trust was average among NHS ambulance trusts for numbers of staff who responded to the survey. The survey was sent to 3,932 staff, and 42% responded (same as the national average for ambulance trusts).

Other indicators relating to culture showed variable results, although all above the national average:

- Recognition and value of staff by managers and the organisation – 3.12 out of five (down from 3.17 in 2016). National average 3.01.
- Support from immediate managers – 3.59 (up from 3.58 in 2016). National average 3.44.
- Staff able to contribute towards improvements at work – 54%. National average 45%.

*Note: In all statistics quoted from the staff survey, the non-percentage numbers are scores within a scale from zero to five, and the higher the score the better. National averages shown are for NHS ambulance trusts.*

The trust board undertook an early review of the staff survey results at their March 2018 meeting, which was reported in the minutes. The board recognised the deterioration in staff satisfaction with the quality of care they provided. The pressure on staff, increasing demand, and the impact of the rota review were all cited as reasons for dissatisfaction. Our conversations with staff throughout the organisation would suggest the trust board’s view was similar to theirs. The board recognised the pressure on staff to clear (that is to leave) a scene or patient to enable them to be available for the next patient, and yet giving enough time to the patient and their relatives as well.

**Health and wellbeing for staff**

Health and wellbeing for staff was important at this organisation. The trust provided staff with a health and wellbeing service called Staying Well. Staff we met in various parts of the organisation, but notably in the clinical hubs, spoke highly of this service. Staff could self-refer to the service or refer a colleague. The service was supported by a mental health practitioner and a member of the human resources staff. They could provide advice directly or promote several other options for staff. These included:

- 24-hour confidential counselling service.
- Trauma support (when staff dealt with difficult or traumatic events and incidents).
- Fast-track physiotherapy after a professional referral.
- Expert legal/financial advice.

The trust signposted its staff to other available resources and services such as handbooks, guidance, therapies and tools, and a mental health charity that offered staff advice. The service was available Monday to Friday 9am to 5pm and was confidential for all staff. There was an employee assistance programme that offered out-of-hours support in an emergency.

The trust’s service lead for the Staying Well service recently won a national award from the Association of Ambulance Chief Executives for Welfare and Wellbeing for their contribution to the service and support of staff through difficult circumstances.

The trust supported a group of volunteer trust staff as Peer Support Guardians to work within a Peer Support Network. The Guardians were trained to support staff with mental health concerns, or other personal or work-related problems. Staff were offered the opportunity to discuss a wellbeing concern with one of their peers in a confidential setting. In May 2018, there were 38 staff in the network and the trust hoped to recruit additional staff to around 60 being in this role in 2018.
In the 2017 NHS Staff Survey, staff rated the organisation and management interest in and action on health and wellbeing as 3.59 out of five. This was slightly better than 2016 which was 3.57 and better than the national average of ambulance trusts of 3.25. Sixty-five percent of staff said their manager took a positive interest in their health and wellbeing. This was slightly higher than 2016 (64%) and was one of the areas which was above (better than) the national average (58%) by more than most other indicators in the survey.

Although the following results around work pressures were not significantly worse that the national average, they were of concern in terms of the number of staff with negative experiences:

- 47% of staff had felt unwell due to work-related stress in the last 12 months. This had not improved since 2016 (47%) and was just slightly below the national average of 48%.
- 61% of staff attended work in the last three months despite feeling unwell because they felt pressure from their manager, colleagues or themselves. This had not improved since 2016 (61%) and was just slightly below the national average of 62%.
- 85% of staff worked extra hours (87% in 2016) which was the same as the national average.

Note: In all statistics quoted from the staff survey, the non-percentage numbers are scores within a scale from zero to five, and the higher the score the better. National averages shown are for NHS ambulance trusts.

Raising concerns

Although senior leaders understood the importance of staff being able to raise concerns around clinical practice without fear of retribution, the work of the Freedom to Speak-up Guardian was underdeveloped. This role was advocated by the Francis report published in February 2015, and expected to be a member of staff recruited and selected, and who would act as an impartial and independent source of advice for NHS workers.

To provide staff with an independent voice among their peers to raise concerns with the leadership team, the trust had appointed a Freedom to Speak-up Guardian (FSG). However, the trust had followed external guidance on how it established its FSG programme and still had some way to go to meet the requirements of the National Guardian’s best practice recommendations and embedding these in the trust. Prior to May 2018, the trust had appointed one of the non-executive directors as FSG, which, although the guidance does not specify who should be in the role, the non-executive role was expected to be a lead and supervisory position. This had been recently addressed, and a member of staff had been asked to take up the role in May 2018. They were shortly due to attend national training.

When looking back at data for reporting to the National Guardian’s Office, which was a requirement of trusts, there had been only one reported by this trust in 2017/18. Many other trusts had reported multiple contacts with staff and FSGs.

The trust had met most of the guidance around how FSG was interpreted in policies and procedures. However, although the person in the role was new, the trust had not followed national guidance and had not given specified funded time to undertake this work. The role had also not been part of a recruitment programme.

To support the FSG were a group of Peer Support Guardians. This was not a role recognised in the national guidance, but an established group within the trust. It had been designed to enable
coverage for the large physical area the trust covered. There were 52 members of staff currently in
the group and eight vacancies.

There was more to do on promoting the FSG and the peer support network. Many staff we talked
with in the organisation had not heard of the FSG, although some recognised the peer support
guardians, but had not linked the roles. The large geographical area the trust covered required a
tailored approach to the FSG role to promote and establish connections with staff. This had yet to
be done effectively, and the limited contact with the guardians from staff was evidence of more
work being needed.

There had been one report to the board in the year from July 2017 from the FSG. This was made
in March 2018 under the previous arrangements. The report was procedural and did not describe
to the board progress at the trust and what had been learned. It did not describe progress against
the 10 recommendations by the National Guardian for the NHS. Although we recognised that the
role at the trust lacked recognition in several key operational areas, there was no report on what
concerns had been raised, what they related to, and how they had been addressed.

Nevertheless, the newly-appointed guardian felt supported by the organisation, and had no
concerns about how they would be received by senior staff if they raised issues with them.

Staff had reasonable levels of confidence for reporting unsafe clinical practice. In the 2017 NHS
Staff Survey, staff had responded with a score of 3.58 out of five in terms of their confidence and
security in reporting unsafe clinical practice. This was better than the national average for
ambulance trusts of 3.49. However, it was a slight deterioration over the 2016 score for the trust of
3.60 out of five. This measure came from a series of more detailed questions, which had varied
responses:

- 96% of staff said if they were concerned about unsafe clinical practice, they would report it.
  This was above (better than) the national average of 94%.
- 66% of staff said they would feel secure raising concerns. This was above the national
  average of 62%.
- 54% of staff said they were confident the organisation would address their concern. This
  was above the national average of 50%.

Note: In all statistics quoted from the staff survey, the non-percentage numbers are scores within a
scale from zero to five, and the higher the score the better. National averages shown are for NHS
ambulance trusts.

Equality and diversity

In the 2017 NHS Staff Survey, there were some significant issues with the experience of Black
and Minority Ethnic (BME) staff when compared with their White colleagues. Furthermore, these
had deteriorated significantly from results in 2016. Each score was worse than the average for
NHS ambulance trusts in England. The scores presented below are the un-weighted question
level score for question Q17b and un-weighted scores for Key Findings 25, 26, and 21, split
between White and BME staff, as required for the Workforce Race Equality Standard.

Note that for question 17b, the percentage featured is that of “Yes” responses to the question. Key
Finding and question numbers have changed since 2014.
<table>
<thead>
<tr>
<th></th>
<th>ambulance trusts 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF25</td>
<td>Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months</td>
</tr>
<tr>
<td>White</td>
<td>44%↑</td>
</tr>
<tr>
<td>BME</td>
<td>45%↓</td>
</tr>
<tr>
<td>KF26</td>
<td>Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months</td>
</tr>
<tr>
<td>White</td>
<td>24%↑</td>
</tr>
<tr>
<td>BME</td>
<td>38%↑</td>
</tr>
<tr>
<td>KF21</td>
<td>Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion</td>
</tr>
<tr>
<td>White</td>
<td>74%↓</td>
</tr>
<tr>
<td>BME</td>
<td>41%↓</td>
</tr>
<tr>
<td>Q17b</td>
<td>In the 12 last months, have you personally experienced discrimination at work from manager/team leader or other colleagues?</td>
</tr>
<tr>
<td>White</td>
<td>10%↓</td>
</tr>
<tr>
<td>BME</td>
<td>32%↑</td>
</tr>
</tbody>
</table>

Source: NHS Staff Survey 2017

Of the four questions above, there were three questions where BME staff at the trust reported a significantly worse experience than White staff. Furthermore, these results had shown significant deterioration since the survey in 2016:

- Percentage of BME staff experiencing harassment, bullying or abuse from staff in the last 12 months. This result had significantly deteriorated from 2016 when 14% of staff reported against this question, with 38% in 2017.
- Percentage of BME staff believing that the trust provides equal opportunities for career progression or promotion. This result had deteriorated from 2016 when 55% of staff reported positively against this question, against only 41% in 2017.
- In the last 12 months have you personally experienced discrimination at work from a manager/team leader or other colleagues? This result had deteriorated from 2016 when 9% of BME staff reported discrimination, against 32% reporting this in 2017.

For all three questions, the difference between the experiences reported by BME staff and White staff was more pronounced for the trust than for staff across all ambulance trusts in England. This was especially the case for the question on whether staff had experienced discrimination from a manager or colleague.

To put this into context, 97% of staff identified themselves in the 2017 NHS Staff Survey as White, which was the same percentage as in 2016. Of the 1,647 staff who responded, 42 staff identified themselves as Non-white. The national average for ambulance trusts for staff identifying themselves as White in 2017 was 96%.

The trust recognised it did not have a well-developed and mature equality and diversity strategy or working group. The trust board saw the deterioration in the results from BME staff at its board meeting in March 2018. The minutes recorded the trust recognition that action needed to be taken...
with some urgency to understand the issues raised. Actions reported to be already underway were:

- Proactive work to promote the trust among the BME communities with a specific focus at an upcoming student conference.
- Review of talent pools and internal development opportunities to identify areas of under-representation.
- A new equality and diversity steering group to start work in the 2018/19 year.
- The national lead for the Workforce Race Equality Standard (WRES) to assist the trust to improve.

The trust complied with NHS England’s requirements to complete and publish a Workforce Race Equality Standard (WRES) survey, but the published report was now two years old and had not been replaced since 2016, which covered the year 2015. The report listed the key indicators as above and therefore described the experience of Black and Minority Ethnic staff. The WRES survey and action plans were published on the trust website, which was a requirement of NHS organisations. However, this information was no longer current and did not represent the current actions of the trust.

**Safety and wellbeing of staff**

Although somewhat below the national average for ambulance trusts, there was, nevertheless, a high level of reported violence, bullying, abuse and harassment to staff from members of the public. The number of staff who had experienced physical violence from patients, relatives or the public in the last 12 months was, sadly, as many as 28%. This was the same as 2016. There would not be much comfort for the trust in this being below the national average for ambulance trusts of 33% of staff. This was coupled with just 55% of staff having reported the most recent experience of violence, and just 41% reported harassment, bullying or abuse. Both these indicators were below (worse than) the national average – so less staff reported this to their organisation when compared with their peers.

Linked to this was a lack of skilled training for frontline staff in physical restraint techniques, and this was a national issue for ambulance personnel. Those staff we spoke with about this said they felt they were given the right training to de-escalate and resolve situations with patients and members of the public, up to a point, and knew when to withdraw when the situation was unsafe.

However, and it was recognised by the trust, frontline staff had not had training to help them to use safe physical restraint techniques. The lead for mental health at the trust was part of a mental-health strategic development group for all ambulance trusts and restraint training was part of the agenda and in development. The trust was developing its own training on restraint to be part of the development programme in 2018. The trust had a policy for staff to follow with those areas it was currently able to support, such as restraining for safety (such as with seat belts and lap belts in wheelchairs) but not beyond that. This issue had been added to the trust corporate risk register with several controls, including those above of de-escalation and withdrawal. Staff were also advised to seek police support when appropriate.

Although also somewhat below the national average, a high number of staff had experienced harassment, abuse and bullying from other staff, and this had deteriorated in the last year. Key findings from the 2017 NHS Staff Survey, showed that 24% of the staff who responded to the survey had experienced harassment, bullying or abuse from other staff in the last 12 months. Staff said 15% of this was from managers and 17% from colleagues. This was below (better than) the
national average of 28%, but up from 21% of staff reporting this in the 2016 survey. Just 35% of staff said they reported their experiences. This was below (worse than) the national average of 38%.

The trust had responded to both the staff survey, and a rise in complaints from staff about bullying and harassment. These issues were raised to the trust board in reports in both March and May 2018. The actions the trust had decided to take were reported to the board. These were:

- Launching an awareness campaign to encourage more reporting from staff.
- Developing a zero-tolerance campaign around sexual harassment to include education and targeted briefings from management.
- Training for managers in handling disciplinary and performance management cases.

The trust had some criticism also in a 2017 report from the National Ambulance Resilience Unit Interoperable Capabilities Review. In this report, several serious concerns were raised in relation to the culture that existed within one of the service lines. With this and the rise in staff reporting bullying and harassment through the staff survey, the trust commissioned an external review by a Professor from Plymouth University (a specialist in discrimination, bullying and harassment in the workplace). This work started in May 2018 and the report and any actions that come from it will be available to CQC when it is completed.

2017 NHS Staff Survey detail – the results better than average of ambulance trusts

The trust scored better than the England average for all ambulance trusts for 16 of the 32 two key findings in the 2017 NHS Staff Survey:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Appraisals &amp; support for development</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KF11. Percentage of staff appraised in last 12 months</td>
<td>82%</td>
<td>81%</td>
</tr>
<tr>
<td>KF12. Quality of appraisals</td>
<td>2.74</td>
<td>2.65</td>
</tr>
<tr>
<td><strong>Equality and diversity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KF20. Percentage of staff experiencing discrimination at work in the last 12 months</td>
<td>17%</td>
<td>19%</td>
</tr>
<tr>
<td>KF21. Percentage of staff believing the organisation provides equal opportunities for career progression / promotion</td>
<td>74%</td>
<td>69%</td>
</tr>
<tr>
<td><strong>Errors &amp; incidents</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KF28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month</td>
<td>32%</td>
<td>35%</td>
</tr>
<tr>
<td>KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents</td>
<td>3.51</td>
<td>3.41</td>
</tr>
<tr>
<td>KF31. Staff confidence and security in reporting unsafe clinical practice</td>
<td>3.58</td>
<td>3.49</td>
</tr>
<tr>
<td><strong>Health and wellbeing</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Key Finding</td>
<td>Trust Score</td>
<td>National Average</td>
</tr>
<tr>
<td>-------------</td>
<td>-------------</td>
<td>------------------</td>
</tr>
<tr>
<td><strong>Job satisfaction</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KF7. Percentage of staff able to contribute towards improvements at work</td>
<td>54%</td>
<td>45%</td>
</tr>
<tr>
<td>KF8. Staff satisfaction with level of responsibility and involvement</td>
<td>3.66</td>
<td>3.59</td>
</tr>
<tr>
<td>KF9. Effective team working</td>
<td>3.29</td>
<td>3.23</td>
</tr>
<tr>
<td><strong>Managers</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KF5. Recognition and value of staff by managers and the organisation</td>
<td>3.12</td>
<td>3.01</td>
</tr>
<tr>
<td>KF6. Percentage of staff reporting good communication between senior management and staff</td>
<td>24%</td>
<td>20%</td>
</tr>
<tr>
<td>KF10. Support from immediate managers</td>
<td>3.59</td>
<td>3.44</td>
</tr>
<tr>
<td><strong>Violence, harassment &amp; bullying</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KF22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months</td>
<td>28%</td>
<td>33%</td>
</tr>
<tr>
<td>KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months</td>
<td>41%</td>
<td>48%</td>
</tr>
</tbody>
</table>

**2017 NHS Staff Survey – the results worse than average of ambulance trusts**
The trust scored worse than the England average for all ambulance trusts for three of the 32 two key findings in the 2017 NHS Staff Survey:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Errors &amp; incidents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>KF29. Percentage of staff reporting errors, near misses or incidents witnessed in last month</td>
<td>79%</td>
<td>82%</td>
</tr>
<tr>
<td>Violence, harassment &amp; bullying</td>
<td></td>
<td></td>
</tr>
<tr>
<td>KF24. Percentage of staff reporting most recent experience of violence</td>
<td>55%</td>
<td>65%</td>
</tr>
<tr>
<td>KF27. Percentage of staff reporting most recent experience of harassment, bullying or abuse</td>
<td>35%</td>
<td>38%</td>
</tr>
</tbody>
</table>

Source: NHS Staff Survey 2017

**Staff appraisal rates**
Appraisal rates had much improved, although staff were less impressed with the quality. After failing to meet its target to provide staff with annual performance reviews at our last inspection,
with some being significantly overdue (and this being a breach of a regulation), the trust had made noteworthy improvements this time. The overall number of staff appraised by the end of April 2018 was 91%, against a target of 85%. The frontline staff (A&E service line) led the way with 90-97% among the three regions. The rate in the clinical hubs (EOCs) was 72%, but this division had been given a target to achieve of 70% as it was recognised staff had been asked to address more pressing priorities. However, many of those left to complete had been booked in people’s diaries.

In the 2017 NHS Staff Survey, 82% of staff said they had an appraisal in the last 12 months. This was 1% above the national average for ambulance trusts. The quality of appraisals was scored by staff as 2.74 out of 5 (a deterioration over a score of 2.77 in 2016). However, this was above (better than) the national average of 2.65.

**Learning and development**

Learning and development was available to all staff who wanted to have these opportunities. Performance in learning and development was reported to the senior leadership team in a monthly report so they were aware of successes and where there were gaps. In the year 2017/18, the trust provided access to staff for 605 modules in either undergraduate or post-graduate courses. Most of these were for clinical development and a small number for leadership and innovation studies. Among several examples, the trust had 31 successful candidates start their Paramedic Science distance learning programme in March 2018. There were a high number of applications (147) and the recruitment process for the next cohort was underway.

In the 2017 NHS Staff Survey, staff rated the quality of non-mandatory training, learning or development as 3.91 out of five. This was about the same as the national average for ambulance trusts at 3.90. It had slightly deteriorated over 2016 when it was rated as 3.95.

There were two areas of notable absence, both of which were recognised by the trust, although only one being on the corporate risk register. The first, which was on the risk register, was physical restraint training for frontline staff which is discussed above. The other was training in mental health for staff dealing with patients and those calling 999. The lead for mental health told us that nationally the subject was very poorly represented in the paramedic degree programme. In a three-year course, even the best universities only cover it in two weeks of the syllabus. The trust had raised this at the Crisis National Concordat Steering Group and was a member of the National Ambulance Mental Health Group. It was working with other national bodies to review the core competencies for mental health training.

There was some training at the trust, and resources included a series of clinical guidelines attached to the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) clinical practice guidelines. This document is the primary clinical guidance used by ambulance trusts, and it only contained eight pages of guidance in over 520 pages. The trust had therefore produced its own supplementary guidelines. There was e-learning for staff on the trust intranet. The trust had introduced a focus on mental health at the staff development day, which was run at intervals throughout the year with all staff expected to attend. In 2018, the trust was planning and developing a two-day session for the development programme which would include both restraint and mental health.

Healthcare Financial Management Association (HFMA) credits were used for development within the trust finance team and several staff were currently undertaking training. The trust has had staff participate in the HFMA developing talent programme for senior finance staff and several staff usually attended the HFMA south west conference.
Each finance manager received a budget holder guide and was assessed against a ‘finance skills for budget holders’ checklist to ensure managers were capable of delivering their financial responsibilities. To provide wider expertise, some trust staff had attended HMFA training in finance for non-finance managers.

NHS Improvement told us the trust found it hard to provide group finance training to service managers because of the location of its sites and geographical-reach issues. Consequently, the trust had organised finance staff to provide local training and support to individual budget managers as and when required.

**Sickness absence rates**

Sickness levels were not a significant concern. The trust’s sickness absence levels from February 2017 to January 2018 were similar to the England average. High levels of sickness can be an indicator of a poor culture in an organisation or staff falling sick from pressures of work. In the most recent performance report, data was added to that below which showed that sickness had decreased marginally over the remaining winter period. However, in each month shown below and up until March 2018, sickness levels had been above the trust’s target of 4%. The staff group with the highest level of sickness were in the clinical hubs, where there was also the most long-term sickness. The lowest group were the support services, which were constantly below the 4% target.

![Sickness Absence Rates](image)

*Source: NHS Digital*

**Culture of financial integrity**

There was strong alignment between finance and operational management, including the development and delivery of savings plans. To achieve this, among other initiatives, management accountants were embedded in operational teams. The finance team engaged effectively with operational management teams. A Standing Financial Summary was produced which all budget holders were asked to read and sign up to before they could be authorised signatories for the trust.

To demonstrate the focus on and importance of finance within the organisation, the finance team completed financial reporting and forecasting within 10 working days of the month end. Forecasts were an agreed joint view between the manager and director. NHS Improvement (NHSI) told us they recognised a strong challenge from management accountants to managers to ensure
forecasts were accurate and comprehensive. NHSI also reported to us that the finance team was an experienced team which ensured that any views or challenge expressed by the management accountants was carefully considered by service managers.

The trust developed a quality improvement plan (QIP) in August 2016 to drive forward the continuous quality development agenda. This plan had since been refreshed each year. QIP 2018, which included 81 actions, was presented at the May 2018 board meeting and was currently supporting continuous quality improvement across the trust.

**Governance**

There were structures, processes and systems of accountability to deliver good quality and sustainable services, although some had provided assurance which was proved to be weak. The information the trust generated was of good quality to show where change or development was needed. The trust governance team recognised that incidents, complaints, audits and engagement with the public and staff were part of the process for recognising the need for change and making improvements. There were examples of changes to clinical practice (some subtle and some more substantial) from incident reporting and analysis, or trends picked up from audits. This included the ‘Rapid Project’ which looked at staff on the scene with patients suffering heart attacks and strokes and how long staff were spending with patients. It was concluded this needed to be made more consistent through a clearer pathway. Consequently, a revised pathway was developed to improve the time to make decisions and improve responsiveness to the patient, and release crews more quickly.

Guidelines, pathways, and standard operating procedures were updated following requirements or recommendations from Coroners’ inquests, new national guidance and local multi-professional approaches to continuous improvement. This had led to, for example, developments in cardiac arrest responses, and recognition of head injury for intoxicated patients. Work had recently been done in collaboration with a local NHS trust looking at improving care for patients with symptoms of supraventricular tachycardia or SVT. A simple procedure of elevating the legs as a first treatment had now been introduced following international trials and successes, and was now a technique adopted by frontline personnel.

The board committees had good terms of reference, and were clear in their responsibilities and accountabilities. Terms of reference were regularly updated. The trust operated with a ‘committee management map’ which ensured the board had assurance that risks and issues were either managed or raised. Our only concern with the committees was the lack of one to specifically oversee and govern information and communications technology (ICT). ICT was critical to the safe operation of an ambulance service, and the service would have significantly reduced resilience if it or any part of it failed or was compromised. The current arrangement for ICT was for it to be part of the audit and assurance committee reporting to the board. Although there were no indications of failures in assurance, this was a large and complex part of the organisation which had an extensive reach throughout the organisation.

In its obligations to meet its legal and regulatory framework, the board members reported any declarations or conflicts of interest at the start of each board meeting. In a sample of board minutes we reviewed, there were none declared.

The board had a focus on quality and safety. The quality committee was chaired by one of the trust’s non-executive directors to provide some degree of independent challenge and scrutiny at each review. The quarterly meeting received a patient safety report which described learning from
incidents, particularly serious incidents, and any recognised themes. The patient experience report was also reviewed at the quality committee, and learning and themes from complaints, comments and compliments was discussed. Specialist groups reported to the quality committee providing specific assurance. This included infection prevention and control, clinical effectiveness, and medicines management. A summary of these reports then went to the public board meeting as the patient safety and experience report. Within this, the board were told about themes relating to issues with quality and safety and what projects or campaigns had been introduced to make improvements. One area of concern from this report was the lack of evidence to support whether these or previous changes which had longer to embed had made a difference to quality, safety or patient care.

Governance procedures and assurance were sometimes not effective. Our core service report into Emergency and Urgent Care found some issues in ambulance stations and on vehicles which the trust’s assurance processes had failed to either find or prevent. This included out of date consumables, issues with security, and issues of cleanliness and preparedness. The senior leadership team with responsibility for governance described their assurance processes and audit, and recognised they were gaining assurance from a process that was either not working, or was too reliant on a snapshot approach. Accountability for these issues had also not been embedded and more work needed to be done.

There was accountability for budgets and expenditure. In relation to financial governance, the trust’s directors were closely involved in the process of budget setting and agreeing budgets within a board meeting before the start of the financial year. Directors were accountable for the delivery of services within the budgets agreed, with the responsibility of the management of budgets delegated to service managers. Accountability for variances against budgetary performance sat with the director responsible for the division concerned, and there was a series of regularly scheduled meetings to raise and address financial concerns.

As was good practice, counter fraud was a contracted-out service with the provider of the service satisfying the requirements of NHS Improvement. This organisation raised awareness of fraud at the trust’s sites and provided handouts for staff. They also investigated allegations. The director of finance was the trust lead for counter-fraud and liaison with the external team. Any cases raised were reported through the trust’s audit and assurance committee and three sets of minutes from committee meetings we reviewed each had counter-fraud on the agenda. Investigations that were reported on included a member of staff working while on long-term sick leave, and three allegations of lost controlled drugs.

The board were made aware of areas of concern or risk to the organisation, safety and quality. For example, a report on the mental health strategy in May 2018 presented by the medical director, described the challenges faced by the health service and ambulance services in treating people with non-physical injuries or illness. The strategy for future service delivery for mental health patients was presented to the board and outlined the workstreams that were to be undertaken to deliver this. To address other areas of risk or concern, the board reviewed the risk register, the board assurance framework, and operational and financial performance. See the section below on Management of risk, issues and performance for further information.

**Handling complaints**

There was a good quality and attention to detail in complaints, but timeliness of the responses had been poor. Complaints were responded to well in terms of the quality and work that went into the response, but they were not getting to the complainant in the agreed timeframe.
Acknowledgement of the receipt of the complaint within three days, as required, was almost 100% in the 2017/18 year. The trust target for a full response to be given following a complaint was 25 days and 35 days for a more complex complaint.

Complaints were not being responded to within the deadlines set by the trust. In the year 2017/18, the trust had responded to just 35% of all complaints within the deadlines, although for the complaints about frontline services, a 60% response rate had been achieved. The trust provided us with the latest information which showed the response for all complaints had deteriorated further in the first month of the 2018/19 year (April 2018) to 18%, but by June 2018, significant progress had been made, and the response was now at 71%.

The number of complaints made to the trust had fallen. In the year 2017/18, the trust received 1,334 complaints, comments or concerns to be investigated. This was a fall of 17% over the previous year. Several of the 1,334 complaints had more than one area of concern, which increased the number of areas of concern to be investigated to 1,665.

The quality of the responses was good. During our regular engagement work with the trust we have reviewed several significant complaints. We have found them to be investigated well, with a thorough response produced. Another measure of the quality of the complaint response being high was from those that needed to be reopened following the initial response. In 2017/18, this was only 28 of the 1,334 received (2%), which was low. Another measure was from complaints escalated to the Parliamentary Health Service Ombudsman. People could complain to the ombudsman if they felt a response from the NHS had been inadequate. In 2017/18, five complaints were made to the ombudsman, and none were upheld.

The organisation learned from complaints. The annual report 2017/18 described some of the 300 actions taken because of complaints made about frontline operations. These included conversations with frontline staff about dealing with pneumonia, checking the use-by dates of medicines on vehicles, and expectations of staff working in care homes. There was also learning on specific clinical subjects, including managing dehydration and stroke diagnosis. There were discussions with several staff about poor communication, and looking at a situation from the perspective of the patient or relative.

**Medicines governance**

There were effective systems of governance with medicines, although we had concerns with some areas of security of medicines and records in frontline services. The pharmaceutical advisor led on medicines optimisation for the trust. The trust board received an annual update on medicines optimisation through the medicines governance report and medicines strategy.

The medicines management group monitored the medicines optimisation within the trust and reported to the quality committee. The pharmaceutical advisor was line managed by the trust chief executive officer and professionally accountable to the medical director, to allow communication directly to the board.

Medicines incidents were reported through an electronic recording system. The pharmaceutical advisor was also the medicine safety officer (MSO), a role created following an NHS England Patient Safety Alert. A multidisciplinary team at the medicines management group reviewed these incidents and acted on them.

The pharmaceutical advisor managed medicines related risks, which were recorded on a divisional risk register. The medicines management group reviewed national safety alerts relating to
medicines. They would review the alert and create a task and finish group to manage the implementation of the alert.

Through peer benchmarking data, the pharmacist was aware of the trust’s position compared to other NHS ambulance trusts with respect to missing and broken morphine ampoules. Work had been undertaken to understand why specific locations had more incidents than most ambulance stations.

There was an internal medicines audit programme. Audits included security of medicines and medicines related stationary. Medicines administration and supply data was also audited. The pharmaceutical advisor had recently completed a programme to visit and meet with ambulance staff across Cornwall. The objective was to hold meetings with front line staff to discuss and clarify the medicines optimisation systems rather than rely on email.

Management of risk, issues and performance

There were comprehensive assurance systems to evaluate trust performance. Trust staff were given a wide range of quality data on which to measure and evaluate how the organisation was performing. The one area where there was a gap was around predicting and contributing to future performance to shape and drive the service of the future for patients.

Financial risks

NHS Improvement told us it had clear evidence that financial outcomes had been consistently strong over the last three years. That is to say, cash, capital and revenue plans had been delivered in line with the trust’s plans. Auditors had not flagged concerns to regulatory bodies. A finance risk commentary was prepared each month and shared with NHS Improvement. NHS Improvement recognised a clear line of communication with regulators outside of standard reporting where any issues and risks were raised.

Performance risks

The trust had recognised there were serious risks to patients from it not meeting performance standards for getting to them on time. Nevertheless, it had met and exceeded other performance measures when compared with other ambulance trusts (which are not set against national standards), such as call handling and how it responded to patients’ needs. However, an external review had reported to the trust that its current resources were not sufficient to meet demand and achieve the national standards on response times.

- **Standard response times**

These standards, as they related to the time to reach a patient, had not been met in the period we have looked back at (starting November 2017), and the trust had not been either better than the national average or the best responder in any category – but it had been the worst. This issue was among the highest risks on the corporate risk register, rated at 20 out of a possible 25 for category one and two calls in one risk together (as actions taken here were the same), and category three calls, where actions were different.

The trust had been failing to get to patients on time, and too many patients were waiting for an ambulance to reach them in the standard time. Although this had been an issue for the trust for a long time, the time to reach the more serious categories of patients was improving as it moved into traditionally a less demanding time of the year. However, the time to reach the less serious categories was deteriorating and there was a considerable gap between the standard and the time
achieved. In June 2018, the time taken to reach the category four patients was almost twice the standard of three hours.

The trust action against the failure to reach category one to three calls was comprehensive in those areas it could influence. However, although there was a long list of controls within the board assurance framework, this key document for the board did not provide assurance as to whether any of these were effective. What was not referred to was the gap in the funding provision for the trust, which had been identified from an external and national review of ambulance services. In January 2017, the National Audit Office published a report stating that ambulance trusts were “finding it increasingly difficult to cope with rising demand”. The demand-management modelling provided by an external organisation that specialised in resource planning in health concluded the trust needed a further £12 million of revenue this year (2018/19) to deliver the 999 performance standards. Capital requirements were an additional £4 million, and a further 241 fulltime staff were needed. The trust had therefore concluded in its financial plan that the current performance standards were not achievable for the trust within the current resources provided by commissioners.

The statistics around response times are reported upon in detail in Emergency and Urgent Care section, but the key data is provided below for the period from 23 November 2017 to 31 March 2018. The reason this data is not a full year is the trust implemented the new Ambulance Response Programme (ARP) standards with effect from 23 November 2017. Data prior to that was measured against the previous standards. Included here is more recent data to show an improving trajectory for the most serious of categories:

<table>
<thead>
<tr>
<th>Category</th>
<th>National ARP standard</th>
<th>23 Nov 2017 to 31 Mar 2018</th>
<th>April &amp; May 2018</th>
<th>June 2018 (most recent published data)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 1 mean response</td>
<td>7 minutes</td>
<td>09:42</td>
<td>08:30↓</td>
<td>7.41↓</td>
</tr>
<tr>
<td>Category 1 90th centile response</td>
<td>15 minutes</td>
<td>17:36</td>
<td>15:48↓</td>
<td>14:23↓</td>
</tr>
<tr>
<td>Category 2 mean response</td>
<td>18 minutes</td>
<td>33:24</td>
<td>24:06↓</td>
<td>26:41↑</td>
</tr>
<tr>
<td>Category 2 90th centile response</td>
<td>40 minutes</td>
<td>1:09:42</td>
<td>0:50:00↓</td>
<td>0:56:24↑</td>
</tr>
<tr>
<td>Category 3 90th centile response</td>
<td>2 hours</td>
<td>2:59:24</td>
<td>2:22:12↓</td>
<td>2:58:38↑</td>
</tr>
<tr>
<td>Category 4 90th centile response</td>
<td>3 hours</td>
<td>4:29:06</td>
<td>4:53:00↑</td>
<td>5:50:15↑</td>
</tr>
</tbody>
</table>

In benchmarking the trust against other NHS ambulance services in England (excluding the Isle of Wight) the following is noteworthy (for June 2018 as the most recently published data):

<table>
<thead>
<tr>
<th>Category</th>
<th>National average</th>
<th>SWASFT</th>
<th>Best performer</th>
<th>Worst performer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 1 mean response (7 mins)</td>
<td>07:37</td>
<td>07:39</td>
<td>06:04</td>
<td>08:42</td>
</tr>
</tbody>
</table>
• **Demand**
  The statistics above must be set against other important indicators. The trust saw an increase in demand of 2.48% or 22,257 incidents from the years 2016/17 to 2017/18. However, this was below incident numbers contracted with the trust’s commissioners by 0.8% or 7,394 incidents. To put this into context, in 2016/17, the commissioners changed the way in which demand growth was calculated. Over 2018/19, the demand calculation was different and below what national planning guidance would have determined. In May 2018, demand increased by 2.72% or 2,067 incidents. This was, however, 1.13% above contracted incident numbers.

• **Handover delays**
  When attending an accident and emergency department in 2017/18, the trust experienced delays of more than 15 minutes for 40% of handovers to A&E staff. However, this was an improvement over 2016/17 when 47% of handovers were delayed by more than 15 minutes. Nevertheless, this contributed to an average of around 2,000 hours of lost time each month in 2017/18 or 68 hours on average each day. Delays were, as with the demand in A&E departments, at their worst in the winter months. The peak was December 2017, where delays accounted for 3,581 lost hours a week or 115 hours a day.

• **Call handling**
  The trust was performing well against other providers in call answering and how it handled the calls. In recent data supplied by the trust, there were no specific issues in the emergency operations centres (clinical hubs) with call answering, and the time taken to identify the most serious incidents. Some notable performance indicators:
  - In April 2018, the mean average call answer time was 4 seconds (national average 6 seconds) and the 95th percentile was 17 seconds (national average 31 seconds).
  - In May 2018, the mean average call answer time was 7 seconds (national average 8 seconds) and the 95th percentile was 37 seconds (national average 45 seconds).
  - In April 2018, the number of calls closed with telephone advice or referral onwards was 5.8% (national average 5.2%).
  - In May 2018, the number of calls closed with telephone advice or referral onwards was 6.6% (national average 5.4%).

• **Patient management**
  In terms of how the trust responded to patients, it performed well against the need to optimise and take responsibility for how many patients were being conveyed to accident and emergency departments. Data below shows how the trust performed to limit A&E admissions in the first three
months of the 2018/19 year (shown against the national average (NA) for ambulance trusts. All these indicators were better than or equal to the national average:

<table>
<thead>
<tr>
<th></th>
<th>Apr 18</th>
<th>May 18</th>
<th>Jun 18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hear and Treat</td>
<td>6% (NA 5%)</td>
<td>7% (NA 5%)</td>
<td>6% (NA 6%)</td>
</tr>
<tr>
<td>See and Treat</td>
<td>37% (NA 29%)</td>
<td>36% (NA 30%)</td>
<td>37% (NA 30%)</td>
</tr>
<tr>
<td>See and Convey to A&amp;E*</td>
<td>53% (NA 60%)</td>
<td>52% (NA 59%)</td>
<td>52% (NA 59%)</td>
</tr>
</tbody>
</table>

Source: NHS England Ambulance Quality Indicators. For See and Convey results, a lower number is better.

In all the performance indicators relating to how the trust responded to patients, the trust’s results were better than the average for NHS ambulance trusts.

**Mental health risks**

There were a number of shortcomings in the support provided to patients and staff for mental health conditions. An area recognised by many trust staff as an issue and possible risk, which applied to all ambulance services using the same triage programme for staff taking 999 calls, was the lack of triage for patients with mental health needs. Although this was a problem which had resulted in over-conveyance of patients, and possible misallocation of resources, it had not been added to the trust’s risk register.

The trust reported it being difficult to know how many patients contacted them each year with a mental health crisis. For example, a patient might call them with a laceration, which turned out to be a self-harm incident. However, the triage system or other reporting mechanisms did not capture this element of the incident. The trust estimated, nevertheless, that it dealt with 60-75,000 calls from patients each year with a mental health crisis. The trust’s patient records would capture information provided by other healthcare professionals to indicate if patients or people living at a certain address had known mental health problems. This would produce a flag for staff taking those calls or sending resources to those patients or addresses, and attending staff would be informed.

The triage system did not deal with patients presenting with possible psychosis or behavioural problems. The default position for the system was either for an ambulance to be sent or the patient directed to attend the accident and emergency department. There was nothing in between these pathways. The trust’s lead for mental health was working with both NHS Improvement and the provider of the international triage system to improve the position around mental health.

Staff we talked with about mental health training told us they did not always feel comfortable when dealing with a patient with a mental health illness or crisis. They told us they did not feel they had the right tools to always risk assess patients effectively. The trust lead for mental health said it had been recognised that patients were generally “over-conveyed” (that is taken to hospital too frequently) when other options would have been better. This tended also to give patients what they wanted rather than what they needed, which reinforced negative behaviour.

To address this further, the trust was starting a pilot in the north of the patch with the local NHS mental health trust. The trust had now received support from the commissioners to enable mental health nurses from the mental health trust to support staff at the clinical hub with Hear and Treat patients. After reviewing the effectiveness of the programme, the trust hoped to have support from another NHS mental health trust in the south of the patch for a similar scheme. The nurses were
also recognised as being a resource to support the work with frequent callers – patients who call 999 excessively without clinical reason, although often due to mental health problems.

Alongside the issues above, the trust had yet to invest in vehicles specifically designed for patients with mental ill health. The lead for mental health told us the Ambulance Response Programme would give the trust the opportunity to investigate whether this was an option for future investment. The trust was aware of another NHS ambulance service which was looking at possible options, and would share its findings. There were also no specialist paramedics trained in mental health as this was not currently a specialisation for paramedics. The Royal College of Emergency Medicine was looking at whether to extend Mental Health Act holding powers to paramedics to enable them to detain unwell patients in an emergency.

**Current and future performance**
The trust had a range of performance measures which were available internally and reported for national comparison. These systems were regularly reviewed and audited for their accuracy and relevance. These measures were related to topics as described above, but also other patient outcome measures and quality metrics. Data therefore included how the trust responded to cardiac arrests and strokes in several different measures. There were also performance measures by division and service line.

The trust also produced a set of current and forecast financial numbers. As with most organisations dealing with budgets, targets, and the need to control costs when performance is unpredictable, the trust had a good view of its future financial position. This was presented through board committees and at trust board. Any significant deviations or threats to the performance were highlighted. Risks were RAG rated (red, amber, green) with red risks being those deviating most from the forecast.

Although financial information was forecasted for the future, one area the trust was not forecasting was operational performance to shape and drive how the service and ambulance services in general evolved to meet patient’s needs. The managers for information management and technology said the systems used at the trust would need some development to be able to enable past information and future predictions to provide future forecasting. We were told this was coming onto the agenda with the appointment of the trust’s new executive director for information management and technology.

**Risk management**
All directors had a clear view of risks in the organisation where they were scored as 10 and above. The corporate and directorate risk register listed the risks in order of risk score with the highest risks listed first in the report. The trust’s new software coming into use for risk management would enable risks to be distributed in different directions. For example, all risks with, among them, potential financial implications were tagged as such, and could be easily be collated for review.

Risk registers were continually updated. The quality & risk assurance group, which had representation from across the organisation, met once a fortnight. This group reported to the trust board and senior leadership meetings each month.

**Audit**
The trust audit and assurance committee was a sub-committee of the board. It received reports from both internal and external audit work. The report from December 2017, for example, showed the committee challenging the confidence of the internal audit team in achieving the 2017/18 audit plan. The internal audit team had displayed confidence in achieving their plan and used past
results in achieving its plan as an indicator for its confidence that year. Over the course of various meetings in 2017, the committee was also informed and given assurance about:

- Meeting the European Working Time Directive.
- Directors’ expenses.
- Fleet management.
- Implementation of the computer-aided despatch (CAD) system.
- Clinical hubs.
- Raising concerns.
- Talent and clinical workforce development.
- Cyber security.
- Sickness management.
- Procurement and tendering.

Although the minutes of the meeting showed there was good challenge from the non-executive directors, we did not find their assurance around raising concerns put the trust in line with national guidance. We note this has since been addressed and arrangements for the Freedom to Speak-up Guardian have been changed.

The audit and assurance committee received a report from the external auditors. No major changes to the approach to external audit were expected for the 2017/18 audit. As was good practice, it was noted by the committee that an initial planning meeting had been held between the external auditors and the finance team and a proposed audit plan was to be presented to the committee in March 2018.

Planning for risks and major incidents
There was sufficient planning for risks and major incidents. One vital aspect of an ambulance service was to recognise and plan for risks to its performance. The trust had a comprehensive Resource Escalation Action Plan (REAP) which was put into operation alongside other key action plans, namely:

- Major incident plan.
- Business continuity plan.
- National Ambulance Resilience Unit (NARU) REAP plan.
- Demand management plan.

The REAP had four levels of management plan from level one (green) where the business was operating as usual to level four (black) where the trust was operating under extreme pressure. What situations constituted each level was described in the plan. The trust would also move to level four if a major incident was declared. The REAP action plan outlined clearly the roles and responsibilities of staff at each level and who was accountable for the various actions. The plan then listed the external people and organisations to be contacted in the event of a major incident or escalation in REAP level.

Each of the emergency services had a memorandum of understanding setting out the training requirements for each service to co-respond to an emergency. The trust told us it was currently negotiating a standardised set of arrangements to cover all emergency services and co-responders. Each team undertook quarterly continuity training sessions provided by the trust, and required all participants, as a minimum, to be proficient in basic life support and use of an automated external defibrillator.
The trust was part of the Joint Emergency Services Interoperability Programme (JESIP). It was involved in the delivery of training and engaged with multi-agency exercises. The trust was represented across the South West Emergency Service Collaboration Group and took the lead for the operational response for the region.

In June 2017, the trust was reviewed by the National Ambulance Resilience Unit in the Interoperable Capabilities Review 2017. This review was commissioned by NHS England to look at ambulance trusts’ capabilities in terms of its:

- Hazardous Area Response Team (HART)
- Casualty preparedness
- Chemical, biological, radiological and nuclear (CBRNe) preparedness, and
- Marauding terrorist firearms attack (MTFA) preparedness.

Each area was looked at under seven different domains including governance, personnel, and operational effectiveness. In these three domains, the trust was found to be not compliant or falling below the national standard. The other four areas were either compliant, or, in logistics, the concerns identified did not directly compromise the delivery of interoperable capabilities.

The trust accepted the findings and produced an action plan and identified key staff to deal with the issues raised. A report to the quality committee in May 2018 by the head of the trust’s Emergency Preparedness, Resilience and Response (EPRR), described the status of the actions and provided assurance on the status of the capabilities. The committee was asked to note that the lead clinical commissioning group had assessed the EPRR assurance programme for 2017/18. For the first time the trust was fully compliant with the 50 core standards.

New governance arrangements had been implemented with a line of reporting that went up to the trust board. Procedures across the two sites running the HART teams had been aligned and the new national standard operating procedures were being introduced. There was a high level of training and appraisal with almost all staff being up-to-date. There has been restructuring among the teams and the HART service was being fully integrated into the trust’s response teams.

**Information management**

There was a clear understanding of the critical importance of timely, accurate, detailed and relevant information. As we have reported above, information in an ambulance service was critical to both performance of frontline emergency services and as a measurement for improvement. Information used was both live and current communication between members of the public and healthcare professionals through with call handlers and clinicians. It included staff making decisions about deployment of crews, teams and equipment, and staff taking operational decisions from information provided. It was also collections and analysis of this information to measure and recognise performance success and failure, and drive improvement. The accuracy and usefulness of this information was therefore vital to the organisation.

The patient communication, triage, call-recording and dispatch systems used by the trust had been assessed, tested, validated and approved by the trust board. At this inspection this was the first time we had been to the trust since it became South Western Ambulance Service and almost all systems used were aligned. The triage and computer-aided despatch systems were now the same in both emergency operations centres. This allowed for both centres to handle calls across the whole region and have the same systems and processes to work with. There was a gap where
some of the clinical information held about a patient who was a frequent caller was not yet shared, but the trust was aware of this and looking for a solution.

**IG Toolkit assessment**
The trust had completed the Information Governance Toolkit assessment, which described how it saw its management and security of information. The trust was self-assessed on measures of assurance which extended to confidentiality and data protection, the quality of information, the secondary uses of information, and a measure of overall performance. In the 2017/18 declaration, the trust assessed its overall performance as satisfactory. The score for 2017/18 was 81%, which was a 1% improvement over the previous year and a 10% improvement over 2015/16.

**Data protection**
Information was protected from external attack or intrusion. Following the recent significant cyber-attack on NHS data, among others, the trust was tested by NHS Digital for its cyber security. The first round of testing found four significant gaps (out of several hundred) and following actions to address this, the second test found the organisation reduced to two outstanding risks, which was considerably low for NHS organisations. Consequently, the ICT team had provided the board with its NHS Digital CareCERT assurance. The executive director of information management and technology (IM&T) had provided assurance to the audit and assurance committee (December 2017 minutes) that the trust’s IM&T security policy had been updated in line with the National Cyber Security Centre’s 10 steps to cyber security. This was then ratified by the board in January 2018.

**GDPR**
The trust had managed and implemented the news rules and guidance around the General Data Protection Regulation (GDPR) 2018. This required the trust to ensure it protected patients’ and staff data under specific legal obligations. The trust had published its statement of what information it held about both patients and its staff and why it needed this information. It described what organisations it was entitled to share information with, and why. It explained the rules about keeping confidential information and how it was securely destroyed when it was no longer needed. Staff we spoke with about GDPR were aware of the new rules, and there were posters up around the offices to remind staff of their legal duties and responsibilities to protect information to this new higher standard.

**Record security**
Patient records were mostly held securely and unauthorised people were prevented for accessing them. Patient records were all held electronically, and only accessible to trained staff who had access systems requiring unique access information and passwords. Our concerns about the security of patient information was seeing an electronic device left unattended on a vehicle without the patient information being closed. We also found some confidential and sensitive patient-identifiable information being in an accessible place on one occasion. We recognise these were two examples from many otherwise good examples of record security. Nevertheless, this was brought to the attention of the senior leadership team who addressed this quickly and with appropriate concern.

**Financial information management**
There was good information management in relation to finances, both current and anticipated positions. The financial information received by the board in the integrated corporate performance report included a balance of board and directorate level detail, and covered both actual and future-looking projections. The finance and performance committee received more in-depth financial
information. As was good practice, these committee meetings were held in advance of board meetings to give members the opportunity to have more time to have detailed financial conversations. This gave them chance to have fully understood the detail behind the numbers before board meetings were held.

Engagement

Engagement with the public
People’s views and experiences were used to improve services. However, more work needed to be done to move away from public relations and into the public being instrumental in shaping decisions and future services.

In 2017/18, the trust attended 267 engagement functions with the public. This included, but was not limited to:

- Educational visits to schools.
- Visits to community groups including those who were hard to reach out to.
- Tri-service shows with the police and fire services.
- Ambulance station open days.

The trust told us it engaged with the public on its quality priorities, including local Healthwatch groups. However, it did not tell us or describe in its previous quality accounts how this had made a difference to what priorities were chosen. We were told that Healthwatch had been involved in the development of the latest (2018/19) quality priorities. The mental health priority had come from the trust’s work with those organisations, so some progress was being made to shape services and priorities around what mattered to the public.

To make the necessary progress it recognised was needed, the trust had produced and shared with us a draft strategy around patient communication, engagement and experience. This encompassed the trust’s mission, vision and values. The trust said it wanted to have a strategy to enable all its ideals around communication, engagement and patient experience to be in one place to have a joined-up approach. Although this was a draft document, what we did not see from it was the strategy being measurable, so achievements could be proven, and how this would be done.

Patients and their families were involved as and how they wanted to be in investigations when either they made a complaint or something went wrong. This included when the duty of candour was applicable. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. It also requires the provider to apologise. In these and other cases, families or those who spoke for the patient were invited to say how they wanted to be involved in any investigation. They were invited to meet with trust staff both during the investigation, when it was finalised, and/or to provide their feedback at the conclusion.

Although we do not have comparative evidence from all other ambulance trusts, the trust told us it applied duty of candour to 48 incidents in the year 2017/18. The board were made aware of the obligations to this duty and given assurance that where the trust could meet it, it was doing so. There were occasions when the duty could not be met, but these were for valid reasons (such as unable to locate a next-of-kin, or that person being involved in criminal proceedings).
Investigations, experiences and feedback from patients and those who supported them were used to make improvements to services, find areas of shortcomings and retrain staff, or change/update clinical practice. Examples from feedback included important reflections for staff on how they communicated with people, which was a common source of complaint and concern.

The trust had an extensive reach through conventional and social media. It was an active user of social media platforms, and was in constant contact with both national and more frequently with local media to report on incidents attended, and promote public campaigns. It also published its latest news on its website. It was recently a high-profile organisation for publicising the dangers and risks of hoax calls being made to the service.

The trust was open and transparent in its reports presented on its website. All public board meeting agendas, minutes and papers were published. There was a wide-range of other information from those reports required to be published by law or national guidance, to technical and clinical guidelines and practice.

**Governors**

There was a committed group of Governors. The trust was established as a foundation trust in 2011 and was required therefore to have a council of independent and mostly elected governors. Those who were not elected were appointed by partner organisations including the clinical commissioning groups and local authorities. The council had 32 members of which 19 were elected public governors, six were elected staff and seven were appointed.

We met with a group of four governors who said they felt engagement with the trust worked well. They said they felt valued and their work was recognised. The lead for the council met regularly with the trust chair and had an open and supportive relationship. The governors felt they were listened to and given an opportunity to challenge the organisation. They had been involved with the recruitment of the non-executive directors and the new chair. Those we met had a good awareness of the risks and the challenges the organisation faced, not least from the geographical scale it reached.

Meetings were held regularly and minutes were available on the trust website. The objectives of an NHS governor were to hold the non-executive directors individually and collectively to account for the performance of the board of directors, and to represent the interests of NHS foundation trust members and of the public. The minutes demonstrated good levels of challenge to the organisation and the non-executive directors. This ranged from performance to upcoming or recent events and programme of work.

A reflection of the meeting and our conversation with the governors showed a focus on operational matters, and concerns about not being involved sufficiently in operational decisions. However, the terms of reference described the role of the governors was to hold the organisation to account, but not to be involved in operational decisions. In the governors’ meetings, we did see limited focus on patients and their experiences being held up for challenge.

**Friends and Family test**

Response rates for patients reporting on the service they had were poor, although most would recommend the service. The NHS Friends and Family Test was launched in April 2013. It asks people who use services whether they would recommend the services they have used, giving the opportunity to feedback on their experiences of care and treatment.
From May 2017 to April 2018, the trust’s score was variable compared to the England average for recommending the trust as a place to receive care throughout the year. Between 83% and 100% of respondents said they would recommend the trust each month.

However, although we recognise the issues with gathering data in the ambulance environment, the response rate for the trust was extremely low, and much lower than the England response rate. Over this period the trust’s response rate varied from 0.02% to 0.07% (between six and 18 patients each month). The England response rate varied between 0.1% and 0.2% over this period. The trust told us there had been a concerted effort to improve response rates at their urgent care centre where responses were easier to obtain.

![Graph showing trust score variability from May 2017 to April 2018](image)

**Source:** NHS Friends and Family Test

### Engagement with staff

Engagement with staff had variable levels of success in this organisation. The 2017 NHS Staff Survey showed a deterioration in some of those questions associated with staff engagement. Some of these questions, although above the national average for ambulance trusts, were still low results, particularly those around question eight (see below). Although the question eight responses were better than the England average for ambulance trusts, they showed between only a quarter and a third of staff felt there was good communication and involvement of staff.

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score 2017</th>
<th>National Average</th>
<th>Trust Score 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4b: I am able to make suggestions to improve the work of my team/department</td>
<td>60%</td>
<td>50%</td>
<td>60%</td>
</tr>
<tr>
<td>Q7d: My immediate manager asks for my opinion before making decisions that affect my work</td>
<td>45%</td>
<td>38%</td>
<td>45%</td>
</tr>
<tr>
<td>Q8b: Communication between senior management and staff is effective</td>
<td>31%</td>
<td>26%</td>
<td>32%</td>
</tr>
<tr>
<td>Q8c: Senior managers here try to involve staff in important decisions</td>
<td>26%</td>
<td>19%</td>
<td>29%</td>
</tr>
</tbody>
</table>
Q8d: Senior managers act on staff feedback

<table>
<thead>
<tr>
<th></th>
<th>23%</th>
<th>21%</th>
<th>27%</th>
</tr>
</thead>
</table>

*Note: for the above questions, the percentage featured is that of ‘Yes’ responses.*

During both this inspection and our previous inspection in 2016, we found one of the most wide-ranging set of responses to questions of engagement and communication. Other CQC inspections in ambulance trusts have provided similar anecdotal evidence of wide-ranging views from staff. Some staff we met felt they had great two-way engagement with the trust. They could find and obtain all the information they needed to do their jobs safely and effectively, or knew who to ask. They said they felt confident to speak up and could be listened to. Some gave examples of when they had made a suggestion, it had been acted upon, or there was a good reason given for that not to be the case. Others in the same or similar roles had the opposite view, and felt communication with them was poor.

We discussed with official staff representatives their views of these issues with communication and why there were problems. Views of staff they gathered had included:

- Staff not always feeling they had the skills to manage others.
- The constant amount of change, and some of it being to revert to arrangements said to previously need improving.
- Staff sometimes felt a lack of humility from senior staff in recognising how much change in the organisation had been problematic for many staff.
- The organisation did not admit when things had not gone well.
- Staff were more fatigued than ever before.

However, staff also reported how they recognised some changes were making good progress. Other changes were being hampered by increases in demand, a lack of resources to provide a full service, and staff shortages and absence having affecting morale and wellbeing.

**External partners and stakeholders**

The trust had and sought positive and collaborative relationships with external partners. This was intended for creating a shared understanding of the challenges within the healthcare system and the needs of the population. To do this, the trust attended many key stakeholder meetings with partners in health and social care, and the public or their representatives. This was a significant undertaking for the trust, which worked across seven English counties.

Staff, and usually the operational manager for the area, had attended a range of local Health Overview and Scrutiny Committees (HOSCs). Many of the relationships with these groups were said by the trust to be “excellent”. This had been supported through members of the HOSCs visiting the emergency operations centres to see what life was like dealing with 999 emergencies. Local councillors had accompanied ambulance crews to experience how they dealt with frontline emergencies.

The trust held open days for the many Healthwatch groups in the south west region. These local organisations were developing a more pivotal role with the trust, which admitted it struggled to engage with such a large and widespread diverse population. Healthwatch were becoming more closely involved with quality priorities and the patient engagement workplan.

As we have written about above in Vision and strategy, the trust engaged to play its role in local priorities through its clinical commissioning groups and other partners. It reported a strong professional relationship with the lead clinical commissioning group which is felt was open,
transparent and measured. Reports on performance, quality and safety were provided to the commissioners monthly in line with agreements, and with other regulators as required. NHS Improvement told us the trust shared a significant amount of financial, cost improvement, activity and demand information with them and partner organisations. The trust worked closely with other healthcare providers and partners, and had ongoing discussions about the development of a joint plan, the implementation of the Ambulance Response Programme, and service sustainability.

Although it was early days in the new organisational structure in frontline services, the new county commanders were already building new relationships and enhancing those with the local NHS trusts and others in their counties. Two trusts in the region we spoke with since our inspection had met with their county commander through their emergency department teams, and were positive about this change of organisational focus.

The trust medicines optimisation group worked collaboratively with NHS hospitals to optimise the transfer of patients, their medicines and information about their medicines. The medicines optimisation group worked with the pharmacy teams in adjacent trusts through networking groups including chief pharmacist, local and area prescribing committees. Within one health economy, several joint pharmacist posts had been created between the local NHS hospitals, community and mental health trusts, and the clinical commissioning groups. This was to develop medicines optimisation and staff across the various links to increase staff understanding of medicines optimisation within the different services.

**Learning, continuous improvement and innovation**

**The Macmillan Cancer Support project**

The trust had been funded by the charity, Macmillan Cancer Support, to develop and innovate in training and development for frontline ambulance staff supporting patients at the end of their life or receiving cancer treatment. It had been recognised that these patients faced anxiety and limited choices when they needed support, particularly out of hours, or the option to be able to remain at home.

Before the project with Macmillan Cancer Support, most patients in these situations would be conveyed to an emergency department at a hospital. The project was therefore designed to enable frontline ambulance staff, through additional knowledge and training, to provide care and treatment for cancer and palliative patients in their own homes. This was known to reduce stress for patients and help them to stay where they wanted to be.

The project started in 2015 with implementation starting in October 2016, and was funded by Macmillan Cancer Support over four years. It was the first project of its kind to be run in England. In the first two years of the project, more than 1,300 staff had received formal professional development by the project team. In most cases these clinicians attended in their own time. The team had provided specific training to around 500 students on paramedic courses at three local universities. Staff in the clinical hubs had received specialist education to enable them to arrange the right support for patients. The team had also:

- Developed and delivered specialist paramedic symptom management training.
- Provided 121 technicians and emergency care assistants with level two distance learning in end of life care.
- Developed e-learning in collaboration with the College of Paramedics and E-learning For Health. This was now available to all ambulance personnel across England.
• Worked with the College of Paramedics, NHS England and Health Education England to agree pre-registration competency frameworks for paramedics.
• Established 50 staff across the trust to be cancer care links – a point of reference for cancer, palliative care and end of life care.

The team also helped with clinical supervision, and supporting staff with difficult cases through individual and group coaching. There were advice lines available to frontline staff with local hospices who would provide advice and guidance in specific circumstances.

Evidence was being built, but the trust had already recognised that hundreds of patients had been enabled to stay at home and be treated by paramedics, avoiding them being conveyed to an emergency department. We have read some exceptional feedback from patients and their relatives and carers who had received care, treatment and support because of this project.

Other projects
The trust was committed to learning, improving and innovating. It reminded us this was set against a backdrop of cost-improvement (savings), rising demand from patients, new targets, and system pressures. Nevertheless, the trust had achieved learning, continuous improvement and innovation in several areas.

The trust had been one of two trusts taking part in the pilot for the recently introduced Ambulance Response Programme. This started in 2014 and involved the trust and its staff testing new initiatives to improve the quality and timeliness of responses to patients depending on what they needed and when. This programme was introduced to all NHS ambulance trusts in November 2017.

The trust had joined an ‘ambulance costing technical focus group’ alongside NHS Improvement to look at the development of costing standards. The current standards were recognised as not achieving the true cost of service delivery. This was an ongoing project at the time of writing which the trust would be supporting. In the meantime, a new costing system had been purchased and was being implemented. The benefits included, but were not limited to: a clearer understanding of cost flows, benchmarking of costs, greater national consistency in understanding costs, and identification of efficiencies and improvement. The trust also had a scheme for staff to suggest cost-improvement savings. This had already resulted in success from, for example, rationalisation of equipment and consumables.

In the summer of 2017, Lord Carter of Coles commenced his review of the operational productivity of ambulance services. The objective was to understand and support efficiencies and improve productivity. The trust was part of several workstreams looking at specific areas such as procurement practices, the efficiency of the fleet, the work of the emergency operations centre, and the model ambulance (among others). The trust was developing best-practice case studies to share learning and provide a basis for recommendations. This included auto dispatch and cancellation, estate rationalisation, and infection prevention and control (among others).

The trust had developed a data tool to look at how emergency 999 calls were triaged, and compare this with the data collected from the subsequent contact with the patient. After analysing 250,000 incidents, the trust used the evidence to enhance its Hear and Treat service, and feed into other triage and clinical trials.

The trust’s medical directorate took an active role, through quality improvement initiatives, in improving care. Paramedics trained and focusing on quality improvement had trialled small tests of
change before implementing wider ideas. The service had recognised and was continuing to develop the practice and procedures it undertook with patients at the scene. This had extended to trained personnel carrying out emergency surgical procedures. The trust was therefore developing its work with doctors who wanted to practice pre-hospital emergency medicine. This included resuscitative thoracotomies. The trust was also developing standard operating procedures to enable this and other procedures to be undertaken.

The trust participated in the sharing of NHS ambulance medicines data and information. This provided benchmarking data and analysis of the trusts safe and effective use of medicines.

The trust was working with local mental health trusts to optimise the care of patients having a mental health crisis in the community where there may be a need for rapid tranquilisation. Estates, logistics and the pharmaceutical advisor were developing a programme of joint working to understand each other’s needs as procurement contracts changed and ambulance stations were refitted.
South Western Ambulance Service NHS Foundation Trust has responsibility for the provision of ambulance services across an area of 10,000 square miles, 20% of mainland England. The trust covers the counties of Cornwall and the Isles of Scilly, Devon, Dorset, Somerset, Wiltshire, Gloucestershire and the former Avon area (Bristol, Bath, North and North-East Somerset and South Gloucestershire).

The trust serves a total population of over 5.5 million, with the region estimated to receive an influx of over 23 million visitors each year. The area is mostly rural but also included large urban centres including Bristol, Plymouth, Exeter, Bath, Swindon, Gloucester, Bournemouth and Poole.

Emergency and urgent care, known within the trust as the accident and emergency service line, was managed over three divisions. The east division covered the counties of Somerset and Dorset. The west division covered Devon, Cornwall and the Isles of Scilly. The north division covered Bristol, Gloucestershire and Wiltshire. Each division was managed by a head of operations. Just prior to our inspection, South Western Ambulance restructured its divisions to operate as six counties and Devon as a county divided in two (north and south) – eight therefore in total.

The counties listed above are now run by eight county commanders with their divisional team. As this restructure was very new at the time of our inspection, we inspected and have reported on the previous divisional arrangements of east, west and north.

Within each division, ambulance stations were managed in sectors by operations managers, while at station level operations officers provided day-to-day management, including incident support at serious incidents.

There were 94 ambulance stations and 1,117 vehicles trust-wide. The vehicles available included:

- 369 ambulances
- 191 rapid response vehicles
- 7 motorcycles
- 13 special event vehicles

Other vehicles included pool and lease cars, training simulators, urgent care vehicles and fleet vehicles.

The trust provides the clinical teams for six air ambulances (two in Devon, one in Cornwall and the Isles of Scilly, one shared across Dorset and Somerset, one in Wiltshire and one based near Bristol).

The trust employs over 4,000 mainly clinical and operational staff (including paramedics, emergency care practitioners, advanced technicians, ambulance care assistants and nurse practitioners), plus GPs and around 2,785 volunteers (including community first responders, BASICS doctors and fire co-responders).

During the inspection visit, the inspection teams:

- In the east division visited ambulance stations in Yeovil, Taunton, Illminster, Sherborne, Shepton Mallet, Glastonbury, Dorchester, Weymouth, Weston-super-Mare, Frome, Poole, Castle Cary, Bridgwater, Blandford, Axminster and Dawlish.
• In the west division visited ambulance stations in Plymouth, Torquay, Totnes, Dartmouth, Paignton, Bodmin, Liskeard, Exeter, Tavistock, Okehampton, Exmouth, Ashburton, Barnstaple, Bideford and Cullompton.
• In the north division visited ambulance stations in Bath, Bristol, Trowbridge, Swindon, Stroud, Keynsham, Soundwell, Staverton, Dursley and Almondsbury.
• Talked with 17 patients, 14 relatives and one carer.
• Observed staff giving care to patients.
• Reviewed 18 sets of patient records.
• Inspected 40 ambulances and their equipment.
• Reviewed medicines storage in 32 stations.
• Looked at trust policies and performance information from, and about the trust.
• Spoke with 155 members of staff at a variety of grades including paramedics, GPs, operations managers and officers, emergency care assistants, technicians, mechanics and administrative staff.

Is the service safe?

Mandatory training

Safety systems, processes and practices were developed using guidance from a range of sources. We saw the trust used, amongst others, guidance from the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) and the Resuscitation Council (UK). Changes and updates were communicated to staff in face to face training sessions, e-learning packages and through emails.

The trust’s training and development policy stated all emergency care assistants, technicians, advanced technicians, advanced nurse practitioners, nurses, paramedics, and specialist paramedics, no matter whether permanent or bank, must attend an annual classroom-based development. The trust training policy stated classroom training consisted of various subjects, as required by the trust during that period. A workbook containing training and information relevant to staff roles was also maintained by the individual staff members. These were reviewed along with other training records at appraisals to help ensure compliance. However, in one station we saw seven training books covering 2016 – 2019 in staff pigeon holes which were still awaiting completion. Staff told us these training books were reviewed as part of the appraisals process, so it was not clear why the books we saw had not been completed.

The trust provided mandatory training on an annual basis to all staff through a development day, and a further assessment day aimed to evaluate operational skills such as driving. Staff we spoke with felt both training days enhanced their learning and improved the standard of care given to patients. They said training was of good quality and was relevant to their role. Following the development day, staff completed an evaluation form to provide feedback on the content and delivery of the training which was used to inform future sessions.

The trust set a target of 85% for completion of mandatory training. Data submitted by the trust showed it was meeting this target for all staff and subjects, except for some support staff.

The trust had broken down their training data into three staff groups, which included the following job roles:

- Qualified: including paramedics, nurses and ambulance technician lead roles.
- Clinical support: clinical roles but not lead roles, emergency care assistant.
- Support: support service staff.

The breakdown of training compliance by training module for all staff in emergency and urgent care as of March 2018 is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Act</td>
<td>3,174</td>
<td>3,236</td>
<td>98.1%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>3,131</td>
<td>3,204</td>
<td>97.7%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>2,949</td>
<td>3,023</td>
<td>97.6%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Development Day</td>
<td>3,291</td>
<td>3,466</td>
<td>95.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>3,287</td>
<td>3,466</td>
<td>94.8%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Learning and Development Review</td>
<td>2,530</td>
<td>2,672</td>
<td>94.7%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>2,677</td>
<td>2,840</td>
<td>94.3%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Mandatory Workbook</td>
<td>3,021</td>
<td>3,332</td>
<td>90.7%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>3,021</td>
<td>3,332</td>
<td>90.7%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>3,021</td>
<td>3,332</td>
<td>90.7%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Preventing radicalisation</td>
<td>3,016</td>
<td>3,412</td>
<td>88.4%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The 85% training completion target was met for all training modules for staff in emergency and urgent care.

The breakdown of compliance by training module for qualified staff is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine management training</td>
<td>2,170</td>
<td>2,204</td>
<td>98.5%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental Health Act</td>
<td>2,185</td>
<td>2,236</td>
<td>97.7%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>1,960</td>
<td>2,016</td>
<td>97.2%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Mandatory Workbook</td>
<td>2,013</td>
<td>2,123</td>
<td>94.8%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>2,013</td>
<td>2,123</td>
<td>94.8%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>2,013</td>
<td>2,123</td>
<td>94.8%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Development Day</td>
<td>2,114</td>
<td>2,236</td>
<td>94.5%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>2,112</td>
<td>2,236</td>
<td>94.5%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Learning and Development Review</td>
<td>1,681</td>
<td>1,789</td>
<td>94.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>1,760</td>
<td>1,878</td>
<td>93.7%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Preventing radicalisation</td>
<td>1,942</td>
<td>2,246</td>
<td>86.5%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
The breakdown of compliance by training module for clinical support staff is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Act</td>
<td>989</td>
<td>1,000</td>
<td>98.9%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>989</td>
<td>1,007</td>
<td>98.2%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Learning and Development Review</td>
<td>849</td>
<td>883</td>
<td>96.1%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>961</td>
<td>1,000</td>
<td>96.1%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Development Day</td>
<td>1,158</td>
<td>1,208</td>
<td>95.9%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>1,156</td>
<td>1,208</td>
<td>95.7%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>917</td>
<td>962</td>
<td>95.3%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Preventing radicalisation</td>
<td>1,051</td>
<td>1,136</td>
<td>92.5%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Mandatory Workbook</td>
<td>914</td>
<td>1,070</td>
<td>85.4%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>914</td>
<td>1,070</td>
<td>85.4%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>914</td>
<td>1,070</td>
<td>85.4%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The breakdown of compliance by training module for support staff is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resuscitation</td>
<td>19</td>
<td>22</td>
<td>86.4%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Development Day</td>
<td>19</td>
<td>22</td>
<td>86.4%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Preventing radicalisation</td>
<td>23</td>
<td>30</td>
<td>76.7%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Mandatory Workbook</td>
<td>94</td>
<td>139</td>
<td>67.6%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>94</td>
<td>139</td>
<td>67.6%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>94</td>
<td>139</td>
<td>67.6%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The 85% training completion target was met for all mandatory training modules for staff in emergency and urgent care overall, and for both qualified staff and clinical support staff. However, for support staff the target was only met for two out of six mandatory training modules.

Source: Trust Provider Information Request – Mandatory training

There was central oversight of all training compliance. The trust had a system to monitor mandatory training and annual updates. Responsibility for attending training was held by the operations officers. Compliance was reported centrally, with the operation officers receiving a report of those staff who required an update. Training compliance was also monitored at a local level, and at one station we were shown a spreadsheet tracker. There was also a visual aid displayed prominently on a white board to remind support staff and to prompt staff members to attend annual updates.
In addition to development days, there were annual learning and development review shifts provided to frontline clinical staff. This provided each staff member with a day-long one-to-one learning shift. A learning and development officer worked with staff on a shift in their normal clinical setting. During the shift, statutory and mandatory assessments, such as manual handling, infection prevention and emergency driving were undertaken. Staff and development officers also discussed care pathways, continuing professional development, clinical assessment and reasoning skills, and staff wellbeing, amongst other subjects. Data submitted for all three divisions for April to July 2018 showed 26% of all 3116 staff had received a learning and development review.

Staff did not always receive effective training in changes to safety systems, processes and practices. The trust communicated changes to policies and procedures to staff through emailed clinical updates, which staff told us they did not always have time to read. However, we were told of a change to the clinical guidelines for resuscitation which required all staff to use an automated external defibrillator (AED) in automatic mode when first assessing a cardiac arrest. Staff explained they were confused, as algorithms referred to within the clinical guidance instructed staff to deliver a shock to a child based on four joules per kilogram of body weight. Staff explained that the new machines could not be adjusted for the electrical current. Staff also had access to JRCALC best practice guidance which stated that AEDs could be used for adults and children of all ages with paediatric pads (which lowered the strength of the shock delivered). We looked at the clinical guidelines which had not been updated to reflect the use of AEDs in paediatric resuscitation.

The trust did not always have assurance that clinical guidelines and updates issued to staff electronically were being read. At our last inspection we saw updates were issued regularly by email and printed copies were left on the table in the crew room to read. At this inspection we found this still to be the case, however staff had recently been given access to a new personal phone application which had been released by the JRCALC. The trust had spent time modifying the guidance to reflect trust policies, and as part of this had added clinical updates to the home page of the app. Staff had an option to indicate when they had read it, which in turn provided assurance to managers which staff had read an update and which hadn’t. This app had only just been released at the time of our inspection, so we were unable to gauge its effectiveness. Staff also had the option to access all clinical documents through the electronic patient record system, which meant staff always had portable access to the most up to date policies, procedures and updates.

Staff told us additional training had been put on which covered human factors in cardiac arrest, during which staff had expressed concerns about changes to the AED policy requiring all staff to start resuscitation in automatic mode. However, staff told us they did not receive any response to their concerns. We reviewed the clinical update sent to staff which stated staff could switch to manual mode at any point during the assessment if their clinical judgement deemed it necessary, however some staff did not seem to be aware of this.

At our last inspection we found staff across all divisions felt the provision of classroom-based training was poor. At this inspection, a significant number of staff still felt they would benefit from having an extra day of mandatory training. Senior staff told us they had received concerns about staff not receiving training in handling difficult conversations, which both managers and staff felt would be a welcome addition to the training days, but were not aware of any plans to incorporate this into the training at present.
Staff were given the time to attend mandatory training days. Training was provided both face-to-face and as on-line training. Staff we spoke to reported they were given the time to attend a yearly educational day, however they often had to complete the on line mandatory training in their own time. Some staff told us they sometimes struggled to get time on shift to complete training, however at three of the larger stations we visited we saw six staff completing training while waiting to be allocated jobs.

Training for staff on mental health and learning disabilities was limited. Staff completed mandatory training on the Mental Health Act and Mental Capacity Act, but they did not feel this training provided them with the appropriate skills to care for patients with mental health needs. Dementia and learning disability training was not mandatory and staff felt it did not meet their needs as staff found it difficult to apply the training to real life situations. Some staff lacked confidence in supporting patients with mental health needs or learning disabilities.

A three-week training course was provided at induction for driving under blue lights, after which staff were assessed every two years. Staff we spoke with told us they were unable to drive using lights and sirens prior to this training. Positive comments were made regarding the usefulness of the training. Driving skills were also evaluated on an annual basis as part of the learning and development day. The outcome of the assessment was shared with the individual and their line manager, and formed part of personal development reviews.

The trust had a responder governance policy which set the initial and ongoing training expectations for all community first responders. Staff were required to undertake three days of classroom training as an induction into the role. This included basic life support training, scenarios set to assist the understanding of the role, life support skills, conflict resolution training, and an overview of the systems and processes used by the trust. Thereafter, they were expected to attend proficiency assessment every six months. The policy stated, "Any responder who fails to achieve the required standard, or has not attended a proficiency assessment within seven months of their last course for responders and on an annual basis for establishment based responders, will be withdrawn from responding until the required standards have been achieved and/or training has been completed". We requested training records for community first responders. Data provided showed 657 community first responders had completed their training within the last 12 months out of 805 staff, and a further 35 were going through recruitment and initial training.

A personnel file update was completed at initial appointment for each responder to verify driving licence and vehicle checks had taken place and that they had completed an assessment of basic life support and use of an automated external defibrillator. These were repeated every six months as part of the ongoing training and gave officers assurance that volunteers continued to meet the required standards.

At our last inspection we saw the trust planned to introduce a nationally recognised level three certificate for community first responders, which was due to be delivered to new recruits from August 2016. The trust advised existing staff would migrate to this qualification with a target for all community first responders to complete over the next three years. We asked for data to show progress against this, but none was submitted.

**Safeguarding**

The trust had clear organisational arrangements for safeguarding, which was laid out in a safeguarding policy. The executive lead role, with the responsibility to champion safeguarding,
was undertaken by the executive director of nursing and quality. The head of safeguarding, supported by two named professionals, had responsibility for the management of safeguarding activity. This included developing and maintaining professional relationships with external partner agencies, providing advice to trust staff, developing high quality safeguarding training, sharing urgent safeguarding enquiries from external partners and contributing to statutory safeguarding investigations. The head of safeguarding also provided quarterly reports on safeguarding strategy and governance to the quality committee for scrutiny. Safeguarding was also discussed extensively in both the trust quality account and the annual safeguarding report. We reviewed both reports and saw detailed breakdown of safeguarding incidents benchmarked alongside previous years activity. The report also included breakdown of the types of safeguarding concerns and any significant learning.

There were systems and processes to keep people safeguarded from abuse. The trust safeguarding policy (updated and issued March 2018) described the legislation underpinning the policy, the guidance used to develop the policy, and the principles behind the processes it required. People who were covered by the policy were described in a good level of detail, as were those staff within the organisation (all staff and agents of the trust) who were required to apply it. The duties and responsibilities of the trust board and its executives, through to all operational managers, were clearly described. The policy went on to describe the differences between processes for children and adults who could be at risk from abuse. These followed different pathways and protocols as required by legislation and guidance. The trust safeguarding policy also detailed the expected actions to be taken in urgent and non-urgent situations. We heard examples when staff had acted on safeguarding concerns, ensuring all appropriate internal and external people were involved to help safeguard patients whilst also recognising the emotional impact these concerns can have. Staff provided several examples of when they had acted to safeguard both adults and children, such as patients living in self-neglect and refusing help, and children who were at risk of abuse.

The safeguarding policy described other trust policies, guidelines, clinical notices, and standard operating procedures to be considered alongside it. This included the detailed safeguarding referral process and the training strategy. The policy also defined the trust’s duty, as with all NHS trusts, to identify named professionals for safeguarding, and described their roles. A named professional is a senior person responsible for ensuring safeguarding procedures are followed throughout the organisation. The annual report to the board listed the appointed named professionals for both children and adults as required. Alongside these staff, the trust had recently appointed a senior manager to the full-time post of head of safeguarding.

The trust understood the scope of safeguarding people at risk from abuse. It had produced and published a statement on its website recognising those people who could be subject to safeguarding, including victims of domestic abuse and radicalisation. The statement described the process we saw in policies and procedures, and staff talked with us about it. The statement also covered training staff to recognise abuse, including recent changes in the definitions, and their duty to report it.

Safeguarding systems, processes and practices were developed, implemented and communicated to staff. Staff had access to a safeguarding lead officer for guidance and information prior to reporting a safeguarding concern. The safeguarding team followed-up concerns and gave feedback to the staff involved. Staff said the system worked well and the safeguarding team usually contacted them after they received the concern.
Staff we spoke with understood their responsibilities and adhered to safeguarding policies and procedures. The trust operated a centralised safeguarding referral system. Frontline staff could submit concerns through a single point of access within the local council using the electronic patient care record or intranet. There was a decision tool incorporated into the patient care record which helped staff make a judgement about the need for referral. Staff we spoke with felt confident to report safeguarding concerns and felt supported to do so. We heard of an example of staff making a non-urgent referral to the multi-agency safeguarding hub; the electronic patient record captured their concerns and was shared as part of the written referral.

Staff received effective training in safety systems, processes and practices. The trust set a target of 85% for completion of safeguarding training which it met for all staff groups and levels, except support staff.

The breakdown of training compliance by training module for all staff in emergency and urgent care for the period from April 2017 to March 2018 is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Level 1</td>
<td>3,530</td>
<td>3,600</td>
<td>98.1%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Level 2</td>
<td>3,249</td>
<td>3,414</td>
<td>95.2%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The breakdown of compliance by training module for qualified staff is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Level 1</td>
<td>2,213</td>
<td>2,246</td>
<td>98.5%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Level 2</td>
<td>2,108</td>
<td>2,246</td>
<td>93.9%</td>
<td>85%</td>
<td>Yes</td>
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</tbody>
</table>

The breakdown of compliance by training module for clinical support staff is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Level 1</td>
<td>1,197</td>
<td>1,211</td>
<td>98.8%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Level 2</td>
<td>1,113</td>
<td>1,136</td>
<td>98.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The breakdown of compliance by training module for support staff is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Level 2</td>
<td>28</td>
<td>32</td>
<td>87.5%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
The 85% training completion target was met for both safeguarding training modules for staff in emergency and urgent care overall, and for both qualified staff and clinical support staff. However, for support staff the target was only met for one of the two safeguarding training modules.

*Source: Trust Provider Information Request – Mandatory training*

Systems, processes and practices protected people from abuse, neglect, harassment and breaches of their dignity and respect. These processes were monitored and improved. At the time of our inspection there was one serious case review being undertaken into the missed recognition of non-accidental injury to a baby. The investigation was still ongoing so the recommendations in response to the case review had not been finalised. However, the trust had taken some initial actions in response to the anticipated actions, which included posters and specific training which was due to be delivered later during the financial year. We saw these posters displayed in the stations we visited.

Information about safeguarding was shared with others in a timely way. The roll out of the electronic care system with the added facility of sending electronic safeguarding referrals made it easier for crews to complete referrals on scene using information from the patient care record. We heard discussion about a significant issue which occurred when there was a requirement to email the referral to the safeguarding team before closing the patient record. This requirement had been missed by many staff. This led to referrals ‘sitting’ on the server with no notification to safeguarding. As a result, a risk assessment was completed and the latest configuration of the electronic care system removed the need for an email to be sent. Staff reported this had been helpful in ensuring the referral was completed quickly and with greater accuracy.

There was a system to alert frontline staff to a safeguarding concern, which relied on the staff in the emergency operations centre alerting staff to any concerns such as violence or aggression. Operational staff we spoke with had mixed awareness of the system and many told us there was no electronic flagging system to inform them of any concerns.

Safety was promoted in recruitment for all permanent and bank staff. We spoke with staff who worked for the trust in a bank capacity, alongside their primary employment. The staff told us they had submitted their Disclosure and Barring Service (DBS) certificates to the human resources department for review before being allowed to have any patient contact. Managers told us they felt the system worked well and protected patients as not staff were able to have any patient contact until the trust had received and reviewed their DBS certificates.

Staff identified adults and children at risk of, or suffering, significant harm. Between April 2016 and March 2017, the trust made 14,110 safeguarding referrals, of which 3,677 were children and 10,433 were for vulnerable adults. This was a 36.5% increase on the previous year. The trust safeguarding quality account showed discussion for the reasons behind the increase including:

- The increase in training to crews with a willingness to report concerns
- Ongoing austerity and levels of deprivation
- Increased awareness in the general population highlighted by publicised cases
- Overall population increase in the over-65 age group

The chart below shows the top four themes which accounted for 50% of all adult referrals.
There were 3,677 child referrals for 2016/17 with a rise in self-harm reported, whilst domestic abuse, lack of supervision and neglect were also in the top four, comprising 47.5% of all child referrals.

The level of safeguarding referrals had increased over the past five years. The trust said this was a result of the duties laid out in the Care Act 2014, improved training for staff, and safeguarding
prompts from the electronic patient care records. Referrals for children had roughly doubled, and for adults’ referrals had roughly tripled across the five years. The head of safeguarding explained some of the referrals had been from crews attending an adult patient and recognising concerns with a child or children in the family.

Staff had awareness of how to identify and deal with concerning situations at the locations they attended including patient’s homes and care homes. For example, the trust liaised with acute hospital emergency departments, GPs and other out of hour’s services to coordinate arrangements for the protection of vulnerable children. There were referral pathways for vulnerable adults to provide extra support. Staff we spoke with found these easy to access. The information could be submitted via the electronic patient record. The electronic patient record also brought up the contact details for services based on the location of the crew, so they had access to information when working outside of their normal areas.

Staff had varying knowledge of different types of abuse. Training was provided in both female genital mutilation and sexual exploitation as part of level two safeguarding training, with further guidance provided on the trust intranet. We saw information was provided on staff noticeboards explaining how to safeguard women with, or at risk of, female genital mutilation. This was in line with Department of Health Guidelines. However, not all staff we spoke with had a good awareness of abuse and the identification of female genital mutilation and sexual exploitation, with some saying they could not remember receiving this training.

The trust supported staff through safeguarding supervision. This involved protected time for certain groups of staff dependent on their exposure to safeguarding issues, to reflect and contain any of their anxieties around working in such a high-pressured environment. In order that safeguarding supervision was undertaken effectively in the trust, a clinical supervision policy was agreed at the clinical effectiveness group meeting in December 2016. This enabled the safeguarding team to undertake supervision in a structured way, and record and send data to the learning and development team for centralised recording. All named professionals and the head of safeguarding received safeguarding supervision externally to the trust. In addition, the head of safeguarding had made supervision a priority for the named professionals for the current year, requesting they each take on six supervisees as practice influencers as part of their development.

The head of safeguarding and both named professionals had received formal safeguarding supervision from independent external supervisors.

**Cleanliness, infection control and hygiene**

There was a mixed picture with regards to cleanliness, infection control and hygiene. Standards of cleanliness and hygiene were maintained by external cleaners in the domestic and office areas of the ambulance stations. However, staff told us the cleaning of stock rooms and the garage areas fell to operational and clinical staff. At one east division station, we saw open plastic containers used to store stock items such as needles and cannulas. We saw the outer packaging of these items was dusty and the boxes used to store them had a thick visible coat of dust and dirt around the top. We did not see any cleaning schedules for stock rooms in any stations we visited, however some other stations had good storage arrangements and used clear lidded and labelled boxes to store all consumable items. Where required, surfaces were resistant to water and bacteria and easy to clean. In one north division station we found the floors, counters and windowsills in the consumables store room and the medicines storage room were not clean. The
floors also had decomposing dry leaves on them, which increased the risk of infection. Staff told us the leaves had been there since the previous autumn.

At one west division station we saw issues identified at our 2016 inspection relating to dirt from birds inside the garage had been addressed. Netting had been erected to prevent birds accessing the roof space and clean laundry was stored in cages inside a protected shelter. We also found the medical devices department in the same station had improved its infection prevention control standards since our last inspection.

A sterile non-touch technique (where physical contact with sterile items is minimised) was used when handling medicines and equipment; this ensured key parts of the equipment were kept sterile to avoid the spread of infection. However, on two occasions we found sterile items which had been opened and not replaced on board rapid response vehicles. On one vehicle we identified a grab bag (a collection of equipment for a specific clinical situation) prepared for a maternity event which had been opened.

In one station we saw a communications book for the contracted cleaner, however we did not see any other formal record or cleaning schedule. The cleaner in one station explained they used a colour-coded mop, mop-head and bucket system depending on the areas they cleaned, and we saw posters displayed to remind cleaners and staff which colour to use in which area. Data from the most recent quarterly station review showed none of the areas achieved the 90% target for average infection and prevention control cleanliness. The lowest performing areas were East Dorset and West Somerset, which achieved below 70%.

Most vehicles we inspected were clean and well-maintained and all equipment was in a good state of repair. However, we saw and heard of issues with ambulance cleanliness. We did not see any written cleaning records to indicate a vehicle was clean and ready for use. Staff explained that on a day-to-day basis, it was assumed a vehicle had been cleaned after the last shift. Staff told us there was no formal system (except the six-weekly deep clean) to record ambulance cleaning, although checklists were on display in each vehicle we inspected. These showed what should be cleaned and how often. On one occasion we observed there was a bag of rubbish left in the ambulance from a previous call, which had not been removed before attending further calls. Staff members stated vehicles were often not fit for purpose when coming onto a shift because they were dirty and untidy. This was due to staff not having the time to clean the vehicles at the end of a shift.

Ambulances were deep-cleaned every six weeks, or sooner if heavily contaminated. A dedicated 'make ready' team completed this. We saw documentation, which demonstrated all ambulances were within date for deep cleaning. These records were audited regularly and we saw copies of these audits, including the most recent audit results for yearly deep cleans. From April 2017 to March 2018 the trust was achieving 89% against a target of 90%. However, performance had worsened in the past two months with 81.8% achieved in February and 84% in March. At one north division station, we found one ambulance which had been 'made ready' three days prior to our inspection and had not been used for clinical duty. We found used gloves and tissues, and sweets on the floor of the cab which meant it could not have been cleaned properly. There were also used gloves in the top of the responder bag stored in the ambulance. A vehicle at another north division station contained dirty gloves and fast food wrappers on the dashboard. Data from the most recent infection prevention and control report showed that only three out of the 17 areas achieved the 90% target of vehicle cleanliness. The lowest performing area was East Cornwall, which achieved 76%.
Some stations did not have an onsite make ready team. If a vehicle required deep cleaning before the routine six-week clean, staff could contact the make ready team at another station to book this in. Staff explained they reported heavily contaminated vehicles to their managers. Arrangements were made to provide a replacement vehicle while the contaminated vehicle was deep cleaned.

Cleaning of vehicles between patients was the responsibility of the ambulance crews. Some staff told us they did not always have time to do this because of operational pressures. There was no protected time for staff to clean vehicles.

At our last inspection we found staff required to complete deep cleaning had not received any additional training in infection prevention and control since their inductions. However, at this inspection staff told us they had undertaken training specific to their roles and showed us a detailed checklist they followed when deep cleaning a vehicle. However, we did not see and staff could not tell us what was covered in the training. We also saw one vehicle which had just returned from a deep clean which still had a full sharps bin on board and two others with full rubbish bins which had not been emptied.

Staff maintained the cleanliness of their vehicles during a shift by stripping down stretchers and other moving equipment and decontaminating all surfaces with anti-bacterial wipes. Staff held a small amount of linen on the vehicles, but could obtain clean sheets and pillow cases from the hospital following a handover. Clinical waste bags and sharp bins were provided. We saw an ambulance arrive at an emergency department with a patient whose condition had resulted in the ambulance becoming contaminated. The crew informed the operations centre they were returning to station to carry out a thorough clean of the vehicle before they could be used for any further calls.

The management and disposal of clinical waste was not always carried out safely. Clinical waste bags and sharps bins were stored in separate bags and locked bins both inside and outside some stations. We found several secure storage bins were unlocked. In most of the west division stations, waste was segregated to ensure clinical products and sharps were correctly disposed of. We saw waste bins located on the ambulance with additional waste bags carried on board if required. Waste was disposed of at the ambulance station where there were specific bins for different types of waste. However, at one station in the west division we found the bins had not been secured to ensure contaminated waste was not accessible. In another west division station, the lids to the clinical waste bins were open and in the infectious waste there was mixed rubbish including domestic waste. We also found one north division station which was not compliant with trust policy. We found an offensive waste container unlocked and not secure. This meant staff or contractors could be contaminated with potentially hazardous or infectious material.

We saw several orange clinical waste bags had normal household rubbish in them. A senior member of staff told us they often reminded staff not to dispose of household waste in the orange bags, and we saw posters reminding staff what to put in each bag.

Sharps bins were not all correctly labelled and the temporary closure mechanisms were not always used to prevent any possible spillage of contaminated equipment. This was not in accordance with Health Technical Memorandum 07-01 guidance ‘Safe management of healthcare waste’, Control of Substances Hazardous to Health and Health and Safety at Work Regulations. In three east division stations we saw sharps bins in clinical waste bags which had not had labels filled in correctly prior to disposal.
In two ambulances at two north division stations we found some sharps bins on ambulances were not appropriately closed. Also, in one of the stations we found a bin specifically for out-of-date consumables had three boxes of unused needles in it. There was no indication on the bag to alert people there were sharps within it. We raised this with a manager on site who said they would be appropriately disposed of.

In one of the large bins used for the disposal of sharps bins, we saw the labels on these had not been completed in full. For example, the member of staff who had used the sharp bin for the first time had not signed or dated this. We also found some that had not been signed or dated when they were closed. This was not in line with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 ‘Guidance for employers and employees’. Crews were made aware of specific known infection and hygiene risks associated with individual patients through the electronic patient care record. Crews said this worked well as they now had access to patient GP records as well as historical ambulance records. In addition, staff were made aware of outbreaks of infection within the local population via an on board electronic system. We saw a staff notice regarding measles in the area that detailed signs, symptoms, and the precautions to be taken.

Personal protective equipment was provided on all vehicles. This included gloves and hand gel. We observed staff washing or cleaning their hands after each patient and gloves were worn as required. We saw most staff used personal protective equipment appropriately, only wearing gloves during patient contact and when cleaning equipment.

The trust policy for infection prevention and control stated all clinical staff had to demonstrate regular hand-washing techniques and carry alcohol gel bottles on their person. Most staff could show us their personal issue antibacterial hand gel. We saw staff accessing hand wash basins within emergency departments and at other services and locations they visited. However, staff at one east division station told us they had bought their own personal antibacterial hand gel as the station had run out of stock.

Staff had a good knowledge of infection control processes. We observed all staff groups adhere to the policy to be bare below the elbow and actively gelling their hands before and after contact with patients. This was in line with the National Institute of Health and Care Excellence (NICE) Quality Statement 61 (Statement 3). In all the episodes of care we saw where staff treated or assessed patients in their own homes, staff always either washed their hands or used antibacterial gel.

Antibacterial hand gel facilities were available on most ambulances we inspected. However, we found a dispenser on board one ambulance was broken and another was empty. When staff on these ambulances handed a patient over to a hospital they cleaned their hands with soap and water and washed them again when they arrived at an ambulance station.

Hand decontamination audits were completed. We reviewed the audits for the year 2017/18 and found poor compliance with nearly all audit measures. The trust set a compliance score of 90% for each measure and recorded the following results:

- 69% hand decontamination compliance, with the worst results seen in two west division stations.
- 85% of staff were bare below the elbow.
- 53% of staff carried personal antibacterial hand sanitiser.
Furniture was mostly clean and in good condition, wipeable, and compliant with the Health Building Note 00-09: Infection control in the built environment. We observed staff wiping down beds after use. However, we saw incidences where blood pressure cuffs were not cleaned following clinical use. This increased the chance of cross-infection. We also found a patient trolley on board an ambulance had several small splits which posed an infection control risk as it could not be adequately cleaned.

Staff were responsible for maintaining their uniforms, and explained that trust policy required them to keep a full clean uniform on station in case their current uniform became contaminated and needed to be changed. Staff showed us their locker rooms and expressed concerns about not having enough space to store uniforms and footwear. Staff were provided with five sets of uniform and laundered them at home. Staff we spoke with reported they had enough uniforms to enable them to wear a clean set each shift. Additional uniforms were available at the stations we visited in case of a staff member’s uniform becoming dirty whilst on shift. Staff informed us if they required more uniforms they could easily order them from the trust. We saw bins in ambulance depots for uniform to be disposed of when no longer required.

Staff had access to the trust’s infection prevention and control lead nurse for advice and support if needed.

Environment and equipment

Station security did not always keep people safe. On several occasions we found stations with ground floor windows ajar when crews had left the buildings un-attended. At one west division station, three windows were open. Windows had restricted catches, however these were broken in all three instances. In one significant failure, an entire office was left open, including a security cupboard. The station shared an office within a local health centre. The inspector was led through a public area with no security doors, which led to the ambulance station office. The office had a digital lock, but had been left open. The inspector had access to uniforms, radios and other materials. This was of concern given the UK terror threat level of “severe”, meaning an attack was highly likely. Security of vehicle and equipment had been reinforced by guidance from various Government security agencies and we saw terror threat levels on display at ambulance stations across the whole trust on threat level boards. The crew arrived while the inspector was on site and it was apparent this office had been left open overnight, as they were the crew who had signed off the previous evening. When challenged, the crew said, “someone must have been in here”, but they took no actions to either report or secure the premises. We escalated this to the station manager and senior leadership team.

Vehicles and their contents were not always secure. At our last inspection we found crews were leaving ambulances unsecured at hospitals. This meant unauthorised persons had access to equipment and medication. At this inspection crews told us due to the tail lift system on the ambulances they generally found it difficult and time consuming to secure the rear of the vehicle after unloading a patient. They told us they would generally leave it open. In four vehicles inspected in the west division during the inspection, the electronic patient care record system was not logged off, meaning patient records were accessible.

At all the ambulance stations we visited vehicle keys were stored securely. Most stations had key safes in the garage areas where keys were stored. However, outside one emergency department, we saw a vehicle was left unattended with its engine running to keep the air-conditioning on inside the vehicle. This meant the ambulance could be accessed by unauthorised persons.
Most ambulance stations we visited were fit for purpose. Garage areas were generally tidy and free of clutter. We saw there were designated ‘in’ and ‘out’ routes for the ambulances and cars to follow. Décor in some of the older stations was tired, but most staff facilities were adequate and comfortable. However, at one east division station, we found the ambulances were too large to fit inside the garage and therefore had to be left outside. Other stations had limited space as they were designed and built many years ago and now more ambulances and cars had been added to the fleet.

Operational officers oversaw fire and legionella checks on a bi-weekly basis at ambulance stations. At the stations visited we saw varying evidence these checks were being carried out. At one east division station, we saw a fire risk assessment had been undertaken in August 2017. Fire drills had taken place six-monthly as per policy. However, we were not able to find records of emergency lighting and fire doors checks, which should have taken place monthly. In addition, fire alarm testing was not always completed weekly. Other risk assessments we saw at the station included a generic assessment, which included many topics. For example, health related issues and the use of some equipment. This was due for review in March 2019. Other risk assessments were in place, including using ladders, the roller doors and security.

There was a standard vehicle and equipment policy, which specified the range and quantity of medical devices and consumables carried on all trust vehicles. It also clarified the minimum standard of equipment that must be taken to the patient. Operational managers were responsible for ensuring the policy was complied with at their stations and that local monitoring procedures were being carried out. However, it was not clear how this was monitored at each station we visited.

The standard vehicle and equipment policy stated clinicians were responsible for ensuring all vehicles were equipped with appropriate, maintained, charged and functioning medical devices, in accordance with the equipment checklist, and for reporting any equipment defects. At the start of a shift, or at the earliest opportunity, staff were required to complete a vehicle daily inspection. A standard operating procedure required that if staff were unable to complete a full inspection, they should carry out minimum checks before mobilisation and a full inspection at the earliest opportunity. At our previous inspection, staff told us they were not always able to complete vehicle checks before being dispatched. We found 15 minutes protected time had now been allowed at the start of a shift to complete their checks, although some staff were still coming in early to ensure they were all done. In the west and north divisions, we found crews were regularly called out before they could make the checks. This meant at the time of leaving the station, the ambulance crew could not be assured they had all the required equipment. In these stations, we were told there was no standard checklist to complete, and we found no records in vehicles to show which checks had been completed, when and by whom. Staff told us that on each ambulance they had a white board where they wrote up any supplies that needed to be replenished during a shift. We saw this was being used in some vehicles across all three divisions.

The vehicle and medical device checks conducted by the ambulance crew were not always documented. This meant the trust could not be assured staff were completing safety checks in accordance with their standard operating procedures. All vehicles contained a log book where staff indicated vehicle, drugs and medical device checks had taken place. At our previous inspection, we found records of daily vehicle checks were not consistently completed. On this inspection, we found the trust had completed an audit of vehicle log books in May 2018 which showed that of the
vehicles inspected, 98% were visibly clean and 92% had evidence of the vehicles last deep clean. However only 65% of the vehicles inspected had the log book filled out.

The maintenance and use of equipment kept people safe. The trust required all medical devices to be checked daily by operational crews at the start of each shift. Every 42 days (six weeks), a secondary check was undertaken by the make ready operatives in line with the vehicle deep clean schedule. Make ready staff removed any medical devices which were required for servicing within the next six-week period (or any that were found to be overdue). Medical devices were recorded on the trust electronic asset management system by unique asset number (and serial number if available), make and model. This system allowed the trust to keep records of the details of servicing and repairs.

Medical device exchange stores were located across the trust to enable crews to replace equipment. Crews left defective devices for collection and repair and replaced them with other units from the store. Mobile and vital signs monitoring equipment were under contract from the suppliers for maintenance and servicing. The trust’s logistics desk supported a manufacturer approved first line fault diagnosis process where staff could swap devices if necessary from a stock held in a ‘spares safe’.

At several stations we visited, we inspected the medical device equipment exchange store. These were locked and some were monitored with closed circuit television. Staff we spoke with said if equipment was faulty it was repaired according to the manufacturer’s instructions. A label was attached to identify it was faulty and the nature of the fault. It was then logged in a register and left in the storeroom where it was picked up by the trust fleet services and returned for repair. Staff said the system worked well. However, we saw variations in practice across the stations we visited. For example, some stores were well-organised with specific areas for faulty equipment, while others had faulty equipment stored with replacement equipment. We also saw at some smaller stations without a medical device equipment exchange store that a small stock of the most frequently used equipment was available so staff could replace any faulty equipment quickly. The designated equipment member of staff visited each station several times a week to collect faulty equipment and return repaired equipment.

The trust managed its selection of medical devices through the Vehicle, Equipment & Uniform Working Group. Operational staff formed part of a user panel to help inform procurement.

The trust invited an external audit company to undertake an external audit of the medical devices. This provided external and independent assessment of the current system. This audit showed the devices in use throughout the trust were not traceable. Devices were allocated to an area rather than a vehicle and, due to operational requirements, medical devices moved between vehicles and areas to replace failed or missing equipment. The audit acknowledged the trust was looking at a new barcoding system the Department of Health was planning to introduce nationally by 2019 to improve traceability of medical devices. The lack of traceability was raised as an issue at our previous inspection.

Systems for the management of equipment did not always keep people safe. Single use items were not always replaced prior to expiry dates. We checked the equipment on ambulances and found medical devices were working correctly, but some were outside of their servicing dates. When we checked rapid response vehicles, we found several expired items including paediatric airways, which expired in November 2017. Single use items have an expiry date stated by the
manufacturer, after this date the integrity of the item cannot be assured. We brought this to the attention of the crew at the time of our inspection; the items were replaced before we left.

We looked at devices and other equipment and found some equipment was past its servicing date. In one ambulance in the north division, there was a scoop stretcher with no service date. There was also a fire extinguisher in the cab of the ambulance which did not have a service due date on it. This meant crews were unable to identify if the equipment was safe to use. We also found multiple additional examples of equipment which had expired service or use by dates.

We were told staff had raised incidents where staff had found equipment missing from the ambulance that was supposed to be checked and supplied by the make ready crew. This meant there was a risk equipment and consumables would not be available for patients when needed. However, we did not see any of the incident reports to support this, and staff were unsure if anything had happened as a result of the incidents they had raised.

Consumables on ambulances were not all within their expiry date. We found numerous consumables at different stations to be out of date. There were several out of date consumables on one ambulance, including two paediatric oxygen masks, a tracheal intubation tube and an oropharyngeal airway device. There was also a selection of consumables which had broken seals on them (such as oxygen masks and needles), which meant the crew member could not guarantee the device was clean or had not been tampered with.

In an ambulance in the north division, the crew found two out of date consumables, one of which was a month out of date. This was removed and replaced with an in-date item. However, these items were discovered after attending their first patient of the day. This meant there was a risk out of date consumables could be used on patients.

In one station, staff explained consumable stock items were reordered through an orders book, and day-to-day stock rotation was the responsibility of the crews. In several stations we visited, we found out of date consumable items, including airways, cannulas and dressing packs. At one station, we found 27 cannulas about to go out of date at the end of June 2018. We raised this with a paramedic on shift who shrugged and walked away. We also found sodium chloride, which went out of date in March 2018, February 2017 and December 2014 at different stations. Where we found out of date consumables, we raised this until the items were removed from use.

Equipment had been standardised across the trust since our last inspection. Crews now carried all equipment in a set of smaller bags. We were shown two of the bags; one contained a standard set of medicines and the other held emergency equipment. Trust policy required the bags to be packed in the same way so staff knew exactly where to locate equipment they needed. It was the responsibility of the crew to check the contents of the bags at the beginning of their shift. However, we saw at one station cannulas were kept in the pocket of the bag where policy stated airways should be stored. Some crews said this was a problem when they worked at other stations because it created a delay in finding equipment.

Staff told us of some recent changes to the use of some pieces of equipment. In one example, staff told us grey cannulas were being phased out, as they were not frequently used. However, two paramedics told us of some maternity-specific training they had attended which encouraged the use of grey cannulas in some situations. Another example was around the removal of a piece of equipment used to monitor carbon dioxide levels in patients. Some crews told us they had not seen the update about why this decision had been made, and had only realised they had been removed when undertaking their daily vehicle checks.
Staff expressed concerns about not having enough of some equipment available. For example, standard equipment for ambulances included a piece of equipment used to help insert artificial airways into patients. One crew reported having to find one at another station before booking on. On another ambulance we inspected we saw it did not have an aerial, which could potentially lead to communication issues and affect the safety of patients and staff.

The trust’s fleet department carried out service and maintenance of stretcher trolleys and carry chairs. Equipment was labelled with an identifying bar code label, detailing the date of the last service and the date of the next service. At our previous inspection when we checked vehicles with staff, they appeared to take no responsibility for checking whether equipment was in date. We found this was now mixed and some staff told us and understood the importance of taking responsibility for the equipment on their vehicles, while others did not.

There was confusion surrounding the guidance and use of automated external defibrillators (AEDs). Trust policy required all staff to use AEDs in cardiac arrests. Staff expressed concerns that the voltage output on the machines was fixed at 120 Joules, and could not be lowered in line with some best practice guidance. However, we saw resuscitation kits contained paediatric pads, which lowered the current down to the recommended amount, which was in line with safe operating and manufacturer guidance. Not all staff were aware of this. The trust also had clinical guidelines, which covered adult and paediatric resuscitation. Guidance from the Resuscitation Council (UK) was quoted in the policy, which stated children under one year of age were to receive a shock equivalent to four Joules per kilogramme of body weight. The Resuscitation Council (UK) website stated the guidance as shown above but also said: “If using an AED for a child of less than eight years, deliver a paediatric-attenuated adult shock energy. If using an AED for a child over eight years, use the adult shock energy”. This additional guidance was not referred to within the trust’s cardiac arrest policy and could have been a point of confusion for staff. Since our inspection, the trust removed the additional guidance from the JRCALC app to ensure staff only followed trust clinical guidelines.

Vehicles were well-maintained. The trust had several garages in each area where vehicles were serviced and had the required road safety checks. We spoke with a lead for one of the garages who told us a list of vehicles requiring service was sent to them in advance so they could arrange for replacement vehicles. Each station was informed when a vehicle needed to be serviced or have a safety check. Spare vehicles were available. These garages also offered a 24 hour a day, seven days a week call-out service. If a vehicle broke down, one of the replacement vehicles would be used. At times, some vehicles had to wait for a service if replacement vehicles were not available. External contractors were used at times for vehicles under warranty or if they required bodywork repairs.

Vehicle servicing schedules were printed out each month. The full history of the vehicle was reviewed on the database prior to the vehicle coming into the workshop. This ensured staff were fully aware of what work was required and they could check required parts had been ordered and were available. Staff told us they kept the vehicles in the workshop for up to three days to complete the servicing and deep cleaning.

Faulty vehicle equipment was reported and replaced. An electronic system was used for reporting defects. These were also logged in the daily check book. Workshop staff raised concerns that sometimes clinicians did not report things through the electronic system. This potentially caused delays when the vehicle was brought in for routine servicing as the specific parts might not be available and the extra work not factored in. Staff told us reporting of repairs to fleet services for
maintaining their vehicles generally worked well. There were appropriate procedures to ensure
ambulances and rapid response vehicles were serviced and had valid Ministry of Transport (MOT)
test certificates. Records of these were kept electronically. We saw copies of service records,
which indicated vehicles were serviced regularly.

Where vehicle equipment faults were more serious, crews talked to their operations officer.
Decisions were then made to take the vehicle off the road. We observed how quickly a vehicle,
which had faulty radio, was taken off the road and assessed for safety, time off road and the cost
of repair. Staff were required to follow the vehicle off road guidance or contact control for
assistance. The trust’s policy stated that if a vehicle was deemed not roadworthy according to
Driver and Vehicle Licensing Agency (DVLA) standards, it would be removed from service
immediately.

The equipment for community first responders was asset tagged and linked to a database. We
saw a monthly update showing which equipment had been serviced, which we were told was sent
to the community first responders’ managers.

There was a standing operating procedure for the transfer and care of bariatric patients on
ambulance vehicles. Bariatric patients are defined as those patients who weigh more than 25
stone (158kg) or who have a body size or shape which may affect their transport or care.
Stretchers, which could carry bariatric patients, and vehicles, which could safely secure these
stretchers, were available at a number of stations in each locality. All carry chairs were suitable for
carrying up to 200kg, and all stretchers could carry up to 300kg. This significantly reduced the
need for bariatric specific equipment to be dispatched.

There were no specific vehicles to convey patients under the mental health act. If staff were caring
for a patient under the Mental Health Act who required transport and was not suitable for a normal
ambulance, ambulance staff would contact the police service for assistance. The trust was not
contracted to provide transport for this patient group currently as clarified in Schedule 2 (Service
Specification) of the trust’s 999 contract. If a patient required secure transportation this would be
directly commissioned by the Mental Health Trust. Where patients required transport under
Section 136, there were no commissioned arrangements to provide secure transportation.

Crews had access to satellite navigation systems, as set out in the 2015 Patient Safety Alert.
Crews reported no problems with satellite navigation systems and combined with their local traffic
knowledge, found the systems worked well.

Assessing and responding to patient risk

Comprehensive risk assessments were carried out for people who used services and risk
management plans were developed in line with national guidance. Staff managed risks positively.
Staff completed dynamic risk assessments when attending patients. They were aware of the
importance of constantly assessing risks and changes to these. In the north division, we saw
computer tablets were fitted to all ambulances where comprehensive risk assessments were
carried out. We reviewed six sets of records in the north division and found assessments
completed in all six. This included observations, medical history and electrocardiogram records.
The computer tablets also included many other assessments that could be completed depending
on need, such as venous thromboembolism, frailty and patients at risk of suicide.

Staff identified and responded appropriately to changing risks to people who used services. Crews
assessed patients using national early warning scores (NEWS), which gave patients a score
based on vital signs such as temperature and breathing rate. We saw one crew use this tool to help decide whether to convey a patient who they suspected was suffering from sepsis. Staff told us they had access to sepsis guidelines, which were promoted throughout the trust, as well as access to a sepsis lead and three consultant paramedics. We reviewed the results of an audit undertaken of the proportion of records with a NEWS score recorded and found only 66.2% had a score recorded.

In another situation, crews attended a patient with a known pregnancy complication. The patient was transported to a maternity unit as the crews felt the risk to the patient was low. Upon arrival at the hospital, crews and midwives had a difference of opinion regarding the risk and requested similar patients in future, were phoned in regardless of risk. Crews said this was often challenging as according to trust guidance they had assessed the patient and acted correctly. Crews told us each hospital maternity unit wanted crews to do something different when transporting non-emergency patients.

Staff recognised and responded appropriately when there was a rapid deterioration in the health of a patient. We saw this was mostly recorded accurately in the patient’s electronic care record. Patients were monitored to ensure the early detection of deterioration. On arrival at the scene, staff took a detailed history from the patient or relative while starting a series of physical tests and examinations. These included blood pressure, pulse, oxygen saturations and blood sugar levels. The physical observations were repeated throughout the course of the treatment and, if necessary, journey to hospital. We saw crews record low blood sugar for one patient and give them some sugary food to help raise this prior to transporting them to hospital.

There was an escalation process for deteriorating or seriously ill patients. If a staff member attended a patient and required additional support, this was requested through the operations centre who then deployed appropriate staff based on a priority score. We observed a single crewed paramedic car request additional support for a patient who was a high risk for cardiac arrest. This resulted in a double-crewed ambulance attending the scene and safely transporting the patient to hospital.

Patients were assessed against relevant protocols. Staff could access guidelines to assess patients. The guidelines used by the trust were based on National Institute for Health and Care Excellence (NICE) and Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines. Guidelines were available on the electronic patient record and we saw well-organised and up-to-date policy folders in most stations we visited. The trust had recently made a new personal phone application from JRCALC available to all staff. The application contained all JRCALC guidance, but also contained modified sections for trust-specific guidance. Staff told us the application downloaded automatically to their phones so guidance was available in areas of little or no mobile data coverage.

When appropriate, some staff made good use of ‘special notes’ to assess and respond safely to patient risks. A warning flag system was used by the emergency operations centre to record and identify any risks for a patient. Warning flags were used to identify patients with known mental health diagnosis, learning disabilities and dementia, as well as patients who might present a risk to staff, such as a history of violent or aggressive behaviour. However, this information was not always passed onto the attending crews. This meant there was a risk that known risks were not always appropriately managed.
Special notes were also used as a method of communicating to a hospital’s emergency department before arriving at the hospital. This meant if important information was shared the receiving hospital could be more prepared to manage the patient’s care. If a crew member had a query or question about the best management plan, staff found they sometimes got a better response through the special note system than by calling the department.

Crews had access to specialist advice when on scene or in transit. Staff we spoke with were confident in escalation procedures and understood the processes for requesting advice or support through the emergency operations centre and clinical supervisors. We were told that if a team on site or while in transit needed specialist clinical advice, they could obtain this through ambulance control by asking to speak to a clinical supervisor. Staff told us this system worked well and there was always somebody to provide clinical advice when needed. In addition, in the east division, crews could contact the GP on shift in the responder cars between 10am and 8pm.

Action had been taken to address areas of potential high patient risk. We were informed there had been long delays out of hours in getting GPs to ring crews back with advice. As a result, a standard operating procedure was changed and required crews to contact the operations officer on duty if they were waiting for more than 45 minutes. The operations officer then contacted the on-call out of hours manager to chase the call back.

Community first responders (CFRs) and co-responders operated only within defined parameters set out by the trust. We spoke with staff who oversaw training and compliance for this group of staff, who told us patient records from CFR calls were regularly reviewed to ensure on scene treatment was appropriate. Staff also told us CFRs never attended calls alone and back up crews followed to formally assess and take over care of the patient. Review of care records completed by ambulance crews also gave managers assurance of CFR compliance with trust policy.

There was a mechanism to assess and manage risks when transporting patients experiencing a mental health crisis. Some staff were aware of the procedures to follow when transporting patients who were experiencing mental health issues. They told us this was based on knowledge gained through their training programme, which was included in conflict resolution training. However, despite receiving additional training, some staff told us they still did not feel confident dealing with patients experiencing mental health crises.

Staff could access advice when supporting a patient experiencing a mental health crisis. Staff told us they could access specialist support in their local areas. For example, in the east division, crews told us they could access mental health crisis teams; however, they could only assist with patients who were already known to them. In all other circumstances, the crisis teams advised transporting the patient to hospital to gain access to assessment and treatment.

There were policies and procedures to manage disturbed behaviour, however, not all staff knew how to manage disturbed or unacceptable behaviour, or behaviour which was challenging. For example, staff we spoke with told us they had been given support from the police when they had experienced challenging behaviour from a patient as they had not felt confident to deal with the situation themselves.

Staff received some training to support patients with mental health problems including legal powers relating to transporting these patients. However, senior managers recognised that staff on frontline duties did not feel comfortable to deal with patients with mental health problems. This had led to an over-conveyance of patients due to risk-averse assessments being made in too many
cases, which tended to give the patients what they wanted rather than what they needed, and reinforced negative behaviours.

Paramedics were supervised in many areas of practice. This extended to mental health support, and included how they performed in risk-taking, decision making, and their physical and behavioural handling of patients with mental ill health.

People were supported to make decisions in line with relevant legislation and guidance. Mental health was treated as a medical condition, and there was a medical health practitioner based in the emergency operations centre. Staff had access to out of hours and community adolescent mental health service teams. The trust also used an automated system, which listed different services that offered help for people suffering with poor mental health.

The trust did not have vehicles equipped for mental health patients. This was typical for ambulance trusts, and staff hoped the Ambulance Response Programme (ARP) would be an enabler to work towards providing these vehicles. The trust did not have any specialist paramedics trained in mental health. The Royal College of Emergency Medicine was looking at whether to extend holding powers to paramedics so they could detain patients in an emergency.

Staffing

Staffing levels and skill mix were planned and reviewed so people received safe care and treatment. The trust had sufficient numbers of staff to respond to emergency calls which kept people safe. The workforce was planned monthly with weekly calls undertaken to review and assess if the required workforce could be achieved and whether actual activity was in line with the projected activity.

The skills mix of available staff was evaluated daily by operational officers to identify any gaps, which were then escalated to more senior managers. When an issue was identified, solutions such as support from neighbouring teams or the relocation of staff to different vehicles were applied.

Staffing levels were reviewed daily by operational officers within each area of the division as part of a strategic teleconference with an operations manager. Where staff levels were below the anticipated number, for example due to short notice sickness, the impact was assessed with consideration for patient safety and possible solutions sought. We observed staffing levels at 97.87% against plan on 28 June, with the planned staffing ranging between 99.7% to 104.4% over the following days. Data regarding workforce levels was available throughout the day and monitored by operational teams. We were told if staffing reduced to 97% of the expected level, escalation policies would be invoked as additional resources would be required. We saw this was discussed on the daily commander calls and saw examples of where blanket text messages had been sent out to off duty and bank staff when staffing levels had fallen below this threshold.

Actual staffing levels and skill mix compared well with the planned levels. Staff at one east division station reported they had extra vehicles on duty for some shifts due to additional staff numbers. These were over their core number of staff needed to cover shifts.

The trust’s reported staffing numbers for emergency and urgent care in March 2017 and March 2018 are in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>March 2017</th>
<th>March 2018</th>
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</table>

61
The overall fill rate improved from 93.6% in March 2017 to 97.9% in March 2018.

The fill rate for qualified ambulance service staff was little changed at 99.9% in March 2018, compared to 100.8% in March 2017. The number of whole time equivalent (WTE) staff in post fell from 1,819.5 in March 2017 to 1,812.4 in March 2018.

The fill rate for NHS infrastructure support staff fell from 99.7% in March 2017 to 91.3% in March 2018.

The fill rate for support to ambulance service staff increased from 80.0% in March 2017 to 94.5% in March 2018.

There was a stable workforce. From April 2017 to March 2018 the trust reported a vacancy rate of 5.3% for emergency and urgent care services. This was higher than the trust target of 5%.

The vacancy rates broken down by staff group are shown below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Annual vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infrastructure</td>
<td>-0.7%</td>
</tr>
<tr>
<td>Qualified ambulance staff</td>
<td>1.0%</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>30.9%</td>
</tr>
<tr>
<td>Support to ambulance service staff</td>
<td>14.7%</td>
</tr>
</tbody>
</table>

The highest annual vacancy rate was for qualified nurses at 30.9%. However, this was against an establishment of only two whole time equivalent staff as of April 2018. The staff group ‘support to ambulance staff’ had an annual vacancy rate worse than the trust target. There were low annual vacancy rates for infrastructure and qualified ambulance staff.

Source: Trust Provider Information Request – Vacancy

From April 2017 to March 2018 the trust reported an annual turnover rate of 10.3% in emergency and urgent care. This was lower than the trust target of 15%.

The turnover rates broken down by staff group are shown below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infrastructure</td>
<td>17.8%</td>
</tr>
<tr>
<td>Qualified ambulance staff</td>
<td>9.9%</td>
</tr>
</tbody>
</table>

Source: Trust Provider Information Request – Total staffing
<table>
<thead>
<tr>
<th>Qualified nursing staff</th>
<th>156.9%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to ambulance service staff</td>
<td>10.5%</td>
</tr>
</tbody>
</table>

Although the turnover rate for qualified nursing staff was very high, as noted above qualified nurses made up only a small proportion of staff employed within the core service.

The turnover rate for infrastructure staff was higher than the trust target.

*Source: Trust Provider Information Request – Turnover*

From April 2017 to March 2018 the trust reported an annual sickness rate of 5.5%. This was higher than the trust target of 4%.

The sickness rates broken down by staff group are shown below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Annual sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infrastructure</td>
<td>2.3%</td>
</tr>
<tr>
<td>Qualified Ambulance Staff</td>
<td>5.3%</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>1.6%</td>
</tr>
<tr>
<td>Support to ambulance service staff</td>
<td>5.8%</td>
</tr>
</tbody>
</table>

Both qualified ambulance staff and support to ambulance service staff had annual sickness rates higher than the trust target. However, qualified nurses and infrastructure staff had sickness rates which were lower than the trust target.

*Source: Trust Provider Information Request – Sickness*

Cover was provided for planned staff absence. Staff had relief weeks planned into their rota patterns. When on a relief week staff were required to fill shifts vacant though planned absence. We spoke with staff who were on permanent relief as part of their working arrangements. These staff gave their availability to the trust one to two months in advance, and voluntarily picked up some of the vacant relief shifts. Staff told us bank staff were also used to fill relief shifts, but were often given first choice of shifts. This often left permanent staff to cover some of the less popular shifts, including night shifts.

Arrangements for using bank, agency and locum staff kept people safe. There were set requirements before staff could fill these temporary roles. For bank staff, this included references, identification checks, Disclosure and Barring (DBS) checks and proof of qualifications. For agency staff, this involved asking the agency for assurance these checks had been undertaken. Operations officers informed us bank and agency staff would be expected to undertake a certain number of shifts, as well as attending development days and learning reviews to continue to cover shifts.

The impact on safety was not always assessed and monitored when carrying out changes to the service or staffing. Following the 2017 rota review we were told vehicles had been redeployed from one rural station to another. Up until the review the receiving station had only provided daytime cover. Many of the staff working at this station were not able to work night shifts. The additional vehicle required a night shift to be covered, and as a result seven of the 13 staff stationed at the ambulance station left the trust. This included two qualified paramedics.

Rotas and shift patterns were mostly aligned to meet demand. The trust had undertaken a rota review in 2017. While staff had a primary rolling shift pattern, they expressed concerns over the
uncertainty of the relief weeks, and told us they had to constantly check their shift allocations for that week as they sometimes changed at short notice and without notification. For example, one staff member told us they “didn't bother checking their relief rota until the week before”. In addition, one member of staff who worked on a relief rota told us they could be sent to work anywhere within 30 miles of their base station. They reported there was a considerable difference in the number of late finishes they had when working on a rural station compared to urban. Staff told us the shift patterns had affected their work/life balance and they were unclear if the revised times of work had positively influenced the service received by patients.

The skill-mix on ambulances was planned and, where possible, a clinically qualified member of staff was placed on the vehicle. Between July 2017 and June 2018 93% of ambulance resources had a clinician on board. Clinically qualified staff included paramedics, advanced technicians and ambulance practitioners.

Staff did not always get adequate breaks. At our previous inspection staff told us they did not always get their breaks. We found this had not changed. Many crews we spoke with said they were not able to take their assigned rest breaks and frequently finished late. They reported that even when they were designated to take their rest break, it was sometimes cancelled and they were called back on duty. Break times could be interrupted if a response to life threatening illnesses or injuries was required. Crews were supposed to receive two 30-minute unpaid breaks during their shift. The first break occurred between hours three and five (on a twelve-hour shift), for which they must be returned to their base station. The second break took place between hours six and eight. This break could take place at the nearest station to their location, even though this may be some distance from their base station. It was not clear how the trust monitored interrupted or cancelled breaks.

Staff at some urban stations told us they felt things had improved since our last inspection. Crews could come back to their base station prior to the start of their primary break, which nearly all staff we spoke with said was an improvement. However, in response to data, ongoing concerns and some staff feedback, the meal break policy had been reviewed and re-issued during our inspection. As a trial, crews were to move away from the two 30-minute breaks to one 45-minute break. Other proposed changes included encouraging staff to take breaks closer to where they were rather than returning to base station. We saw comments from staff on an online trade union group expressing concerns that staff had not been consulted over the proposed changes.

Some staff we spoke with in the north division reported they were always stood down to have a break. This included giving them the time to return to station before the break commenced. A system had been recently introduced to ensure staff had breaks every three hours. If, for any genuine reason such as attending a patient, this was not possible, an enforced break was given every five hours. This meant the crew was taken off calls for a period. One member of staff commented having enforced breaks meant they had better wellbeing and could make better decisions, another member of staff commented “if you are thinking about food you can’t properly think about the patient”.

Although staff were given some breaks, they were not always given in the correct timeframe. Data supplied for January to June 2018 showed that only 53.22% of staff received their break within the correct window. We were therefore not assured staff received the required rest needed for optimal clinical performance.
Staff did not always get enough time off between shifts. Staff informed us they often worked more than their 12 hours shifts. This was due to finishing late when completing their work with a specific patient. Staff also told us that time towards the end of the shift was not always protected, which meant they often worked overtime. Two staff members told us they frequently worked an additional four hours of unplanned overtime a week. Other staff told us they had become reluctant to plan leisure activities after work due to the unpredictability of their finish time.

When staff finished late and were working the following day they did not always have the 11-hour break between shifts as required by Agenda for Change. In more rural stations we found staff were keeping logs of overruns (late finishes). In one station we found overruns of over three hours recorded and one entry claimed a crew had been allocated an urgent call one minute after the end of their shift. We were given another example where within the previous week crews had been sent on category two calls within the final 10 minutes of their shift, which had led to them being more than three hours late finishing. There were frequently not enough vehicles at some rural stations to allow on-coming crews to book on until the crews finishing their shifts returned to station.

In the west division we spoke with 10 staff who reported for the last working month that they had accumulated between seven and 18 hours of shift overruns. The trust tried to protect the last half hour of a shift so that only grade one or two calls were sent to crews; however, front-line staff felt that due to the nature of the triage system this included almost all the calls received.

Staff told us they had the option to take the extra hours as overtime or to start their next shift later. However, because staff often worked in pairs, they told us this sometimes created problems if they were not paired in the same crew. We saw one paramedic who was due to start late offer to accompany a technician to a category one call and heard the control centre tell the crew they could not authorise this as the staff member had not had 11 hours rest between shifts. Staff explained that although the control centre could not authorise the deployment, staff could override this in emergencies and this decision was documented by control room staff.

The trust did not audit their response to Resource Escalation Action Plan (REAP) levels to get assurance these were working. We asked the trust for this data and they told us they were devising a new escalation plan. This new plan would contain a response option, where teams would reply to advise that all actions had been considered or completed. It was thought this would provide an audit option to ensure departments were completing required actions.

**Records**

Patient records were legible, timed and dated. The Royal College of Physicians’ recommendations for general medical record keeping standards (2015) state the name and designation of the person making the entry should be legibly printed against their signature. Every page in the medical records should have the patient’s name and identification number. We reviewed six sets of records and found they were clear and complete with dates, times and who had carried out the care given. This also applied to electronic records.

People’s individual care records, including clinical data, were written in a way that kept people safe, but were not always stored securely. In one ambulance station we found old paper records and safeguarding referral forms in staff pigeon holes and lockers. This was immediately escalated to the operational officer for the station.
The trust used an electronic patient record form for all patients, which had been rolled out to all divisions since our last inspection. Each vehicle had an electronic pad, which was used for accessing and recording patient care records. Staff were positive about the electronic patient record form as it provided useful information about patients with pre-existing conditions and up-to-date information regarding end of life planning and resuscitation. We saw many members of staff use it to refer to earlier episodes of care and treatment for patients they attended. This provided staff with useful information regarding the patient’s medical history. Staff also showed us individual access cards which had recently been distributed. These allowed staff to have access to patient GP records. This system also allowed GPs to view ambulance records. We reviewed two summaries sent to patients’ GPs and found they contained drug interventions, treatment given and a care summary. However, it was not clear how staff who had not been on shift at the time of the card distribution were planned to receive their access cards.

Patient documentation was fully completed in a timely manner to ensure an accurate account of events was recorded. All clinical staff used and contributed to the patient record from the point of referral, up to and including handover to other services. The electronic record was initiated by the call handler. This was available for clinical staff when the case was allocated to them. The ambulance crew used this information to identify procedures which may be needed, and to inform their decision-making regarding possible causes and diagnoses. We also saw some of the special notes, which included, for example, information about previous admissions or allergies.

The document template on the electronic devices was organised into tabs and included prompts for specific clinical conditions. The content varied between adults and children, with the latter being divided into age ranges. This meant features were adapted for the specific patient age group. For example, pain assessments for children were displayed in pictures instead of a numeric range. The information captured within the patient record could be shared electronically with other providers who delivered care. For example, we saw electronic documentation was sent to GPs and emergency departments as part of the handover of care. This prevented repetition and allowed those delivering onward care to compare the condition of the patient over time.

All the information needed to deliver safe care and treatment was available to relevant staff in a timely and accessible way. Operational crews had access to the summary care record for a patient, provided they had the key information to do so (for example postcode, name, date of birth). The records provided staff with additional information on the patient, including their NHS number. However, the summary care record was not yet accessible from the emergency operations centre, although this was planned as part of the trust’s Commissioning for Quality and Innovation (CQUIN) targets for 2017-19.

When people moved between teams, services and organisations, all the information needed for their ongoing care was shared appropriately. We saw several transfers of patients’ records from the crew member who attended the incident first to the crew who were called to the incidents and took the patients to hospital. Since both crews could access all the electronic information, there was no physical handover. Instead, the receiving crew continued to fill out the same record. Records were passed to the relevant staff at the receiving provider. We saw staff completed records in detail when taking a history, during the treatment period and prior to leaving hospital. We saw the crews completed forms on the hand-held devices and they showed us how this information could be shared with other health care professionals. Once the crew member had completed their records the hand-held device could be send the form electronically.
Staff told us they had the ability to print their notes where paper records were still being used, and could hand over a duplicate copy to a member of hospital staff. The notes we reviewed were concise and provided sufficient detail on the care and treatment provided to the patient.

Any paper records were returned to the ambulance station and stored in secured bins. Once full, these bins were moved securely to the medical records department for processing. However, in one north division station we found a confidential waste bin to be so full that further confidential waste could not be disposed of.

All records followed the Joint Royal Colleges Ambulance Liaison Committee and National Institute for Health and Care Excellence guidelines. The trust had also developed their own guidelines for record keeping based on current best practice, which had been updated to reflect the rollout of the electronic records system. We reviewed 18 sets of electronic records and found they were all clear and complete, signed and had an identifiable patient number.

Regular records audits had been undertaken prior to the introduction of the patient electronic care record (ECR). These audits had been modified since the rollout to reflect the different categories and free-text boxes on the ECR. Data from the most recent audit in January 2018 showed a high level of compliance was achieved, with the recording of all seven key data fields examined. The trust reviewed 67,724 sets of electronic records and found three of the seven operational areas scored 100% across all measures. The other four operational areas showed mixed compliance. For example, Glasgow Coma Scale (GCS) recording was above 95% in all areas except one. In East Devon, the standard achieved was 93%. The compliance for respiratory rate recording was between 89% and 96%. All areas achieved above 92% for the recording of a patient’s pulse rate, whilst blood pressure monitoring was recorded in over 87% of all operational areas, except for East Devon (84%). The audit included recommendations, including helping operational managers and clinicians to develop other methods of feedback on clinical record keeping.

The audit also found results were not always recorded in the correct place. A recent audit into the use of free-text boxes on the records system showed 50% of records had free-text recorded when it should have been recorded in a more appropriate place. This was a decline in performance from 39% in the previous year.

The trust made sure up-to-date Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders and end of life care plans were appropriately recorded and communicated when patients were being transported. Staff could speak to clinicians based at the emergency operations centre for advice and support. Senior clinicians were also available to give support and advice for patients with complex needs. Staff we spoke with understood their responsibilities where a patient had a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order.

Records travelling with the patient were passed to the relevant staff at the receiving provider and signed for electronically. This indicated the patient had been formally handed over to the receiving provider.

There were arrangements for recording triage decisions for major incidents or mass casualty events. Triage cards were available to staff. These were nationally recognised and placed with a casualty to determine their treatment priority during a major incident.

**Medicines**

Medicines were not stored securely at all the stations we visited. We reviewed the storage arrangements for medicines, oxygen and pain-relieving gases. We found multiple examples where
medicines were not stored securely. For example, at one north division station, we found ambulances were unlocked and inspectors could access the medicines on board. At one north division station, we found the medicines cupboard on one ambulance was unlocked. This cupboard contained, among other items, liquid paracetamol, lidocaine and glucagon. If the ambulance had been left unlocked and unattended, these medicines could be taken. Staff told us they did not have the key to lock this cupboard if they needed to.

Medicines cabinets in most ambulance stations were locked. The codes to these cabinets were regularly changed. Where controlled drugs which required secure storage were stored in ambulance stations, they were stored in a locked room within a locked safe. Vials of controlled drugs were signed out by qualified ambulance staff and signed back in at the end of each shift by the individual crew member. We found these records to be clear, correct and well-kept. All the ambulance stations we checked had correct stock levels when these were checked against the controlled drugs registers. Where there had been a recording error, we saw from records this was identified during a stock check and was raised as an incident. However, in one station in the north division, unauthorised staff could gain access to the store room, where paramedic bags which contained medicines and prescription only medicines, were kept. We saw that although medicines were stored in a locked room, some medicines including oral morphine, diazepam and lignocaine were not further locked away to ensure only authorised staff could access them.

Controlled drugs were audited daily, and this was reflected in the controlled drugs book. All out of date medicines were also stored appropriately and audited. These medicines were collected by the medicine requisition officer to be destroyed appropriately. We saw an audit trail which showed this was happening.

Paramedics were permitted to carry a limited number of controlled drugs for administration on scene and during conveyance. When not on duty, the drugs were securely held at the station and were accounted for through a signing out and in process. The supply held by paramedics was audited monthly as part of stock control procedures. We checked the personal log books for three paramedics; we found all had been audited within the last month and were in good order.

Staff did not always monitor or record room temperatures within the buildings and at two stations room doors were held open. At three stations in the east division we saw controlled drugs cupboards and stores containing over 300 morphine ampules with no monitoring of room temperatures.

There were no dedicated medicines refrigerators at most stations we visited. Medicines, such as glucagon, which should be stored in refrigerators were stored in a medicines cupboard but with a shortened shelf life, as per manufacturer’s instructions. However, we did not see any formal recording of temperatures in the rooms where medicines were stored. This meant staff would not necessarily be aware if there had been a temperature spike which may affect the shelf life of other medicines stored in the room, although we did see escalation procedures printed and on display in most stations we visited.

All medicines used within healthcare are issued with an expiry date. When the date has lapsed, the quality of the product cannot be guaranteed and the product must be disposed of. During our inspection, we checked a sample of expiry dates of medicines held at ambulance stations and on vehicles. We found all medicines were within date, except for four vials of sodium chloride which were stored on a response vehicle at one station. We brought our findings to the attention of staff who promptly acted on our concerns and replaced the medicines.
Medicines-related stationery was not always managed in a way that kept people safe. At our previous inspection in May 2016, we saw at a few large ambulance stations the controlled drugs register containing patient identifiable information was accessible by all staff. At this inspection we saw that whilst these records were now out of sight at large ambulance stations, at a few smaller stations these records were still accessible. For example, in one station we were told by crews that they re-stocked their bags and used the controlled drugs register in the coffee area of the station as the work surface area in the medicines store room had been reduced in size.

Medicines were stored in sealed bags on the vehicles. At each station staff prepared, checked and sealed these tagged bags. At the beginning of a shift they checked the bags had green tags and were fit for use. At the end of a shift, or during a shift if used, bags were checked and repacked. Staff expressed concern about the risks of packing errors occurring at the end of a shift that may have also overrun because staff may pack bags in a hurry which could lead to errors. The trust had established an easy to use and practical tagging system for the medicine bags and pouches used by crews and paramedics. A red tag indicated a need for repacking for various reasons, such as medicines being used or out of date, and a green tag indicated it had been quality checked and contained full stock. However, we conducted an audit of four paramedic bags and found two had the wrong quantity of medicines and incorrect expiry dates recorded. Two of the paramedic bags had the green seal tag broken. At one station we saw crews had used red tags for re-stocked bags because they had run out of green tags. This risked confusion, especially if staff did not work at that station regularly, and potentially placed patients at risk.

We were informed of incidents where staff members had not restocked the medicines bags correctly but had placed a green tag on the bag to indicate it was fully stocked. This had led to crews not having the medicines required for the clinical situation. On one occasion, we saw a paramedic administer some paracetamol and re-seal the bag with a green tag without re-stocking the bag. This meant other staff may have thought the bag had the right number of medicines in when it did not. We were informed some of these issues were raised as incidents, but the process had not changed and was not audited to ensure compliance. However, we did hear in one station how staff who had not been restocking bags correctly were spoken to by the drug management team. If they had then continued to not restock the bags, the issue would have been raised with the operations officer.

Medicines were appropriately prescribed, administered and supplied to people in line with the relevant legislation and current national guidance. The trust purchased medicines from the NHS hospital pharmacy service. These purchases included pre-packs of medicines to treat patients for specific conditions, either as single doses or TTO (To Take Out) packs. Nominated staff at each ambulance station monitored stock levels and expiry dates of medicines. Staff at the trust’s medicines distribution centre supplied medicines to the ambulance stations against completed requisition forms. Staff at the medicines distribution centre remotely monitored the stock held at the ambulance stations. This allowed the medicines team to redistribute stock if limited stock was available, or to transfer short-dated stock to a station where it may be used before it expired.

People received specific advice about their medicines in line with current national guidance. Patient information leaflets explaining common conditions and the management and treatment of these conditions (including medications used) were available for staff to give to patients or their relatives and carers.
The trust made sure people received their medicines as intended, and this was recorded appropriately. Staff recorded the details of all administered medicines within the trust electronic patient record system.

Audits were carried out to assess for medicine compliance. A recent audit of clinical records showed 100% of the 67,000 records looked at had the time and route of drug administration. Drug dosage recording was also above the 95% target in all areas.

Medicines management policies adhered to best practice. Paramedics, ambulance technicians and emergency care assistants were supported to administer medicines via trust policies, guidelines and the UK Ambulance Services Clinical Practice Guidelines. Paramedics, via patient group directions, were authorised to administer or supply a wider range of medicines depending on their role, additional training and competency. Staff accessed these documents via the trust patient record system and a mobile phone application. Patient group directions (PGDs) provide a legal framework that allow the supply and/or administration of a specified medicine, by a named, authorised, registered health professional. The trust used PGDs to facilitate authorised paramedics giving urgent medicines to patients. We found where PGDs were available they had been appropriately authorised and were in date.

The trust had a process for the disposal of controlled drugs prepared for administration during treatment on scene. We observed paramedics disposing of controlled drugs into the sharps bins carried on board the vehicles. Cat litter had been placed in the bin to absorb the medicine and prevent re-use. We observed this process on one occasion and saw the drug name and quantity was checked with a second crew member who validated the discarded drug and witnessed the disposal. The description by most staff of how they would dispose of part-used syringes of medicines was in line with trust procedure. However, alternative disposal routes were suggested by some staff we spoke with, for example down a road drain. We also saw staff disposing of leftover controlled drugs in sinks and regular sharps bins.

The trust did not always exhibit good medicines management practice for the use of medical gas cylinders. The manufacturer delivered medical gases to agreed locations. Medical gases were not always managed appropriately, for example some gas stores could be driven into, lacked appropriate signage, or had cylinders incorrectly stacked. Medical gas delivery notes and cylinder wrappers had accumulated in some gas stores. However, in the 24 ambulance vehicles we looked at in the west division, which included eight rapid response vehicles, we found medical gases were consistently in date and stored securely.

Patients were informed about what medicines they had been given and why. Patients were also informed why other medicines may not be given. We observed a paramedic explain to a patient why they were unable to give them an anti-sickness drug. They clearly explained the risk posed based on the clinical situation, but reassured them they would discuss this with emergency department staff on arrival at the hospital.

**Incidents**

The trust managed patient safety incidents well and took appropriate action in response to significant incidents. They were reviewed annually as part of the patient safety and experience report, which was presented to the board. For the year 2017/18 there were 51 serious incidents, compared with 57 in 2016/17. Of those incidents, 21 related to delays, compared with 36 incidents during the previous year. Feedback from external stakeholders indicated 346 actions had been
identified as learning from serious incidents, which had been completed and closed. A further 49 were incomplete but within target date, and 94 were in progress but past their target date.

In accordance with the Serious Incident Framework 2015, the trust reported 17 incidents in emergency and urgent care which met the reporting criteria set by NHS England from June 2017 to May 2018.

The breakdown by incident type was as follows:

<table>
<thead>
<tr>
<th>Incident type</th>
<th>No. of incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sub-optimal care of the deteriorating patient</td>
<td>11</td>
</tr>
<tr>
<td>Treatment delay</td>
<td>3</td>
</tr>
<tr>
<td>Abuse/alleged abuse of adult patient by staff</td>
<td>1</td>
</tr>
<tr>
<td>Accident e.g. collision/scald (not slip/trip/fall)</td>
<td>1</td>
</tr>
<tr>
<td>Major incident/ emergency preparedness, resilience and response/ suspension of services</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>17</strong></td>
</tr>
</tbody>
</table>

*Source: Strategic Executive Information System (STEIS)*

From June 2017 to May 2018 the trust reported no incidents classified as never events for emergency and urgent care services. Never events are serious incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.

*Source: Strategic Executive Information System (STEIS)*

All staff we spoke with understood their responsibilities to raise concerns and record safety incidents, concerns and near misses. Reporting of incidents was via an electronic reporting system. All staff members we spoke with were confident in the process, and received confirmation emails that the incident had been logged. However, some felt at times they were too busy dealing with emergency and urgent work to report all incidents. In the 2017 staff survey, the percentage of staff reporting errors or near misses was one of the worst five results in the survey with a result of 79% compared to a national average of 82% (the higher the score meant more staff reported incidents). We were therefore not assured all incidents were reported and all learning was identified and acted on to prevent incidents occurring again.

Most staff knew what incidents and near misses they should report and how to report them. However, not all incidents that should be reported were being reported. We saw an outcome from an investigation around a faulty piece of resuscitation equipment which had been returned to the manufacturer following the initial incident. Several staff told us similar incidents with the same piece of equipment had happened to them and other staff they knew, however many told us they saw no value in reporting them as they felt the equipment would not be removed from use despite raising safety concerns to managers about it. We were shown emails from senior managers thanking staff for initially raising concerns about equipment, but we were told the concerns were never followed up.

Incident investigations were allocated dependent on the level of patient harm that had occurred. Serious incidents were investigated by a dedicated team, while managers with additional training examined all other incident reports. Incident reports were sent through the electronic reporting
system to senior staff and managers who reviewed them and, if necessary, investigated them. Once completed, they were sent to the quality and risk team who reviewed the reports and identified themes and patterns. Operational managers also told us they monitored incidents for themes and concerns.

The electronic reporting system required managers to complete the incident by providing feedback to the staff member who had reported it. Incidents could not be closed until the feedback box was ticked. Some staff said they received feedback, however a large number told us nothing had changed since our last inspection. Some staff we spoke with said they received little or no feedback from the outcome of investigation or from incidents they reported. Of the six members of staff we spoke with in the west division who had reported an incident, none had received feedback from the investigation and none could describe changes in the service which had been made as part of wider learning. This conflicted with the view of senior managers who felt the findings of investigations were shared with those who had reported the incident. Three staff members told us they did not report incidents because they saw “no point” as when they did receive feedback they found it dismissive and concerns were not addressed. Those staff who did receive feedback told us they felt it was a standard response.

There was an investigation of each serious incident, which followed NHS guidance for examining and reporting serious incidents. Actions were identified and these were followed until they were completed. We reviewed investigation reports and found they contained trust-wide recommendations, service line recommendations and local recommendations. They also had clear action plans which reflected the root cause and contributing factors. For example, following an incident involving a failed intubation on a child, practice was reviewed with a decision made that paediatric intubation would only performed by specialist critical care paramedics. Staff we spoke with knew about this change and why it had occurred.

The trust carried out a clinical review of delayed responses in June 2017 and found the results showed some incidents of delayed response and patient harm were not being recorded in the electronic incident reporting system. This had been escalated to the board and plans to re-audit were being developed at the time of our inspection.

During one of our shadow shifts with a paramedic on the response cars we were sent to the wrong address for a patient who was having difficulty breathing. The paramedic informed control immediately when we arrived at the wrong address. We obtained the correct address and informed the control centre. Following the call, the paramedic checked with control that this was to be reported as an incident and investigated. The patient did not suffer any harm due to the delay in the response car arriving at their address. Between June 2017 and June 2018, there were 40 instances where a vehicle had been dispatched to an incorrect location or address. When things went wrong, learning was shared to make sure action was taken to improve safety. Specific actions were identified to help prevent incidents occurring again and we saw these actions were shared beyond the team where the incident had occurred. Staff could tell us about learning from different incidents. For example, following an incident involving a head injury, staff told us the care pathway for head injury patients was revised and the learning from the incident incorporated and shared at a trust development day for clinical staff. Also, additional training in head injury management had been given to staff in one team, and there were plans to roll this additional training out across the trust. Staff also reported learning from incidents was shared through bulletins and emails, although not all staff had time to read these. These briefs also contained information of certain conditions to look out for, such as measles and sepsis. However,
some staff were unable to identify the link between the bulletin and learning from incident reporting. Some staff reported they rarely received feedback from incidents which involved other staff or other ambulance stations. This reduced the opportunity for learning for staff and did not act upon learning identified across the trust.

The trust had recently introduced a ‘quality buddy’ whose role it was to provide a link between the board and staff at operational manager level, and share learning from incidents and examples of excellence. A quality buddy had been assigned to each operational area. Reports were generated quarterly, which gave an overview of serious incidents and themes, adverse incidents, safeguarding referrals, duty of candour, complaints and compliments, patient engagement and a risk register overview. The scheme was developed to pick up an action from the last CQC report on the disconnect between operational managers and senior staff in relation to quality and risk. The scheme aimed to ensure operational managers had the right support and information to brief frontline staff. This scheme was intended to link the quality team with operational managers, and to date had been very well received within operations management.

The trust attempted to make sure staff on the front line knew about changes in policy or procedure that had been made following safety incidents or safety alerts. At several ambulance stations, there were clinical notice boards where clinical updates, messages and documents outlining learning from incidents were displayed. A quarterly report called ‘Reflect’ was produced, which reported on emerging themes and learning following incidents. We reviewed four copies of this bi-monthly newsletter. We saw details about incidents and learning from these and information about duty of candour. In addition, the new Joint Royal Colleges Ambulance Liaison Committee (JRCALC) phone application allowed staff to view and acknowledge clinical updates remotely. Trust-specific policies and procedures appeared on the home page of the app and were highlighted in blue and clearly marked unacknowledged if the staff member was yet to read the update.

Staff had mixed awareness of the duty of candour regulation. In the east division most staff we spoke with from all levels of the organisation understood duty of candour, when they would use it and the actions they would take. Staff were aware of their responsibilities surrounding duty of candour in the incident reporting policy and the serious and moderate harm incident policy, as well as via the trust bulletin. We saw in the annual patient safety and experience report and in feedback form local commissioners that in all 51 reported serious incidents, the duty of candour had been applied in all cases where is had been appropriate and possible to do so. However, staff in other divisions were not aware of what it stood for or meant.

Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person.

Staff were debriefed and supported after a serious incident. Several members of staff spoke about the support they received from senior managers following a serious incident and the changes made in practice. Other staff we spoke with informed us they had accessed the service and felt they had received good support. Staff received a telephone call from the welfare service if they had been involved in a serious incident and were appointed a welfare officer if required to provide ongoing support. Managers reported staff members received ‘hot’ and ‘cold’ debriefs following a difficult call out or incident. The staff we interviewed reported they had received these debriefs sporadically.
Is the service effective?

Evidence-based care and treatment

People's physical, mental health and social needs were holistically assessed, and their care, treatment and support was delivered in line with legislation, standards and evidence-based guidance. The service was provided in line with national guidelines including the National Institute for Health and Care Excellence (NICE) and the Joint Royal Colleges Ambulance Liaison Committee (JRCALC). Clinical staff had access to personal clinical guidance folders. Guidelines included pathways for the assessment and management of patients presenting with acute onset stroke symptoms and suspected transient ischaemic attack (TIA). We saw up-to-date, organised policy folders in stations. Guidelines were also available on the electronic patient record form. Most staff felt comfortable using pathways and had an awareness of the pathways available.

JRCALC was routinely used. At our previous inspection, we found the trust were planning to develop their own guidance and pathways in partnership with hospital trusts, which reflected local variations. We found this was established and saw on the newly released JRCALC plus application, trust variations were highlighted in blue. Staff said the introduction of the application would help them keep on top of clinical updates as they had access to it all the time. This included in areas of poor mobile signal as the application downloaded some content to the phone automatically. Remote working staff also welcomed the release of the updated trust application. Previously, staff had received all revised guidance on a weekly basis through emails, and some had reported struggling to stay on top of this, especially when busy.

We reviewed seven policies on the trust intranet and found most were in date. One policy covering waste management was due for revision in January 2018. Staff could access the system to view the policies and procedures at stations. However, in one of the medicines store rooms we found a printed copy of the medicines optimisation policy, which dated back to 2016. All staff we spoke with told us they would access polices electronically in the first instance to be sure they were accessing the most up to date version.

Protocols and procedures were reviewed and developed by a specific clinical team of clinical development officers. At the time of our inspection they were in the process of developing a pathway for hypoglycaemic (low blood sugar) patients. It was hoped this new pathway would enable patients to access diabetic nurses rather than needing a hospital admittance.

Staff could explain the policy for ‘see and treat’. Patients were supported at home in accordance with both JRCALC and NICE guidelines when it was safe to do so. For example, paramedics could supply a course of corticosteroids to patients who had recovered following an asthma attack, rather than taking them to hospital. We attended a call to a patient who was having a suspected allergic reaction. Staff assessed the patient and determined they were not, so gave them advice to manage their symptoms without taking them to hospital.

Staff could explain the procedure for not conveying patients to hospital and providing ‘see and treat’ care instead. There were pathways to reduce the number of unnecessary transfers to hospital. For example, the trust had supported staff to complete additional training regarding wound care. We saw immediate first aid and wound care being provided to a patient in their own home by a paramedic. We also saw two occasions where care was best provided by alternative services, such as the GP. Crews provided a verbal handover to the surgery, which was immediately supplemented with a copy of the written record.
The trust ensured patients had timely access to acute facilities. Suitable patients who had experienced a suspected TIA could be referred directly to an outpatient clinic. In one case, we attended a patient who had been seen previously by the service and had been attending these clinics, however they had called an ambulance because crews had advised them to do so if their original symptoms worsened. The crews contacted the hospital before arriving so they could take the patient straight for a head scan without having to wait in the emergency department first.

Treatment was provided to patients following trust policies and nationally recognised guidelines. For example, staff were aware of sepsis management and used appropriate assessment tools via the trust application based on the JRCALC guidance.

Technology and equipment was used to enhance the delivery of effective care and treatment and to support people’s independence. Staff who worked remotely had access to pathways on their hand-held devices. We observed staff asking questions about patients’ medical conditions based on these pathways to help with diagnosis and treatment. Staff told us they found these a useful aid and could record the patient’s responses on their devices. Ambulance crews could also send patient information related to their current condition, for example stroke or trauma, to the receiving hospital ahead of their arrival. This meant the hospital would be aware and prepared to receive the patient and have the required staff and equipment available in a timely manner to give the patient the best chance of survival or recovery.

The rights of people subject to the Mental Health Act 1983 (MHA) were protected but not all staff had regard to the MHA Code of Practice. There was a policy for patients experiencing mental health issues. This included information for transporting patients appropriately. Staff we spoke with said they had received training but not all were able to describe the actions they would take in these circumstances. Staff told us patients with mental health problems would usually be accompanied by their carer or a relative. Where patients were found to be alone, some staff said they used local police services to assist them if the situation required it.

Crews identified patients with mental health problems and acted accordingly. Staff were alerted through the electronic patient record form of patients with a mental health problem. We observed staff treating a patient with mental health problems and they followed trust policies and guidelines in the delivery of care. Staff told us they had access to mental health crisis teams, however in the east division the teams were only able to assist if the patient was already known to them. When suspected mental health issues were disclosed, the ambulance crew spoke sensitively to the patient and those close to them. The crew found out when the patient felt their mental wellbeing began to decline and what their triggers were. This information was passed onto the GP.

People were advised who to contact when they needed to seek further help and advised what to do if their condition deteriorated. In all see and treat cases we attended, patients were advised to dial 999 if their symptoms worsened. We also saw staff explaining about the 111 service which patients could access as an alternative to calling 999 if their condition was not serious.

The trust followed local policies and procedures for acute care pathways with location-specific information to the region. Guidance for ambulance crews included information about pre-hospital early warning scores, referral for acute ST-segment elevation myocardial infarction (STEMI), stroke pathways, maternity care pathways and tools for major trauma triage. The trust had direct access to specialist stroke services and the pathways for admitting patients to these were outlined in the trust clinical guidelines. Staff we spoke with were knowledgeable regarding stroke pathways, which ensured patients received prompt and appropriate treatment. Agreements were in place and
patients who were assessed as suffering a stroke were transported directly to the computed
tomography (CT) scanner as opposed to the emergency department. A CT scanner uses a
computer to take data from several x-ray images of structures inside the body and converts them
into pictures on a monitor. This enables clinicians to monitor the degree and extent of damage
potentially caused by a stroke and ensures appropriate treatment could commence without delay.

The trust ensured patients went to the most appropriate hospital for treatment. Staff we spoke with
had a good understanding about where patients were transported. This decision was based on
clinical need and services required. Staff also spoke about considering patient preference where
they could.

Suitable guidelines and protocols were available for children. We saw up-to-date policies for
treating children, and staff could describe how they would care for children. However, there
appeared to be mixed guidance around the use of automated external defibrillators (AEDs) for
paediatric patients. Trust policy quoted Resuscitation Council (UK) guidance where the electrical
shock was based on administering four Joules per kilo. JRCALC guidance stated AEDs with fixed
Joules could be used, but only with paediatric pads to attenuate the shock down to the appropriate
level for the age of the child. We saw the Resuscitation Council (UK) website had further guidance
around the use of AEDS in paediatric cardiac arrest, which was not reflected in the trust policy.
Since our inspection, the trust has removed the additional JRCALC guidance from the JRCALC
app, to ensure staff only followed trust clinical guidelines.

At the time of our inspection, we raised concerns regarding the communication of changes to
policies and procedures. We were told staff were notified of amendments via email, training and
newsletters. However, there was no assurance mechanism to guarantee those delivering patient
care were aware of changes, or understood the impact of their clinical practice. For example, the
policy for the use of AEDs had been updated and stated staff should use the defibrillator set to
automatic until enough competent clinicians were available to interpret the current heart rhythm
displayed on the electrocardiogram (ECG). The trust explained that the AEDs in use in the trust
advised a shock for ventricular fibrillation (VF) well within recognised thresholds where a shock
was likely to be effective. Manual override was not required for fine VF, as if the unit was not
advising a shock, it was below the level where research demonstrated that it would be effective.
The trust therefore concluded there were therefore no risks of missing a patient who may have
benefited from a shock by using the AED mode. However, we asked six members of staff for their
understanding of the policy, and received mixed responses. These ranged from only using
the defibrillator in automatic mode to initiating care in automatic mode and switching to manual when a
staff member could stand back from delivering patient care to carefully review the readings.

When patients were discharged into the care of other providers, a verbal handover was given to
the appropriate health professional. This discussion included a briefing on patient history, clinical
status, interventions, and any preferences expressed by the patient. We observed interactions
between ambulance crews and staff at receiving hospitals during rapid assessment. We found
information was communicated in a clear and concise manner. We observed how the information
was used to direct patient care, for example an immediate transfer to an area for further
assessment or minor injury pathways.

Enhanced clinical advice and support was available to staff. Staff we spoke with told us if
specialist clinical advice was needed they would contact the emergency operations centre and
speak with a clinical supervisor. They told us this system worked well and there was usually
somebody to provide clinical advice when needed. In the east division, staff had access to a GP
who worked as part of the GP responder service. There was a GP on shift everyday between 10am and 8pm who staff could contact for additional advice.

**Pain relief**

Patients’ pain was assessed and managed, particularly for those who had difficulties communicating. There were guidance and protocols for ambulance staff on managing patients’ pain. The guidance for pain assessment and the administering of pain relief was aligned with NICE guidelines. The electronic patient record had a dedicated pain tab, which contained a selection of pain scoring tools including the Abbey Pain Scale (observational and number-based scoring) for use with patients who were unable to communicate the pain they were in, and the Wong-Baker Scale (picture-based) for children. We saw ambulance staff responding to patients who were experiencing pain using these scales as an indication of severity. In one case, we saw crews administer ‘just in case’ pain relief to a patient prior to transporting them, to make their journey more comfortable.

Patients we spoke with told us they were asked about their pain and appropriate pain relief was offered and provided in a timely way. We observed staff using a pain score tool which rated pain from zero (no pain) to 10 (severe pain). The pain score was recorded on the hand-held devices.

Pain was assessed to determine the patient’s clinical status and to evaluate changing levels of discomfort because of further assessments and interventions. Where appropriate, patients were asked to mobilise to evaluate changes in pain on movement.

A safe method for administrating pain-relieving medicine was used, which followed a step-by-step approach to graduate the use of pain relief. Responses to medicines were assessed through physiological observations and patient feedback. Consideration was given to the management of breakthrough pain (where pain can flare up despite pain relief having already been given).

The trust had Patient Group Directions (PGDs), which increased the range of pain relief available for staff to give to patients. Based on the findings from assessment, pain relief was administered according to the severity of pain.

The trust carried out regular pain audits to ensure patients were receiving the most appropriate and effective medication. Results from the most recent audit into the assessment and management of pain in patients suffering a suspected STEMI showed that in 72% of cases patients received the full care bundle. On investigation of the remaining 28% of patients, it was identified that clinicians were heavily focused on administering morphine and that there was a general lack of consideration for alternative pain relief. The requirement for at least two pain scores was also identified as an area for improvement, as many clinicians would record one pain score without a subsequent assessment. In addition, the trust also performed a pain management for dementia audit, which highlighted a lack of use of the Abbey Pain Scale which resulted in less effective pain management in some patients. As a result, the trust had developed some additional online training for staff.

**Response times**

The trust monitored real-time performance against the Ambulance Response Programme (ARP) and took actions when performance dropped; however, response times were poor. At our previous inspection the trust had been piloting the ARP system, but had fully implemented it in November 2017. The system aimed to improve response times to critically ill patients by allocating appropriate resources when patients first contacted the service. The impact on patient care and
trust performance because of these changes was reviewed internally daily and reported to the National Ambulance Advisory Council (NAAC) for benchmarking against all other NHS ambulance trusts nationwide.

The trust also carried out several audits of specific patient groups, including stroke patients. Geographical modelling was used to help inform local commissioners about impacts of the work being undertaken by sustainability and transformation partnerships may have on travel times for patients.

All measures of ambulance performance were changed as part of ARP to reflect the new ways of working.

The charts and graphs below display how the trust was performing with their overall response times. It shows how long it took a qualified clinician to get to a patient. The information first explains the definition of emergency categories responded to. The 9th centile is a deeper review of performance within a given percentage of calls. This shows the trust was failing to get to patients within the target response times. This has the potential for increased mortality rates for patients who are most in need and at risk from delays in response times.

**Ambulance systems (AmbSYS) indicators prior to NHS England Ambulance Response programme (ARP):**

The indicators below were in use prior to November 2017.

This indicator measured the speed of all ambulance responses to the scene of potentially life-threatening incidents and measured whether those patients that were most in need of an emergency ambulance got one quickly.

1. **Category A, Red 1 (Cat A8 – Red 1):** incidents may be immediately life-threatening and should receive an emergency response within 8 minutes of the call being received in 75% of cases.
2. **Category A, Red 2 (Cat A8 – Red 2):** incidents may be life-threatening but less time-critical and should receive an emergency response within 8 minutes from 'clock start' in 75% of cases. Clock start was a maximum of 60 seconds after the call was received.
3. **Category A, Red 1 and Red 2 (Cat A19):** incidents may be immediately life-threatening and should receive an ambulance response within 19 minutes in 95% of cases.

The trust started participating in the Ambulance Response Programme clinical coding trial in April 2016. Under this programme the categories above were replaced with new call categories. Therefore, the trust supplied no data to NHS England for these three metrics from April 2016 until November 2017, when it started to submit data under the new ambulance systems indicators introduced under the ARP.

**Ambulance systems (AmbSYS) indicators introduced under the NHS England Ambulance Response programme (ARP):**

The following measures were introduced for this trust in November 2017 to reflect the new way of working under the ARP.

Performance should be seen in the context of the new system, which requires embedding into practice, and winter pressures. Performance standards were due to be reviewed by NHS England in spring 2018.
Under ARP four new categories of call were introduced with new national standards. Mean (average) and 90th centile measures were introduced to help improve performance management of response times.

Please note for category three and four calls there are no mean response time standards, just 90th centile measures.

- **Category 1: Calls regarding people with life-threatening illnesses or injuries** such as cardiac arrests and serious allergic reactions.
  
  These calls should be responded to in a (mean) average time of seven minutes, with 90% of all calls responded to within 15 minutes.

- **Category 1T: Life threatening illnesses or injuries with transport.**
  
  This is an additional category one transport standard to ensure these patients also receive early ambulance transportation.
  
  These calls should be responded to in a (mean) average time of seven minutes, with 90% of all calls responded to within 15 minutes.

- **Category 2: Emergency calls** dealing with conditions and injuries such as strokes, epilepsy and burns.
  
  These calls should be responded to in a (mean) average time of 18 minutes, with 90% of all calls responded to within 40 minutes.

- **Category 3: Urgent calls** dealing with conditions such as late stages of labour, non-severe burns and diabetes. In some instances, patients may be treated by ambulance staff in their own homes.
  
  90% of these calls should be responded to within 120 minutes (2 hours).

- **Category 4: Less urgent calls** dealing with conditions such as diarrhoea and vomiting and urine infections. In some instances, patients may be given advice over the phone or referred to another service such as a GP or pharmacist.
  
  90% of these calls should be responded to within 180 minutes (3 hours).

Please note, despite the charts below showing England average data from August 2017, the new ARP measures were only introduced to South Western Ambulance Service NHS Foundation Trust on 23 November 2017. Therefore, data for this trust is only available for the six-month period from November 2017 to April 2018, including a partial return for November 2017.

**Category 1 calls:**
The trust consistently failed to meet the seven-minute national standard for category one mean response time from November 2017 to April 2018. The trust also consistently performed worse than the England average over these six months. There was a trend of improvement from 10 minutes 27 seconds in November 2017 to eight minutes 32 seconds in April 2018.

Over the same period the trust consistently failed to meet the 15-minute national standard for category one calls 90th centile response time. The trust also performed worse than the England
average over these six months. There was a trend of improvement from 18 minutes 17 seconds in November 2017 to 15 minutes 50 seconds in April 2018.

The trust consistently failed to meet the seven-minute national standard for category one calls with transport mean response time from November 2017 to April 2018. The trust’s performance was worse than the England average in four of these six months, and very similar to the England average in the remaining two months. There was a trend of improvement from 14 minutes 35 seconds in November 2017 to 12 minutes 43 seconds in April 2018.
Over the same period the trust also consistently failed to meet the 15-minute national standard for category one calls with transport 90th centile response time. The trust's performance was similar to the England average over these six months. Performance was variable, with an improvement from 26 minutes and seven seconds in November 2017 to 23 minutes and 17 seconds in April 2018.

Category 2 calls:
The trust consistently failed to meet the 18-minute national standard for mean response time to category two calls from November 2017 to April 2018. The trust's performance was also consistently worse than the England average over these six months. The trust's best performance over this six-month period was for April 2018: 23 minutes 25 seconds. The trust’s worst performance was in December 2017: 37 minutes 16 seconds.
Over the same period the trust also consistently failed to meet the 40-minute national standard for category two calls 90th centile response time. The trust’s performance was also consistently worse than the England average over these six months. The trust’s best performance over this six-month period was for April 2018: 48 minutes 24 seconds. The trust’s worst performance was in December 2017: one hour, 17 minutes and 27 seconds.

**Category 3 calls:**

![Category 3 90th centile response time chart]

The trust consistently failed to meet the two-hour national standard for category three calls 90th centile response time from November 2017 to March 2018. In April 2018 the trust met the national standard with a performance of one hour 58 minutes and 50 seconds. The trust’s performance was worse than the England average in three months and similar to the England average in the remaining three months.

**Category 4 calls:**
The trust consistently failed to meet the three-hour national standard for category four calls 90th centile response time from November 2017 to April 2018. The trust’s performance was also consistently worse than the England average over this period. The trust’s performance varied from three hours 32 minutes and 37 seconds in January 2018 to five hours 32 minutes and 25 seconds in March 2018.

We were told by several paramedics in different locations, and saw via a call holding screen, that category three and four calls were ‘held’ so crews were available for category one and two calls. While this prioritised responses to the most poorly patients, it meant a category three patient could wait for several hours before being responded to. Staff felt was bad practice and led to poor care for those patients.

We asked a county commander and deputy county commander what the trust was doing to improve response times. They told us how the rural area creates its own difficulties and that initiatives such as changes to staff meal break times and ringfencing response cars were being implemented. It appeared additional resources were not an option and that most of the attention was being focused on improving staff efficiency. Feedback from frontline staff indicated they were constantly stretched and, except in the case of improving the quality of the triage system, there was no more room for improvement in this area.

**Patient outcomes**

Information about the outcomes of people’s care and treatment was routinely collected and monitored. The quality of care and patient outcomes were measured using Ambulance Clinical Quality Indicators for heart attacks and strokes. The trust scored poorly for patient outcomes.

There was participation in relevant quality improvement initiatives, such as local and national clinical audits. We saw the trust had carried out audits into stroke modelling, chain of survival, delayed responses and time to shock. The audits helped the trust inform commissioners and other
external stakeholders about geographical effects on response and travel times, and helped the trust focus on some essential internal improvements. The time to shock audit had resulted in significant changes to the trust cardiac arrest policy, requiring all staff to begin resuscitation with defibrillators in automatic mode. The chain of survival audit was focused on developing clearer guidance for staff in situations where resuscitation would not be successful.

Although there were areas of poor performance, action had been taken to try and improve performance. A project had recently been undertaken to determine what was causing delays at the scene for stroke and ST-elevation myocardial infarction (STEMI) patients. This project determined the main causes were:

- A fundamental delay in getting the right resource to the patient in time.
- An issue with response prioritisation in triage. Expectations were that the reprioritisation following the introduction of the ARP programme will address this with a change of priority from amber to red.
- Delays in conveyance from a double-crewed ambulance (DCA) not always being in the scene. This was also expected to be improved following the introduction of ARP and a larger fleet of DCAs.
- Issues with staff around recognition of symptoms. Training had been rolled out and was being embedded.
- Information in the patient record not always being completed. This led to incorrect data being captured. Changes to the patient records from February 2018 ensured records were not closed until they were completed.

Alongside this, information was given to staff to access the hazardous area response team if needed. These changes had resulted in improved performance with stroke patients being on scene for 33 minutes compared to 38, and for STEMI patients from 46 minutes to 42 minutes.

While the trust consistently managed a higher proportion of face-to-face calls without the need for transport compared to the England average, meaning less pressure on accident and emergency departments, all other measures performed poorly with limited improvement over time. This meant the trust had low patient survivability after suffering a cardiac arrest or stroke. Those who did survive sometimes endured a significant reduction in their quality of life due to delays in pre-hospital care.

The charts below show how effective they had had been in achieving the best survivability and outcomes for their patients.

Heart attack, or ST-elevation myocardial infarction (STEMI), is caused by a prolonged period of blocked blood supply to the heart muscle. It is therefore vital that blood flow is quickly restored through clinical interventions such as thrombolytic ("clot-busting") treatment or primary percutaneous coronary intervention. In addition to these primary treatments, patients with STEMI need to be managed in the correct way, including the use of an appropriate care bundle (a package of clinical interventions that are known to benefit the health outcomes of patients). For example, patients should be administered pain relief medicines to help reduce their ongoing discomfort.

Early access to reperfusion (the restoration of blood flow) or thrombolysis and other assessment and care interventions is associated with reductions in STEMI mortality and morbidity.
This indicator reflects the three key interventions undertaken by ambulance services for these patients that are known to influence outcome. The indicator will define those patients who receive the appropriate care bundle, those who have timely delivery to the cardiac catheter lab for intervention, and those who have timely thrombolysis.

**Proportion of patients with initial diagnosis of definite STEMI receiving primary angioplasty balloon inflation within 150 minutes (January to October 2017)**

From January to October 2017, the proportion of patients with an initial diagnosis of definite STEMI who received primary angioplasty balloon inflation within 150 minutes was consistently worse than the England average. The trust’s performance ranged from 67.8% to 79.9%. There was no overall trend in performance over this period.

Following an investigation into the reasons for this performance being consistently below the England average (see above), and changes to several key areas being made, the trust reported an improvement in February 2018 to 70.8%, March to 84.1% and April to 82.4%.

**Outcome for patients admitted to hospital with an initial diagnosis of definite myocardial infarction (November and December 2017)**

From November 2017 the metric above was superseded by two new metrics relating to patients in the Myocardial Ischaemia National Audit Project (MINAP). The new metrics measured are the mean and 90th centile time from call to help until catheter insertion for angiography.

Both metrics exclude patients:

- Under 20 years of age or with age not recorded;
- Where the time is not available, or not realistic (call to angiography times less than zero or more than 1,000 minutes);
- Already in hospital, repatriated after coronary intervention, self-presenters, inter-hospital transfers, and any other or unknown admission methods;
- With cardiac arrest before arrival at hospital.
The trust’s results for these two new metrics for November and December 2017 are shown in the tables below, together with the England performance for comparison.

**Mean time from call to help until catheter insertion for angiography for patients admitted to hospital with an initial diagnosis of definite myocardial infarction (hours:minutes)**

<table>
<thead>
<tr>
<th>Month</th>
<th>South Western mean</th>
<th>England mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 2017</td>
<td>2:21</td>
<td>2:12</td>
</tr>
<tr>
<td>December 2017</td>
<td>2:25</td>
<td>2:18</td>
</tr>
</tbody>
</table>

The trust mean was worse than the England mean in both months. There was a deterioration in trust performance from two hours 21 minutes in November to two hours 25 minutes in December.

**90th centile time from call to help until catheter insertion for angiography for patients admitted to hospital with an initial diagnosis of definite myocardial infarction (hours:minutes)**

<table>
<thead>
<tr>
<th>Month</th>
<th>Trust 90th centile</th>
<th>England 90th centile</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 2017</td>
<td>3:24</td>
<td>2:58</td>
</tr>
<tr>
<td>December 2017</td>
<td>3:17</td>
<td>3:07</td>
</tr>
</tbody>
</table>

The trust’s 90th centile performance was also worse than the England average in both months. However, the trust’s performance improved from three hours 24 minutes in November 2017 to three hours 17 minutes in December.

**Proportion of patients with a pre-hospital diagnosis of suspected STEMI confirmed on electrocardiogram (ECG) who received an appropriate care bundle**

From January to December 2017 the proportion of patients with a pre-hospital diagnosis of suspected STEMI confirmed on electrocardiogram (ECG) who received an appropriate care
bundle was consistently worse than the England average. The trust’s performance improved from 67.4% in January to 71.1% in December.

Source: NHS England – Ambulance Quality Indicators – Clinical outcomes

Following a cardiac arrest, the Return of Spontaneous Circulation (ROSC) (for example, signs of breathing, coughing, or movement and a palpable pulse or a measurable blood pressure) is a main objective for all out-of-hospital cardiac arrests, and can be achieved through immediate and effective treatment at the scene. The return of spontaneous circulation is calculated for two patient groups.

**ROSC Overall**

The overall rate measures the overall effectiveness of the urgent and emergency care system in managing care for all out-of-hospital cardiac arrests.

![Graph showing ROSC on arrival at hospital](image)

From January to December 2017 the overall proportion of patients who had return of spontaneous circulation (ROSC) was worse than the England average in eight out of 12 months. The trust’s performance was better than the England average in three months, and similar to the England average in one month. The trust’s performance varied from 25.0% to 33.4%.

**ROSC Utstein comparator group**

The rate for the 'Utstein comparator group' provides a more comparable and specific measure of the management of cardiac arrests for the subset of patients where timely and effective emergency care can particularly improve survival. For example, 999 calls, where the arrest was not witnessed and the patient may have gone into arrest several hours before the 999 call, were included in the figures for all patients, but were excluded from the Utstein comparator group figure.
From January to December 2017 the proportion of patients from the Utstein comparator group who had return of spontaneous circulation (ROSC) was worse than the England average in seven out of 12 months. The trust performed better than the England average in two months, and similar to the England average in three months. There was an improvement in trust performance over this period: four of the five months where the trust performed better than or similar to the England average were in the second half of the year.

The trust’s performance varied from 37.8% to 54.1%.

*Source: NHS England – Ambulance Quality Indicators – Clinical outcomes*

Coronary heart disease (CHD) is the single most common cause of death in the UK today, and the most common underlying condition that causes patients to die as a result of a cardiac arrest. The presence of a paramedic (or doctor) significantly improves response to, and outcome from, a cardiac arrest, as the paramedic or doctor on scene can begin advanced life support. By including both out-of-hospital and in-hospital periods of care, this measure reflects the effectiveness of the whole acute healthcare system in managing out-of-hospital cardiac arrests, reflecting the care delivered by ambulance services and acute trusts. Survival to discharge is calculated for two patient groups; the overall group, and the same Utstein comparator group.

**Proportion of patients who had resuscitation commenced/continued by ambulance service following an out-of-hospital cardiac arrest who were discharged from hospital alive – all patients**
From January to December 2017 the trust’s proportion of patients that had resuscitation and were discharged from hospital alive was worse than the England average in seven out of 12 months. There was a modest overall improvement in trust performance, from 8.2% in January to 9.1% in December.

**Proportion of patients who had resuscitation commenced/continued by ambulance service following an out-of-hospital cardiac arrest who were discharged from hospital alive – Utstein comparator group**

![Graph showing the proportion of patients discharged alive from hospital from January to December 2017.](image)
Over the same period the proportion of patients in the Utstein comparator group that had resuscitation and were discharged from hospital alive was worse than the England average in eight out of 12 months. There was an overall deterioration in trust performance from 27.1% in January to 25.4% in December.

Source: NHS England – Ambulance Quality Indicators – Clinical outcomes

As set out in the NICE national quality standard, the health outcomes of patients can be improved by recognising the symptoms of a stroke or transient ischaemic attack (TIA), making a diagnosis quickly, and early transport of a patient to a stroke centre capable of conducting further definitive care including brain scans and thrombolysis.

**Proportion of Face Arm Speech Test (FAST) positive patients (assessed face to face) arriving at hospitals with a hyper acute stroke centre within 60 minutes (January to October 2017)**

![Proportion of Face Arm Speech Test (FAST) positive patients (assessed face to face) arriving at hospitals with a hyperacute stroke centre within 60 minutes](image)

From January to October 2017, the proportion of Face Arm Speech Test (FAST) positive patients assessed face to face that arrived at hospitals with a hyper acute stroke centre within 60 minutes was consistently worse than the England average. Over this 10-month period there was a deterioration in trust performance, from 38.7% in January to 32.7% in October.

**Outcome from stroke: patients that were FAST-positive and / or had a provisional diagnosis of stroke (November 2017)**

From November 2017 the metric above was replaced by three new metrics. These related to the time from call for help to hospital arrival for patients that were FAST-positive and/or had a provisional diagnosis of stroke. Both patient groups are included in the new metric, because acute trusts can record equivalent clinical episodes under either of these two categories. Patients can be excluded if they are found to have had a transient ischemic attack (TIA) and their symptoms resolve while with the ambulance crew.
The three new metrics, all measured as mean, median and 90th centile, are:

- Call to door (Number of patients either FAST positive, or with provisional diagnosis of stroke, transported by ambulance service)
- Door to scan (timings related to stroke patients in SSNAP who had a CT scan)
- Door to thrombolysis (timings related to stroke patients in SSNAP who had thrombolysis)

The trust’s results for these three new metrics for November 2017 are shown in the tables below together with the England performance for comparison. Because of the SSNAP data collection timetable, data for December 2017 are not available at the time of writing. It is expected these will be published during the summer of 2018.

**Call to door:** time from call for help to hospital arrival for patients that were either FAST positive, or had a provisional diagnosis of stroke (hours: minutes), November 2017:

<table>
<thead>
<tr>
<th>Metric</th>
<th>South Western</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>1:20</td>
<td>1:13</td>
</tr>
<tr>
<td>Median</td>
<td>1:16</td>
<td>1:06</td>
</tr>
<tr>
<td>90th centile</td>
<td>1:59</td>
<td>1:49</td>
</tr>
</tbody>
</table>

For November 2017 the trust’s mean, median and 90th centile waiting times from call to help to hospital arrival were worse than the England performance for all three metrics.

**Door to scan:** time from hospital arrival to CT scan for stroke patients in SSNAP (hours: minutes), November 2017:

<table>
<thead>
<tr>
<th>Metric</th>
<th>South Western</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>2:50</td>
<td>3:03</td>
</tr>
<tr>
<td>Median</td>
<td>0:35</td>
<td>0:44</td>
</tr>
<tr>
<td>90th centile</td>
<td>4:10</td>
<td>3:58</td>
</tr>
</tbody>
</table>

For November 2017 the trust’s mean and median waiting times from door to scan were better than the England averages, but the 90th centile showed a worse performance.

**Door to thrombolysis:** time from hospital arrival to thrombolysis for stroke patients in SSNAP (hours: minutes), November 2017:

<table>
<thead>
<tr>
<th>Metric</th>
<th>South Western</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>0:53</td>
<td>0:54</td>
</tr>
<tr>
<td>Median</td>
<td>0:43</td>
<td>0:46</td>
</tr>
<tr>
<td>90th centile</td>
<td>1:29</td>
<td>1:33</td>
</tr>
</tbody>
</table>

For November 2017 the trust’s mean, median and 90th centile waiting times from door to thrombolysis were similar to the England averages.

**Proportion of suspected stroke or unresolved transient ischaemic attack patients assessed face to face who received an appropriate diagnostic bundle**
From January to December 2017 the proportion of suspected stroke or unresolved TIA patients assessed face to face who received an appropriate diagnostic bundle was worse than the England average in 10 out of 12 months. The trust’s performance was similar to the England average in April and December 2017.

Over this 12-month period there was an overall improvement in trust performance, from 96.3% in January to 97.4% in December.

*Source: NHS England – Ambulance Quality Indicators – Clinical outcomes*

**The proportion of patients treated and discharged at the scene who re-contacted within 24 hours (pre-ARP metric)**

The trust started reporting against the new ARP measures on 23 November 2017, and as a result stopped reporting against this metric at that time. Therefore, the trust figure for November below is based on a partial return for that month, and there is no trust figure for December.
From January to November 2017 the proportion of patients treated and discharged at the scene who re-contacted the trust within 24 hours was constantly lower (better) than the England average. There was a trend of improvement in trust performance, from 5.2% in January to 4.4% in November.

Source: NHS England – Ambulance Quality Indicators – Systems indicators

Of the calls that receive a face-to-face response from the ambulance service, proportion managed without need for transport to Type 1 and Type 2 A&E

Data for the trust for this measure is only available from 23 November 2017, when the trust started reporting against the new ARP measures. Therefore, the trust figure for November below is based on a partial return for that month.
From November 2017 to April 2018 the trust consistently managed a higher proportion of face-to-face calls without the need for transport compared to the England average. The trust’s performance was quite consistent. In November 2017 the trust managed 38.2% of face-to-face calls without the need for transport compared to the England average of 28.0%. In April 2018 the trust’s performance was 39.1% compared to the England average of 29.3%.

Source: NHS England – Ambulance Quality Indicators – Systems indicators

Competent staff

The systems and processes implemented by the trust ensured staff had the appropriate knowledge and skills to carry out their work.

All paramedics were registered with the Health and Care Professions Council (HCPC) and had completed an approved qualification in paramedic science, which could be a BTEC, diploma, the IHCD (Institute of Health and Care Development) award, a foundation degree or a degree. As part of continuing registration with the HCPC, paramedics were required to revalidate their registration every two years. As part of that process, they were required to undertake continuous professional development (CPD) and receive clinical supervision. This included self-reflection and reading journals. The paramedics and other staff we spoke with were up to date with their mandatory training, but clinical supervision was varied across the west region due to demands on the service.

People had their needs assessed and their preferences and choices were met by staff with the right skills and knowledge. For example, we spoke with an emergency care practitioner (ECP), who told us they were a qualified paramedic with additional training, for example, in wound care and catheterisation. They told us they kept their skills up-to-date as they also worked with the urgent care teams.

There were arrangements for supporting and managing staff to deliver effective care and treatment, which included one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and revalidation. Staff were required to complete an annual performance appraisal called a ‘career conversation’.

There was a mixed view from staff on the usefulness of appraisals. Some staff told us they had several appraisals a year and others told us there was limited time to undertake the appraisals. They told us they would often get interrupted. Some reported their appraisals were undertaken over coffee breaks.

From April 2017 to March 2018, 93.2% of staff working within emergency and urgent care services had received an appraisal. This was higher than the trust target of 85%. It was also a considerable improvement from the appraisal rate of 75.3% the previous year (April 2016 to March 2017).

Appraisal rates for 2017/18 broken down by staff group are shown in the table below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Number of staff eligible</th>
<th>Number of staff completed</th>
<th>Appraisal rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>31</td>
<td>29</td>
<td>93.5%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Support to ambulance service staff</td>
<td>751</td>
<td>700</td>
<td>93.2%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>-----------------------------------</td>
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</tr>
<tr>
<td>Qualified ambulance service staff</td>
<td>1,598</td>
<td>1,488</td>
<td>93.1%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2,381</strong></td>
<td><strong>2,218</strong></td>
<td><strong>93.2%</strong></td>
<td><strong>85%</strong></td>
<td><strong>Yes</strong></td>
</tr>
</tbody>
</table>

Source: Trust Provider Information Request – Appraisals

Staff had their learning needs identified and received appropriate training to meet them. During our inspection we saw several members of staff completing e-learning packages and checking emails. Staff told us they were expected to keep up to date with clinical updates during their working hours. Some staff expressed concerns that during busy shifts this was not always possible.

Staff we spoke with had variable responses when asked about the usefulness of appraisals. Some staff said they found them to be productive and drove development, whilst others reported the usefulness of them varied depending on who was undertaking them.

Staff working in small or remote teams were supported and could access training. Staff we spoke with who worked in smaller rural stations said they were well supported by their managers and had received an appraisal in the last year. They were kept informed of training opportunities through an internal web page and knew members of staff who had accessed these.

At our last inspection we found opportunities to access professional development training was variable. We found this was the same on this inspection. Some staff continued to raise concerns about the lack of additional role-specific training. They remained unhappy they had to complete training in their own time and some courses were not funded. Staff also told us that if they wanted to become a paramedic this had to be self-funded, which meant not all staff were able to access this course. However, other staff we spoke with said they were offered extra training courses, which were paid for by the trust and attended in work time.

Some staff felt encouraged and given opportunities to develop. In one station in the east division, staff told us they had been able to undertake mental health training specific to veterans to help them identify exact mental health conditions in this group of people. Other staff reported they were given the opportunity to undertake degrees, which were part-funded by the trust. However, they were not given time off to attend this training so had to complete it in their own time.

There were development opportunities for all staff. In the north division they had recently introduced the role of lead emergency care assistants. The aim of this was to utilise the skills and experience of emergency care assistants and provide another area of support and mentorship for the emergency care assistants.

Mentors were available to support new and existing staff. Following induction training, new staff were allocated a mentor. Mentors were paramedics who had undergone additional training to become paramedic placement educators. Mentors rostered their shifts so they could work with and provide support to newly registered staff.

Actions were taken to identify and address areas of poor performance. If an area of poor performance was identified and the staff member was placed on restricted practices, this was managed through consideration of the Scope of Practice process. This meant clinicians with their practice restricted could only practice under the direct supervision of another paramedic and would be crewed with one on an ambulance.
Volunteers were recruited where required and were trained and supported for the role they undertook. The trust provided training to community first responders for the equipment they would be expected to use during their duties. A learning log was provided for each piece of equipment to identify if the responder was competent in its use.

Staff were offered the necessary support during induction and training. All newly qualified paramedics were provided with a corporate trust and local induction prior to working alone or as part of a double crew. We were told the local induction consisted of a day in the station, three days observing on shifts and one month working with a paramedic. Following this staff were fully operational. However, newly qualified staff were seen more frequently by the learning development officers, and newly qualified paramedics were assessed after one month, six months and again at 12 months.

Staff were supported in their development. Staff from all stations had access to a fully equipped training room in one of the larger ambulance stations in their area. They could book a session with a learning development officer to update their skills. Newly employed staff we spoke with told us they felt their induction training was adequate, but they had very limited opportunity to complete the workbooks due to operational demands.

Staff could access elective training courses on dementia, but these had to be completed in the staff’s own time. Staff were unaware of any training courses on caring for patients with a learning disability.

Staff competence in delivering patient care was assessed by managers and supervisors through annual development days and learning and development shifts. Each staff member had a day-long one-to-one learning shift where a learning and development officer worked with them for a shift in their normal clinical setting. During the shift, mandatory assessments, such as manual handling, infection prevention and emergency driving, were undertaken. Staff were also asked about care pathways, their own continuing professional development, their clinical assessment and reasoning skills, wellbeing and other subjects. Staff told us they had received this within the last 12 months and found the experience to be beneficial. The development day this year included restraint and safe hold techniques for staff to use with patients who exhibited violent or aggressive behaviour.

Operational officers were responsible for clinical supervision of staff in their teams. We were told by staff we spoke with this did happen, although not regularly. Team leaders also stated they worked with staff and provided verbal feedback. However, the discussions were not always documented.

Some staff received training to support patients with mental health problems, including legal powers relating to transporting these patients and could describe how they would manage patients with mental health problems. However, in the west division, staff had very little training in mental health beyond their mandatory training. There was no further training to manage patients who presented with complex mental health conditions and were in a crisis. Staff felt unprepared and gave examples of how they improvised management plans to ensure the safety of those patients. However, these examples presented issues of using soft restraint in preventing patients from free movement. We were not assured that all staff recognised that some of the improvised safety measures (such as modifying seatbelts to hide release buttons) as this and staff saw these measures as maintaining both staff and patient safety. The trust had recently revised its restraint policy to reflect the use of soft restraint and we were told further changes had been made to mental capacity act training to help staff identify the use of soft restrain in their day to day jobs.
The trust ensured those responsible for vehicle maintenance were competent. All mechanics working for the trust were required to have a minimum level of experience and a recognised qualification. In addition, all mechanics undertook an external course in vehicle inspection which gave them an additional qualification. Staff also told us they had begun undertaking training in the safe maintenance of hybrid vehicles, as some of the officer and pool cars had these types of engines.

The trust wanted to remove bank staff that had not worked in the last three months. The trust required bank staff to work one shift every month to ensure they were up-to-date and current with all trust standard operating procedures and safe practices. However, we were informed there was a problem with the bank contracts, which stated a bank staff member only needed to work one shift a year.

**Multidisciplinary working**

All necessary staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment. The trust regularly met with other stakeholders, including clinical commissioning groups, commissioning support units, patient representatives and local acute hospitals. Senior staff expressed concern that some acute trusts did not engage as well as others about handover times; however, meetings were planned involving commissioners and acute hospitals to discuss possible improvements to the handover process.

Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved. The trust had agreed care pathways with other healthcare providers to ensure patients achieved the best possible outcomes. For example, the stroke pathways ensured potential stroke patients were taken to an acute stroke unit to reduce delays in receiving appropriate care and treatment. At one north division station we heard of positive relationships with mental health teams in the local area. Staff reported the mental health teams were happy to discuss and share information about their patients where appropriate. In another north division station, staff reported they could refer patients to a local organisation for support or onward referral to other local mental health services.

Managers in the east division attended a monthly emergency department meeting with staff members from the local emergency departments. During these meetings the previous month’s operational pressures were discussed and upcoming operational pressures were reviewed. For example, upcoming local festivals or events were discussed so both organisations could plan resources.

Staff worked well with other health care services to meet the needs of people. Every day a hospital ambulance liaison officer was nominated in each division. It was their role to monitor the time ambulances were having to wait at emergency departments. If specific triggers were met, for example crews waiting over an hour for a handover, they would contact the emergency department to determine what could be done to help improve the situation. Staff reported they had a good working relationship with the trusts, which helped drive this improvement.

A trust-wide procedure was available to all operational staff covering alternative patient referral pathways. These pathways provided other options for hospital conveyance. The document was available electronically on the electronic tablets and personal mobile phones. This meant staff had access to the updated document while they were on scene.
The trust tried to provide people with consistent, coordinated, person-centred care and support when they used, or moved between, different services. The trust was working with a specialist cancer charity to provide more appropriate care for end of life patients and avoid unnecessary admissions into emergency departments. The trust had specialist paramedics who carried ‘just in case’ medicines. End of life training had been made available for staff, although this was not mandatory. This was part of a ‘mind the gap’ project to address the lack of emergency care available to patients at the end of their life, and recognising these patients were increasingly regular callers to the emergency services.

Ambulance crews working on the county borders reported cross-border working with the other ambulance trusts was also good.

We saw excellent interactions among staff at hospital emergency departments and with private ambulance providers. For example, at one emergency department where there were queuing ambulances, a patient had a significant seizure. Three different ambulance crews went to assist the patient and displayed excellent communication and working with doctors and nursing staff in the emergency department.

Relevant teams, services and organisations were informed when people were discharged or were seen and treated. We observed staff discuss with patients when they needed to contact other services for advice and support, for example their GP. A copy of the notes contained in the handheld devices of the visit by the crew could be sent to the patient's GP. We observed this taking place.

There were effective handovers between ambulance and hospital staff. The trust policy was for clinical staff to handover care to emergency departments using a specified model called ATMIST. The initials stood for age, time, mechanism, injuries, signs, and treatment. This ensured information relevant to the patient was passed on in a consistent way. We observed several handovers at emergency departments. We saw this information provided to emergency department staff in line with trust policy.

The trust worked with other providers to reduce admissions to hospital. The trust helped educate staff in residential and nursing homes to identify when patients who were unwell required transport to hospital or where care and treatment could be provided by an alternative means. At one north division station, a falls team had been developed to work with patients who were aged over 65 who had suffered a fall. The team visited the patient following an emergency call, attended to their healthcare needs, and assessed their home with an occupational therapist from another provider to arrange equipment for re-enablement at home. This included moving their bed downstairs or providing walking aids. The service was provided to 70 patients a month and the numbers of patients attending hospital and having an overnight stay had reduced from 65% to 13%.

Two additional trials had been set up in collaboration with GP services in the Bath area. These trials delivered a paramedic-led service in a GP practice to assess and treat a range of patients for symptoms such as abdominal pain. This reduced the pressure in the GP service and provided patients with more options to be seen in their community. It also meant patients could attend hospital through ambulatory care rather than the emergency department or as an inpatient.

Staff we spoke with regarding these trials discussed how a big focus of the ambulance service, acute hospital services and the clinical commissioning groups was admission avoidance, and they were looking to extend these services to other counties and areas.
The trust was working in partnership with emergency departments and commissioners to reduce waiting times at emergency departments. At our previous inspection we saw a standard operating procedure (SOP) for handovers had been agreed to reduce delays at busy times, which crews reported had worked well. At this inspection we saw the use of the SOP was discussed in the daily operational call to indicate where areas of higher demand may arise throughout the course of the day. For example, the north division indicated the SOP had been triggered at one large acute hospital trust due to the numbers of patients waiting in the corridor when this began to impact on handover times.

Patients were transported to the appropriate service based on their needs. We attended one emergency call triaged as immediately life-threatening. Following assessment, the crew decided the patient would get more appropriate treatment if they were taken straight to a maternity unit rather than the emergency department. The crew carried out a documented risk assessment based on best practice and trust guidance before making this decision.

There were agreed care pathways with other providers to ensure patients received the best care. Staff were very clear about acute pathways, such as cardiac and stroke care. However, staff told us there were limited options available to them in relation to mental health patients, especially at night and weekends, and they frequently had to take patients to the emergency department instead. We saw one pathway in action when a patient with a suspected stroke was transported directly to the computed tomography (CT) scanner to reduce delays in treatment.

There were arrangements for the trust to work with other agencies such as the police, acute hospitals, coastguard, and fire and rescue services. Staff we spoke with were very positive about their professional working relationships and links with other agencies. Two members of staff told us they attended a monthly Local Safety Advisory Group meeting with the local police and fire and rescue service.

The trust was part of the national memorandum of understanding in the provision of mutual aid. This is a framework through which NHS ambulance trusts jointly agree to provide assistance on a national scale in the event of a major incident.

**Health promotion**

People were identified who needed extra support, including patients in the last 12 months of their lives and those close to them. The trust was working with a specialist cancer charity to provide more appropriate care for end of life patients and avoid unnecessary admissions to emergency departments as part of the ‘mind the gap’ project. In helping patients to stay at home in accordance with their wishes, staff felt this was a way of promoting better mental health for patients coming to the end of their lives and for their families.

People who used services were empowered and supported to manage their own health, care and wellbeing and to maximise their independence. Some patients received a ‘see and treat’ service from ambulance staff. Staff supported patients safely at home or referred them to a more appropriate health service. This helped avoid hospital admissions and reduced travelling for patients as they could access the appropriate treatment locally. In addition, staff signposted patients to support services, and we saw one member of staff give out information about a smoking cessation service to a patient with breathing problems.

There had been an initiative to improve health promotion. We observed a learning review take place where staff were discussing an initiative called ‘make every contact count’. The aim of this...
initiative was to improve the supporting information given to patients and promote other aspects of health. For example, providing patients with healthy eating advice, how to stop smoking and advice on taking medicines.

Patients were given advice to help them manage their own health when hospital admission was not required. We saw evidence in patient records of staff members informing patients of symptoms and signs to be aware of. Advice was also given about the appropriate people to contact for support if they were concerned, for example their GP or out of hours doctors.

Where abnormalities or risk factors were identified that may require additional support or intervention, advice or changes to people’s care or treatment was discussed between staff, people and their carers. At the time of our inspection, the region was experiencing some prolonged high temperatures. We saw staff giving advice about hydration to one patient they were called to, and giving the patient several bottles of water, which they watched them drink some before leaving.

Frequent patients were identified and supported to access other services if appropriate for their ongoing care and treatment. The trust had a frequent caller policy, which was designed to support patients with complex needs to access other services where the attendance of an ambulance may not be necessary. Operations officers attended multidisciplinary meetings to discuss how individuals’ needs might be better met in the community. Staff informed us they were often informed by the emergency operations centre if a patient was a frequent caller prior to them attending the scene.

We saw multiple examples in acute hospitals of reviews of frequent attenders to ensure best care and use of resources. There were shared plans of care, which included, for example, working with psychology departments and reviews of medicines to reduce calls and conveyance to hospital.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children’s Acts 1989 and 2004. Staff were clear about their responsibility to obtain consent for care and treatment. We witnessed ambulance crews explaining care and treatment and obtaining consent. We saw crews asked patients to sign their electronic record to say they were happy to be treated, although in one instance this happened after the initial treatment had already taken place. Consent for any treatment was obtained verbally and the patient was asked to sign the record when convenient or at the end of the episode. Patients were not asked to sign it straight away as this could lead to a delay in emergency or urgent care being provided to a patient. We also observed patients signing the hand-held devices to provide evidence of their consent if they were happy for information to be shared with other parties, for example, their GP.

Most staff had a good understanding of the Mental Capacity Act. They followed the principles of the Act in assuming all patients had capacity unless they found evidence to suggest otherwise. Staff felt confident in making capacity assessments when required and could speak about how they would make these assessments and where they would be recorded. Staff could discuss making decisions in patients’ best interests.

We observed crew members assess the capacity of patients as part of the consent process. Staff considered the ability of the patient to retain and comprehend the information. A short capacity assessment was recorded as part of the electronic patient record.
Most staff we spoke with were clear about assessing mental capacity to provide consent and the requirements of the Mental Capacity Act 2005. The trust had a policy regarding the Mental Capacity Act and there was guidance for staff in the form of a leaflet ‘assessing capacity’ which set out the requirements of the Mental Capacity Act 2005. The leaflet also had information to help crews decide if a patient lacked capacity to give consent. Guidance could also be accessed via the hand-held electronic patient care record device. Policies and procedures for managing disturbed behaviour were available, however these provided limited detail for staff. The mental health and mental capacity guideline detailed the procedure to follow when restraint was required, such as contacting the police for assistance.

The process for seeking consent was monitored and reviewed to ensure it met legal requirements and followed relevant national guidance. The trust undertook frequent snapshot audits of the consent process. The most recent results from April 2018 showed a high level of compliance (83.4%) was achieved with the recording of decisions relating to patient consent. The audit noted there was scope to improve documentation relating to the reason a best interest decision was made even though the recording of a reason was not mandatory. Of the 1,608 records audited where a best interest decision had been made, 419 (26%) indicated the reason the decision had been reached. Of the 1,577 cases where a best interest decision was recorded for information sharing, this was explained in 190 (12%) of records. The report was due to go to the clinical effectiveness group to agree recommendations. The functionality for patients to sign the electronic record (or indicate they were unable to) was used in 82% of cases sampled.

When patients were unconscious or confused, staff acted in the patient’s best interests. Staff we spoke with could explain this process. When a patient was unable to give consent due to confusion, a mental capacity assessment was completed and recorded on the electronic patient record form. Some staff we spoke with could describe an assessment tool they used called CURE (communicate, understand, response, evaluate) to assess a patient’s capacity.

The breakdown of training compliance for Mental Capacity Act and Deprivation of Liberty Safeguards training for all staff in emergency and urgent care as of March 2018 is shown below.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deprivation of Liberty Safeguards</td>
<td>3,175</td>
<td>3,236</td>
<td>98.1%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental Capacity Act</td>
<td>3,174</td>
<td>3,236</td>
<td>98.1%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

A breakdown of training compliance for these two modules for qualified staff in this core service is shown below.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
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</tbody>
</table>
A breakdown of compliance for these two modules for clinical support staff in this core service is shown below.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deprivation of Liberty Safeguards</td>
<td>990</td>
<td>1,000</td>
<td>99.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental Capacity Act</td>
<td>989</td>
<td>1,000</td>
<td>98.9%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Nearly all staff in emergency and urgent care had completed both modules. No support staff in emergency and urgent care were eligible for either of these two modules.

Source: Trust Provider Information Request – Mandatory training

The trust did not have vehicles equipped for mental health patients as standard vehicles were safe for the conveyance of mental health patients. However, if a patient presented a physical threat to staff, then a police officer would be present for the journey. This was typical for ambulance trusts, and staff hoped the Ambulance Response Programme (ARP) would be an enabler to work towards providing these vehicles. The trust did not have any specialist paramedics trained in mental health. The Royal College of Emergency Medicine was looking at whether to extend holding powers to paramedics so they could detain patients in an emergency.

The trust did not ensure that when restraint was used, it was done so in a safe, proportionate, and monitored way as part of a wider person-centred support plan. The trust promoted supportive practice to help avoid the need for physical restraint. Training in restraint had recently become part of the mandatory training programme, although senior managers recognised that training for frontline staff in physical restraint was not detailed enough and did not give staff the skills and knowledge they needed to safely restrain patients. Training was being further developed because the need for this was increasing. Staff were being made aware that low-level practices did constitute restraint, such as wrapping patients in a blanket, or putting seatbelts on patients. Staff were also trained in conflict resolution and de-escalation techniques, but there was no training in safe physical restraint.

Staff did not understand the legal powers in relation to transporting patients experiencing a mental health crisis. Ambulance crews told us they did not feel adequately equipped to deal with users who suffered from poor mental health. When asked what they would do if a person was having a mental health episode in the back of the ambulance, one staff member stated they “would just drive faster”.

There was additional support for staff to help care for and treat children under 16 without parental consent. The electronic reporting system contained a set questions for staff to consider when treating a child under 16 who did not have parental present. These questions helped ensure capacity to give consent was considered in line with legal requirements to establish Gillick
competence. Gillick competence helps decide whether a child (under 16 years of age) can consent to treatment, without the need for parental permission or knowledge.

Is the service caring?

Compassionate care

Staff understood and respected the personal, cultural, social and religious needs of people. When providing care, treatment or advice, staff took this into account in the way they delivered services. We saw multiple examples of crews going the extra mile to try to understand their patients' needs. For example, one crew had ensured a patient had their headscarf with them before leaving to transport the patient to hospital. Another example we saw a patient soothed by some familiar music following a period of challenging behaviour. Crews also be shared what they had learned about their patients with the receiving hospital or clinic via the electronic patient record.

Staff respected patient choice. For example, we saw staff respecting a patients' decision to not tell friends where they were being transferred. They did this in a compassionate way, not only making sure the patient's needs were respected, but also respecting the anxiety the patient's friends might have been feeling.

Staff took the time to interact with people who used the service and those close to them in a respectful and considerate way. Staff were kind, caring and showed empathy and understanding to both patients and their relatives or representatives. We saw staff delivering compassionate care in ambulances, patients' homes and in hospitals. We saw multiple episodes of care and in all cases staff spoke with patients in a respectful and patient way, which took account of the situation. We saw one staff member sit down and help a relative read through and understand a medicines list. We saw staff positioned patients comfortably before assessing them.

Staff took the time to provide additional care to patients. This included helping patients pack for hospital admissions and ensuring homes were left safe, secure and clean.

All staff were polite to patients and ensured the patient was put at ease. This regularly included having jokes with the patients and showing an interest in their personal lives by asking questions about their jobs, families and interests. This was in line with National Institute for Health and Care Excellence quality standard 15 statement 1.

Staff made sure patients' dignity was respected. For example, during one call out a response car was sent but as the patient required further tests and the patient was in a public place, an ambulance was called instead. We also saw on all the calls we attended, staff prioritising patient dignity. This often involved using physical barriers such as blankets, or ensuring examinations were done inside vehicles.

Staff ensured, as far as possible, dignity was maintained during treatment and care in public places and when transporting patients to and from vehicles. Staff used blankets to cover patients at the scene of incidents and when removing or disturbing clothing to carry out tests. Staff covered patients with a blanket while transferring them to hospital, to maintain their dignity and keep them warm. We saw ambulance staff maintaining the dignity of patients when they transferred them from a stretcher or a wheelchair to a hospital bed. We also saw staff drawing curtains to maintain patients' dignity in their own homes while having tests and being assessed. We were also given an example where a patient had suffered a cardiac arrest while in a public shopping centre. We were told how the operations officer attended the scene and ensured members of the public were directed different ways to ensure privacy was maintained.
Staff were polite and courteous to patients and their relatives or carers. We spoke with patients and relatives who consistently gave positive feedback. They spoke very highly of the ambulance staff, and the care and treatment they had received. Comments included:

- “I wouldn’t be here if it wasn’t for them.”
- “I don’t know how they do it. They’re wonderful and so kind.”
- “my mother was so confused and they were so patient.”

Staff showed an encouraging, sensitive and supportive attitude to people who used services. For example, we saw one staff member helping a patient take some tablets by breaking them up to help them swallow them. We also saw one crew assessing a patient with some sensory loss. The crew made sure the patient understood what was happening and warned them before touching them, to prevent any further distress.

Staff raised concerns about disrespectful, discriminatory or abusive behaviour or attitudes. Staff told us if the concern was about a member of staff, they spoke to their line manager in the first instance. If staff saw abusive behaviour in patients’ homes or care homes, they always considered safeguarding referrals. In one example, when transporting a vulnerable patient, crew members spoke in a calm manner to provide reassurance to the distressed patient. The paramedic maintained communication throughout the journey to reduce the patient’s fears and confusion.

In another example, we were told of a situation where staff attended a call where a patient was being aggressive to a relative. Staff took the time to understand the reason for this behaviour and contacted different healthcare providers to make them aware of the behaviour. Following this, staff received a card from the relative thanking them for their care and informing them that thanks to their support and actions the patient was now due to get the support and treatment they needed.

We saw the response of crew members to a passer-by who raised concerns about a vulnerable member of the public seen staggering in the street. The crew responded sensitively, immediately observing the person as they approached the ambulance. The crew showed care for the individual and approached them discreetly while asking tactful questions to assess their condition and identify their care needs. The crew could reassure the member of the public who had alerted them while also respecting the individual’s right to privacy.

Staff made sure vulnerable patients such as bariatric (patients who are very overweight) patients had their dignity maintained during transport. The trust had a standard operating procedure with information about additional support and additional equipment to help staff care for bariatric patients. At ambulance stations, we saw designated stretchers to help staff convey bariatric patients to hospital.

Staff had access to clinical photography and CCTV policies to help maintain patient dignity during incidents. Every time the vehicle engine was started, an automated message was played in the ambulance informing patients and their relatives that CCTV was in use on the vehicle.

Staff responded in a compassionate, timely and appropriate way when people experienced physical pain, discomfort or emotional distress. We saw staff utilising patient ‘just in case’ pain relief medicines prior to transferring them to the vehicle. Staff explained when they had frail patients, they often made sure they had received a dose of their own pain relief before they transported them, to help make the journey more comfortable. Staff also explained this was only done if the patient had not recently taken any pain relief, and we saw this documented in the electronic patient care record.
Staff took time to interact with patients to ensure they were put at ease in a stressful situation. This included building a rapport with patients by making jokes appropriate for the mood of the patient. For example, a paramedic made a joke with a patient on a stretcher asking them to “scream if they want to go faster”. This put the patient at ease and made them more relaxed.

Staff were caring, compassionate and respectful towards patients. Many staff acknowledged that caring for patients with dementia or learning disabilities was a challenge due to a lack of confidence, knowledge and skills. However, we were given examples where staff had acted in an extremely caring way. One example was a paramedic who attended a care home following a report that a gentleman with dementia had fallen. The gentleman was very agitated and aggressive, however the paramedic decided to play some music from the war and this instantly calmed the gentleman down.

In another example of staff integrity and compassion, a paramedic who was on his break saw a patient was on hold in the call system that needed assistance sooner than help would have been available. This paramedic informed the emergency operations centre and responded to the patient because they were the nearest crew and the patient potentially had a time critical condition.

Staff ensured handovers were conducted in a way that supported patient confidentiality and privacy and, where possible, involved patients and their relatives. We saw six handovers and in all cases the handover was done in a private cubicle with relatives present. Where clarification was needed, we saw staff speaking with the patient directly where possible. On our last inception staff told us this could be a challenge at times as they sometimes had to handover patients to hospital staff in the corridors when hospitals were exceptionally busy. We found on this inspection that the introduction of the electronic patient record across the whole trust meant handovers had to be done at a terminal, which were away from public areas.

Staff showed respect and compassion towards relatives and carers who were travelling with patients. Staff attended to patients, in the presence of a relative or carer, with compassion and professionalism. A crew responded to a 999 call and introduced themselves to the patient and their family. Staff assessed the patient after gaining consent. They spoke with the patient and relatives about what they were doing and why.

Staff dealt with deteriorating patients in the presence of relatives or carers in a calm and professional way. In one case, we saw staff calmly and clearly explain their concerns to the patient and their relative to justify their decision to transport the patient to hospital.

The trust used the NHS Friends and Family Test to gather views about the service they were providing. The overall response rate for see and treat (where the patient was assessed and treated by ambulance crews but not taken to hospital) at the trust was 0.03% from March 2017 to February 2018. This was much lower than the 0.1% response rate for England overall. There were only 106 responses for the trust in total over these 12 months. The number of responses varied from six to 12 per month over this period. Staff told us they often forgot to ask for feedback as they were already thinking about their next job and booking back on.

The monthly percentage of patients recommending the trust for see and treat is shown below together with the England data for comparison.

The trust performed better than the England average in six out of 12 months; in all six of these months all the patients surveyed said they would recommend the trust. However, it should be
noted the response rate for this trust was very small in comparison to the overall England response rate for ambulance trusts.

![Friends and Family Test (see and treat)](image)

**Source:** NHS England Friends and Family Test

**Emotional support**

Staff understood the emotional or social impact a person’s care, treatment or condition could have on their wellbeing and on those close to them. Staff told us they understood the impact their decisions to convey could have on the confidence of some patients, especially if they had only recently been discharged from a stay in hospital. We saw staff calmly and clearly explaining to a patient and their relatives why they felt they needed to return to hospital, and providing reassurance this was necessary for their ongoing care and wellbeing. We were also told how staff had respected a patient’s decision to remain at home for a night before being admitted to hospital. Staff respected the patient’s wishes and realised the emotional impact it would have on the patient if they were admitted prior to this. In this instance the patients GP had also been consulted to ensure it was safe for the patient to delay their admission.

We saw ambulance crews providing emotional support to patients and those close to them to reduce anxiety and provide reassurance. They supported patients, relatives and other parties during distressing events. Relatives we spoke with reported staff kept them updated on what was happening and why, making sure they felt supported. A staff member shared an example of ambulance crews offering emotional support to children following the death of a family member. They spent time speaking with them and answering questions the children had.

Staff supported patients, relatives and other parties during distressing events. We saw staff caring for a patient who was distressed on arrival at the emergency department. They provided emotional support, reassuring the patient about what was happening and that they were safe. The staff stayed with the patient until they felt comfortable in the department. In another example, one bank staff member told us they had spent five hours comforting a family after they had been involved with a distressing event. We also saw on most calls we attended, crews having general supportive discussions with relatives and families. In one instance we saw a paramedic discreetly enquire how one relative was coping so as not to upset the patient.
We saw sensitive conversations took place with relatives when discussing the declining health of those close to them. Crew members took a considered approach, gently asking questions in a caring and kind manner. When explaining changes in the patient’s condition and health needs, both crew members demonstrated empathy, understanding the concerns of the patient and the relative. The crew thought of the needs of the relative, how the situation was affecting them emotionally and answered their questions in a gentle and thoughtful manner.

Staff gave appropriate and timely support and information to help patients and their relatives cope emotionally. In one instance, we saw a staff member having a discreet conversation with a patient’s relative about additional support and assuring the relative that the records from the call would be sent to the patient’s GP.

When care was provided to children in a non-life-threatening situation, we saw staff allowing time for the child to familiarise themselves with the ambulance crew to reduce anxiety. The crew considered the feelings of brothers and sisters and actively engaged with them to build rapport, which relieved their anxiety.

Some staff used appropriate humour to reduce people’s anxiety levels and we witnessed friendly and light-hearted conversations between patients and ambulance staff.

Staff gave emotional support to the relatives of patients who died in their care. The trust had policies and protocols to guide frontline staff when caring for patients who had died, and their relatives. We saw staff providing care and support to relatives following a sudden bereavement. At one incident we attended, where a patient had passed away, we saw staff provided kind and considerate care to relatives and others who had been involved. Staff maintained the privacy and dignity of the patient and treated patients with compassion and consideration. Staff ensured relatives had an opportunity to ask any questions and had somebody with them before they left, if appropriate. We also saw a staff member liaising with a local funeral director and GP following the death of a patient.

Staff provided emotional support to patients who were self-harming, distressed, anxious or confused. One staff member told us they had attended a call to an elderly patient who had become confused and was not coping at home. The staff member supported the patient to arrange a ‘meals on wheels’ service, and helped them to understand and access some online financial services. We also saw staff supporting a patient who was suffering adverse effects from medicines. They helped calm the patient who reported they were experiencing hallucinations.

The trust had a frequent caller policy, which was designed to support patients with complex needs to access other services where the attendance of an ambulance may not be necessary. Operations officers attended multidisciplinary meetings to discuss how individuals’ needs might be better met in the community.

The values of kindness, dignity, respect, compassion and empathy were demonstrated and embedded in all staff interactions with patients experiencing a mental health crisis. Staff routinely invited family and friends to be involved or accompany patients who were experiencing a mental health crisis. Staff also gave us an example where they had attended a scene with a patient who was threatening to commit suicide. Staff spoke with the patient and kept the patient calm until the police arrived with trained negotiators.
Staff also provided care which went further than caring for a patient's medical needs. We were informed of multiple occasions where staff cleaned up soiled linen and helped change and wash patients prior to them attending hospital.

**Understanding and involvement of patients and those close to them**

Staff communicated with people so they understood their care, treatment and condition or any advice given. We saw one crew took time after their initial assessment to make sure the patient understood how to use all the mobility equipment they had been given in their home. We watched staff help set up tables and walking aids at the correct height for the patient to maximise their independence in their home. Patients and relatives reported they were kept informed of what was happening and why, and they were given the opportunity to ask questions for clarification.

Ambulance crews demonstrated a good understanding of consent. Each procedure was fully explained, and the patients' permission gained before providing care. The information given was clear and described the purpose of the actions they wanted to take. Staff could adapt their communication style to meet the patient's needs. For example, when treating children, we saw the crew speaking in simple language in a way the children could understand.

We saw crew members assess the capacity of patients as part of the consent process. Staff considered the ability of the patient to retain and comprehend the information. A short capacity assessment was recorded as part of the electronic patient record.

Patients and those close to them told us they were happy with the care and support they received from the crews. They felt included in what was taking place and the crews discussed their plans with them and checked they were happy with the plan.

Ambulance crews spoke with patients in a kind and supportive manner while treating them. We overheard crews interacting with patients on a personal level and chatting to them in a reassuring way. We saw staff talking to patients and relatives while waiting to give handover in a calm, unhurried way, answering questions where they could and providing reassurance.

Staff sought accessible ways to communicate with people when necessary. We accompanied a crew who attended a patient who did not speak English, which meant the crew had to communicate through a family member. Another staff member explained they sometimes used an online search engine translation programme to convey important message and questions to patients and had done so for many different patient nationalities. Crews explained there was sometimes a delay in accessing telephone interpretation services, and only used alternatives in time critical situations.

Staff made sure people who used services and those close to them could find further information, including community and advocacy services, or ask questions about their care and treatment. Staff recognised when patients and their relatives needed additional support to help them be involved in their care and treatment. We saw one staff member offer to call a patients' GP and other family members on behalf of the patient’s relative, who had become upset during the initial assessment.

Staff routinely involved people who used services and those close to them in planning and making shared decisions about their care and treatment. People told us they felt listened to, respected and had their views considered. At one call, a patient’s carer arrived when the crew were undertaking their assessment. We saw the crew and carer go through the patient's care record and medicines prior to transporting the patient to the hospital. They also discussed the patient’s fluid intake and output in the hotter weather.
Ambulance crews involved those close to the patient when considering the individual’s clinical needs and treatment options. Relatives and other care staff who knew the patient were actively involved in the conversations to determine the patient’s current clinical status. For example, in one case relatives were asked if the patient’s breathing had changed and, in another case, relatives were asked if a child’s appetite in the previous 24 hours had changed. Those close to the patient could participate in discussions regarding treatment options, including not attending the emergency department. Relatives and care workers were asked for their opinion, alongside the patient, to ensure they were happy with the treatment plan and any further actions they may need to take.

People’s carers, advocates and representatives were identified, welcomed, and treated as important partners in the delivery of care. In all the journeys we went on, relatives and carers were always encouraged to accompany the patient in the ambulance. We saw open discussions about treatment which involved both patients and those close to them. For example, we accompanied a pregnant patient and their relative to hospital, and we saw the ambulance crew clearly explain their treatment decisions to both patient and relative, giving time for questions.

We were assured information about patients was treated confidentially in a way that complied with the Data Protection Act. Staff supported people to make and review choices about sharing their information. We saw crews ask patients for their permission to share their care records with other healthcare providers, including their GP.

Some staff went above and beyond to ensure all patients had proposed treatment and options explained to them. We attended one emergency call to a patient who was unable to communicate verbally. The staff member clearly explained the treatment to the patient and sought non-verbal responses and consent from the patient. Staff also used picture-based pain scales as part of their assessment to ensure the patient could indicate their level of pain.

Patients were routinely involved in decisions about whether they needed to be conveyed to another place for care or treatment. We saw a detailed discussion take place between a patient, their relative, carer and the crew about the decision to transport the patient to hospital. The patient and relative expressed concerns as the patient had only just been discharged a day earlier, but acknowledged they had lost a lot of confidence at home since being discharged. They agreed a return to hospital was in their best interest. One comment sent in by a relative to the station thanking them for care given stated: “staff arranged extra care and ensured they weren’t sent to hospital…they found the best option rather than the easiest”.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

South Western Ambulance Service NHS Foundation Trust worked with commissioners and other providers so services were planned to reflect the population’s needs and to promote flexibility, choice and continuity of care. The trust planned staff and vehicle levels using different methods. For example, the trust used computer software to identify demand for emergency and urgent care staff, vehicles and their locations. In November 2016 the trust also introduced a GP 999 car scheme in the east division. This acted as a mobile treatment service providing primary care support to paramedics, specialist paramedics and other ambulance clinicians. The primary aim of this service was to manage patients at home and avoid unnecessary admissions to hospital unless clinically appropriate. Results for November 2016 to February 2018 showed that 78% patients
seen by the GP scheme were treated in the community, which equated to 982 patients. The scheme had recently increased to a seven-day service with a second car running on Saturdays and Sundays from December 2017.

Variations to core staff and vehicles were discussed at a divisional and local level via a weekly resource management group meeting, chaired by heads of operations (now County Commanders). Any demand issues for emergency and urgent care services were dealt with through the meeting, including traffic and travel issues. This information was subsequently shared with staff, so that they could consider alternative routes if necessary.

The trust worked with other providers to help meet demand. For example, events and other seasonal variations were discussed at monthly meetings with local emergency departments. These were attended by operational officers and staff from the emergency department. At these meetings decisions were made about what resources should be available to meet any increase in demand.

Where people’s needs and choices were not being met, this was identified and used to inform how services were improved and developed. For example, the trust had identified a need to engage with people who had used services during a mental health crisis. The aim was to establish what people felt were the priorities when responding to people experiencing mental health crises.

Other providers and relevant stakeholders were involved with planning services. For example, the trust liaised with organisations such as Healthwatch. The trust also linked with other emergency services and had recently worked with Gloucestershire Fire and Rescue to develop and pilot a first responder service for non-injury fallers, which was due to be rolled out in the summer. This service identified patients who had fallen and required assistance, but were not injured, and despatched a fire crew to assist the patient rather than an ambulance. We were also told a similar pilot had recently started involving the community first responders.

The facilities and equipment were appropriate for the services that were delivered. The trust operated 396 ambulances, which were equipped with standard equipment and mobility devices to assist patients into and out of the vehicle, including stretchers. Stations were located throughout urban and rural areas with the numbers of vehicles reflecting historical activity and local populations. As part of a rota review in 2017, some vehicles had been reassigned to different stations to extend their operational hours, for example in Axminster.

Staff told us there were differences (such as rurality) between different areas and counties, which provided challenges to providing prompt care and treatment in some areas. The trust attempted to address this using the Ambulance Response Programme (ARP), which was being trialled at the time of our last inspection in 2016. The trust used data from this system to review the safe level of care that was provided. The trust had fully migrated to this system in November 2017 from the previous monitoring system. The ARP monitored performance for the different category calls against agreed national standards, and the England average.

Following the move to the ARP in November 2017, in the east division, the trust worked with the local commissioning group in Dorset to develop a joint action plan to improve efficiency in the service. The joint approach identified several key challenges to meeting the response targets. An action plan was produced, which showed seven areas of focus split into three phases covering 2018/19 and 2019/20, and further actions to be carried over in to 2020/21. Areas for focus included reducing and supporting high intensity users (frequent repeat callers), reducing falls, handover delays and improving access to mental health services. The trust had previously
identified a funding and resource shortfall, in part due to the rurality of some of the areas, which the action plan hoped to reduce, resulting in improved ARP performance.

The trust had effective partnerships with other healthcare providers to plan, monitor, and improve the service offered to local people who required emergency or urgent care. A local accident and emergency board met monthly to evaluate the performance of individual organisations and the care provision provided collectively across the wider healthcare system. Improvement initiatives identified from the meeting were agreed and implemented locally. During our inspection, the focus was on the ‘front door challenge’, which aimed to reduce admissions to hospital by signposting patients to appropriate community services. If admission was required then receiving hospitals would assess the urgency of care required to ensure patients were seen in a timely way and in the most appropriate environment. For example, a patient experiencing a non-urgent deteriorating condition could be seen by their GP, or a patient with a possible simple fracture of a limb could be admitted to the minor injury department.

There were a range of clinical pathways planned to meet the needs of patients with longer-term conditions. The trust told us it was committed to continually improving the pathways and care options available to patients. This met patient’s needs by reducing the need to be transported to an emergency department by using more appropriate clinical pathways and delivering patient care closer to home. For example, we were informed about a diabetic pathway which was in the process of being developed. This would mean patients would be able to access diabetic nurses in the community rather than having to be admitted to hospital.

Staff were trained in admission avoidance. Staff reported there was a training module available called ‘patient assessment for minor ailments’. The aim of this module was to increase the number of patients who could be treated at home.

Meeting people’s individual needs

The trust identified and met the information and communication needs of people with a disability or sensory loss and used the electronic patient record to share this information with other relevant providers. The trust took account of the needs of patients and callers living with dementia or a learning disability. The trust had developed a range of resources to help staff support patients with different and sometimes complex needs. We saw examples of resources for meeting people’s needs on station noticeboards and electronic resources.

Services were delivered, made accessible and coordinated to take account of the needs of different people, including those in vulnerable circumstances. We saw ambulance staff engaging with patients who were in vulnerable circumstances, for example patients left at home with a diagnosis of dementia or other cognitive difficulties. Discussions with other professionals, including GPs, and the patient’s relatives were involved in ensuring appropriate support was available for these patients. All records from the visit were passed electronically to the patient’s GP for their ongoing care and treatment.

The trust worked with local services to offer transport for patients detained under the Mental Health Act. Staff were aware of their responsibilities under the Mental Health Act for the transport of patients. However, the trust did not have any vehicles designed for the transportation of patients experiencing a mental health crisis or those requiring secure transport. This meant patients could be put at risk if transported in inappropriate vehicles. For example, seating arrangements for both patient and crew member travelling in the rear of a standard ambulance did not keep either occupant safe. In the event of a patient having a violent episode, staff travelling with the patient
were a risk of harm. Ambulances also contained unsecure equipment such as oxygen piping which may be used a ligature points.

Services were delivered and coordinated to ensure people who were approaching the end of their life were identified. The needs of end of life patients were recognised. The organisation had specialist paramedics who could administer and supply end of life medicines under patient group directions. This service had been operating since 2015 and had been developed and delivered in partnership with a nationwide cancer charity. The charity had estimated that ambulance crews attended at least one patient per shift who was living with cancer. The project team developed training packages for paramedics and other staff and implemented a series of additional specific pathways and protocols for paramedics to use to treat patients in their own homes if appropriate. The project team used case studies to learn from including one account of a patient and their family where the family had no longer been able to cope. The paramedic in attendance had been given additional training to have sensitive conversations with patients and their relatives, and had managed to keep the patient in their own home by utilising the additional pathways and skills. In this case, the patient’s GP was contacted and the paramedic could administer some specific pain relieving medication. These actions had helped the family feel they could cope again, and the patient was able to remain at home until they passed.

There were arrangements for staff to access translation services. For patients whose first language was not English staff could use a telephone translation service, which they told us was easy to use and access. In the period June 2017 to May 2018, the frontline emergency and urgent care service had contacted the interpretation service 1,679 times. We did not see the service in use during our inspection. Staff told us that at times friends or relatives were used to translate. Using friends and relatives to translate or interpret can lead to errors in communication, especially if patients do not want to share intimate details with relatives. At our previous inspection we were told communication aid cards were available on some ambulances for staff to use with patients. However, these were not available on all vehicles. At this inspection we did not see any communication aids on any vehicles we inspected, and some staff were unaware they were available.

The needs of people living with dementia were understood and used to influence the care they received. Staff said they had updates for dementia training on-line and during development days. There were learning resources on the intranet to help staff support patients living with dementia, including an e-learning package. However, staff were unable to identify tools used to communicate with patients who were not able to communicate verbally or had hearing difficulties. Resources such as pictures or communication books were not carried on vehicles and staff told us they relied on a mixture of hand signals and support from those close to the patient.

The trust had taken action to comply with the Accessible Information Standard. They had recently undertaken a patient survey which was in easy-read format and was sent to other organisations and published on the trust website. Patients had reported they would like to have access to British Sign Language video services to help them contact the trust and their services; however, we did not see any of these aids during our inspection and were not made aware of plans to introduce them.

Bariatric patients are those with excessive body weight which is dangerous to health (over 25 stone or 158 kilograms) or a size and shape which may impact on their transport and care. For most patients in this group, the first crew on scene provided immediate support for the patient’s physical needs and requested further support following the trust’s policy. Crews said they
sometimes used the fire service or hazardous area rescue team (HART) who had specialist lifting equipment available if required. Most vehicles and stretchers in the trust’s fleet could transport patients up to 50 stone or 318 kilograms. Staff told us control would know when specialist equipment had been used in the past for a patient and inform crews. Several crews showed us how the stretchers could be modified to accommodate bariatric patients and were aware of the weight limits for the equipment.

Staff were not always equipped to deal with violent or aggressive patients. Staff told us they sometimes worked with potentially violent or aggressive patients. Staff had received breakaway training and training to deal with violent or aggressive patients to enable them to remove themselves from physical harm. At our previous inspection staff told us they had not had training on physical restraint of a violent patient and did not feel equipped to deal with violent or aggressive patients. On this inspection we found training for frontline staff in physical restraint was poor. Training was being developed, as the need for this was increasing. Staff were being made aware that low-level practices did constitute restraint, such as wrapping patients in a blanket, or putting seatbelts on patients. Staff were, nevertheless, trained in conflict resolution and de-escalation techniques, but there was no training in safe physical restraint. The trust had a restraint policy in place with a link to May 2015 guidelines from NICE for appropriate restraint, which some staff were aware of.

Mental health advice for staff was available through the emergency operations centre and the trust had a mental health lead. The trust told us ambulances were arranged for patients experiencing a mental health crisis and there was an agreement with local police forces, which covered all aspects of interagency working with mental health. For example, the use of custodial safe places or police escorts.

We were told patients who needed mental health support were transferred with a carer to support them when available. Crews told us the safety and well-being of the patient was a priority and if they felt the patient was a risk to themselves or others the police were called for further assistance. They did not have direct contact with a mental health team unless the patient was already known to mental health services. A safeguarding quality report showed the trust raised 910 adult safeguarding alerts for mental health issues, and 1,242 for self-neglect. For children, 196 referrals were raised for mental health, 485 for self-harm, 219 for suicidal thoughts and 217 for parental mental health issues.

The trust worked with other providers to support people who were in vulnerable circumstances, such as homelessness. When the service received calls about the welfare of homeless people, they responded appropriately. If the individual could not be located, the crew contacted the homelessness support service to establish the usual movements of the person and visited these locations. In one example, the crew obtained an update from the community-based support worker about the welfare of the individual and if urgent care was still required. In that instance the crew were informed it was not and were stood down.

Through an electronic directory of services available on all vehicles, staff could access contact information for local resources and signpost patients to alternative services to suit their needs. Staff told us they found the directory useful. Where appropriate, staff were also able to manage patients without admission to the emergency department. For example, those with urgent social needs could be referred to out of hours social services.

**Access and flow**
Patients did not always have timely access to initial assessment, diagnosis, or treatment. We saw from the most recent ARP data that where vehicles were dispatched, the trust was failing to get to patients within the target response times. This had the potential for increased mortality rates for patients who were most in need and at risk from delays in response times.

People with the most urgent needs had their care and treatment prioritised. Emergency operations centre staff prioritised calls and dispatched ambulance vehicles to patients with the highest priority first. The call prioritisation determined how quickly and what type of ambulance resource was dispatched. Patients who received an ambulance response were assessed in person by qualified ambulance staff. Ambulance staff used a recognised clinical decision support system. The decision support system followed the format of national early warning scores (NEWS) and assessment guidance to provide a safe alternative to emergency department admission for the patient.

Action was taken to minimise the time people had to wait for treatment. We saw evidence care and treatment was only delayed when it was necessary. For example, when there were not enough ambulance staff or vehicles in the immediate area or when resources were diverted to other calls as priorities changed. As part of the daily National Ambulance Advisory Council (NAAC) calls, reasons for missed category one and two calls were discussed across the whole trust.

Newly qualified paramedics were required to seek validation of their decision to leave a patient at home rather than transporting them to hospital. This involved waiting for a clinician at the emergency operations centre or an operations officer to validate the decision. There were not always enough validators available, which caused delays in the staff being able to take on another call. Some staff reported they had to wait as long as 50 minutes. However, the trust reported this waiting time had reduced in the three months leading up to the inspection, although no data was submitted to support this so we were not assured this was being effectively monitored.

The trust took account of rurality when responding to calls. Voluntary community first responders and other qualified responders, such as doctors, supplemented core ambulance resources. The community first responders had been trained to attend medical emergencies and deliver basic life support, oxygen therapy and defibrillation using an automated external defibrillator. Dispatchers sent community first responders to cardiac arrests and other appropriate incidents where they were closer than an ambulance, particularly in more rural areas.

The community first responders were available across the trust. Between June 2017 and June 2018 community first responders arrived on scene to 28,301 calls.

At our previous inspection we were told about the successes of the ‘right care, right place, right time’ initiative, which was a commissioner-funded agreement to reduce unnecessary admissions to emergency departments by 10%. Since the end of the initiative the trust continued to promote see and treat among all staff.

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<td>40,302</td>
<td>41,410</td>
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<td>47,704</td>
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<tr>
<td>% of incidents resolved without conveyance to ED</td>
<td>54.2%</td>
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The trust operated a single point of access. This was a contact point which health and social care professionals could use to arrange the right care for urgent and non-urgent patient needs. It was available to ambulance staff and provided them with direct clinician to clinician contact.

Paramedics and other ambulance staff could gain access to out of hours GPs to support clinical care at home or via walk-in centres. All staff we spoke with thought this process was beneficial to patient care, but sometimes there could be a wait to get advice. The trust monitored the length they had to wait for call backs, and if it went past a certain amount of time, a clinician from the emergency operations centre chase the call back.

Since our last inspection, the use of electronic patient records had been extended across the whole trust. This system allowed crews to view patients’ previous ambulance records and special notes about their presenting condition. The system also allowed crews to transmit information about a patient’s condition to receiving hospitals and the patient’s GP. We saw these records utilised by crews for all the episodes of care we saw.

We saw information terminals in emergency departments provided by the trust. Hospital staff could see details of patients arriving by ambulance, their estimated time of arrival and condition. This helped hospital staff prepare to take a handover of care and for patients to be better supported and managed. This also helped the ambulance crew to be released quicker to respond to other work.

Handover times started from the arrival of the ambulance at the emergency department, and finished when the patient was handed over to the care of the emergency department. According to national guidance ‘Addressing ambulance handover delays: Actions for Local A&E Delivery Boards’, acute hospitals must always accept handover of a patient within 15 minutes. While this measure does not indicate the ambulance service’s performance, it is a useful measure of the operational ambulance time lost because of delays at the hospital.

The trust provided weekly handover data for weeks commencing 27 March 2017 through to week commencing 26 March 2018. The average handover time increased during the winter period, from 14 minutes and 19 seconds for the week commencing 30 October 2018 to 18 minutes and 51 seconds for the week commencing 25 December 2018. In the first half of February 2018 there had been an improvement. Performance improved from 16 minutes and 44 seconds for week commencing 29 January, to 12 minutes 41 seconds for week commencing 26 March 2018.

From 27 March 2017 to the middle of November 2017, approximately 40% of handovers exceeded 15 minutes. This proportion increased during winter (middle of November 2017 to end of January 2018) to a peak of 48.7% in the last week of December 2017. However, from the week commencing 5 February to the week commencing 26 March, there was improvement with average
of 31.8% of handovers delayed by more than 15 minutes.

![Count of handover delays and average handover time](chart.png)

*Source: Trust Provider Information Request – Handover delays*

Delays in handover at emergency departments sometimes impacted on the service. Crews were sometimes needed to respond to other calls but were delayed in handing over patients to emergency department staff in acute hospitals. In such circumstances, a general broadcast call would go out to all available crews in the area to assist. The trust also used operational managers and operational officers to work with staff in the emergency department to reduce handover delays.

**Learning from complaints and concerns**

The trust’s complaints policy (November 2016) gave a structured approach to the management of patient feedback. However, information about how to make a complaint was not available on vehicles and staff involved in a complaint were not kept updated or informed of improvement from patient feedback.

People who used the service knew how to make a complaint or raise a concern and felt comfortable doing so in their own way. Patients and their relatives told us they knew how to make a complaint if needed, but had not had cause to do so. However, information to inform patients and carers how to raise concerns about their care or make a complaint was not always available on vehicles. On several vehicles we checked, staff were unable to provide written information but told us that if patients wished to raise a concern this could be done verbally or through the ‘Getting in Touch’ page on the trust’s website.

People were encouraged to make complaints, and staff told us they viewed it as an opportunity to review and learn from situations where things had gone wrong or fell below patients’ expectations.

The process for people to complain to the trust was straightforward. People could complete an online form on the trust website, write to or telephone the trust. The instructions on the website were clear for people to follow. However, on some vehicles we saw signs advertising a single phone number for feedback. It was not clear how patients with hearing were able to access this telephone-based feedback service, or how people with sight loss would know of its existence.
The trust had a dedicated patient experience team who oversaw the complaints process. We spoke with two members of staff who had been involved in responding to complaints and, although they had been asked to provide a statement of events, they told us they had not received any further feedback and were unaware of any lessons learnt. We spoke with a further four staff regarding actions or improvements taken because of patient feedback. None of the staff were aware of trends or themes identified through the complaints process, or any service changes implemented to improve the quality of services. This was also true at operational officer level, where no feedback on the quality of the investigation into a complaint was received.

A significant number of frontline staff stated they did not want to educate the public if they had incorrectly summoned an ambulance for fear of having a complaint made against them.

Complaints were responded to well in terms of the quality and work that went into the response. However, responses were not always timely, although this was improving. The trust acknowledged almost 100% of complaints received within three days in the 2017/18 year.

Complaints were not being responded to within the deadlines set by the trust. The trust target for a full response to be given following a complaint was 25 days, or 35 days for a more complex complaint. In the year 2017/18, the trust responded to 60% of complaints relating to emergency and urgent care within the target time. The latest performance information showed response rates had deteriorated significantly to only 16% in April 2018, but by June 2018 significant progress had been made with 71% of complaints receiving a response within the required timeframe.

The number of complaints made to the trust had fallen. In the year 2017/18, the trust received 1,334 complaints, comments or concerns. This was 17% less than in the previous year. Around 40% of the complaints received related to the emergency and urgent care service. Most concerns for frontline operations were about the clinical assessment provided (41%), followed by communication and poor attitude of staff (31%).

The quality of complaint responses was good. During our regular engagement work with the trust we reviewed several significant complaints. We found them to be investigated well, with a thorough response produced. Additionally, in 2017/18, only 28 complaints (2%) had been re-opened because the complainant was not happy with the response. In 2017/18, five complaints were made to the Parliamentary and Health Service Ombudsman, of which none were upheld.

The organisation learned from complaints. The 2017/18 annual report described some of the 300 actions taken because of complaints made about frontline operations. These included conversations with frontline staff about dealing with pneumonia, checking the use-by dates of medicines on vehicles, and managing expectations of staff in care homes. There was also learning on specific clinical subjects, including managing dehydration and stroke diagnosis. There were discussions with several staff about communication and looking at a situation from the perspective of the patient or relative.

**Is the service well-led?**

**Leadership**

Leaders had the skills, knowledge, experience and integrity needed both when they were appointed and on an ongoing basis. Staff spoke highly of the chief executive and told us when they had contacted them directly in special circumstances, they had been very responsive and had replied to the staff members personally. However, some staff felt their line managers (operations
managers) were not very supportive and felt they did not have all the right skills, experience and knowledge to meet the demands of the role.

Some management roles were in the process of change at the time of inspection. County commanders had been developed and had been in post for only a few days. The new role included an increase in administrative duties and a reduction in time on the road, which was hoped would enable this staff group to provide better clinical and managerial leadership.

The restructure of operational management had resulted in uncertainty for many staff. The restructure was almost complete with only a few roles left to fill. Staff reported there had been many changes to processes and assessments over the last few months, which they found unsettling. We were told by the county commanders that the reasons for this restructure were:

- To provide clearer links for communication through a county-based model.
- To improve consistency internally and externally with stakeholders.
- To improve financial management following the re-banding of operations officers to band seven.

Some staff told us barriers remained at the management level below the executive board. We were told staff only heard from this level of management if there was a problem. Long-serving staff explained the style of management had not changed for many years. They felt the service “could not move on until this changed”. Some staff told us they would only be “summoned” to meet with these managers if they had done something wrong. However, we heard how some staff met directly with the executive board through individual meetings, executive walk arounds, and development days.

All staff, including remote and lone-working staff, could identify the different leads up to county commander level. However, some staff did not know who key managers and leaders were above this level, besides the chief executive.

Some operational staff from all divisions did not feel valued or respected by managers. We spoke with seven staff from all divisions, specifically about their relationship with their line manager. Five staff did not feel supported by their line manager and did not feel they had a good rapport with them. Although these staff appreciated their line managers oversaw large geographical areas, they often described leaders as absent. The presence of line managers at a station was ad-hoc. There were no structured meetings or forums where staff gathered to receive information or to collectively discuss changes or share their views. However, the experiences of the other two colleagues were quite different. They described engaged line managers who were highly visible and communicated well with them.

Some operational staff in the west division saw their direct line managers on a regular basis. Staff described them as knowledgeable, experienced and approachable. One member of staff said, “they always give a quick and appropriate response to questions”. Another member of staff said the local leadership team was strong and “provided good leadership, not just good management”. However, some staff expressed concerns about the recent restructure, which would reallocate staff to different managers. Previously managers had been responsible for staff at one station. Under the new structure, managers would be responsible for named staff working at several stations. Staff expressed concerns this would reduce their face-to-face contact with their manager.

Leaders and managers were not always visible and approachable. Staff told us they saw the station managers, and some came and had lunch with staff in their mess room, which staff
appreciated. It meant staff could talk about minor issues on an informal basis. Staff told us they did not see managers above this level, despite them having offices in the same building at some bigger stations.

Managers had tools in place to monitor sickness. Operational officers were responsible for weekly welfare contacts for any members of staff who were on long term sickness, which was measured at over 28 days. All staff had free access to a ‘staying well’ service, which included counselling and physiotherapy. Positive feedback about this service was received from staff. However, some staff felt there were inconsistencies in the way managers treated them during and following a period of sickness absence. They gave instances where some managers had telephoned staff when they were off work for wellbeing checks. Others had no contact with their manager.

Leaders and managers understood the challenges to quality and sustainability, although they did not always identify the actions needed to address them. Some staff told us the recent change in the management structure had caused a lot of anxiety and anger. They felt there was little information provided to them and they had to apply for roles where job descriptions and other information were not available. Many lead paramedics had stepped down from their roles due to changes with the pay grading. Operations managers were in the process of applying for their roles under new titles (deputy county commanders). Staff did not know who their new area managers were as some had not been appointed. Staff felt they were losing very experienced staff due to this restructuring.

Managers talked about challenges caused by operational pressures, the impact this had on the quality of services, and response times. The trust had developed a three-year transition plan with commissioners, to enable the organisation to achieve national required levels for response times.

Managers understood the challenges to quality posed by the failure to meet the response time standards with an ever-increasing demand for services. Action had been taken to try and help with these challenges, for example work had been undertaken with the 111 service and clinical desks to help reduce the number of calls resulting in an unnecessary ambulance attendance.

The leadership team held regular conference calls with the operational officers to share intelligence and learning from incidents, complaints and audits. This happened on a six-weekly basis and was called the ‘sector health huddle’.

There were clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership. The trust had a development programme, which included succession planning. The trust had also introduced a leadership programme called ASPIRE for staff to undertake leadership development courses.

**Vision and strategy**

There was a clear set of values, which were published and displayed around the stations we visited. The values were “working together for patients, respect and dignity, commitment to quality of care, compassion, improving lives and everyone counts”. Staff we spoke with were aware of the organisation’s values and spoke of patient care and safety being at the forefront of their job.

Some staff were involved in the development of the core values. This was achieved through ‘time to care’ focus groups. Leaders ranging from operational managers to directors were then involved in establishing the specific wording of the values.
Some staff knew about and understood what the vision, values and strategy were, and some staff understood their role in achieving them. The trust had a clear vision with a realistic strategy to achieve it. The trust’s vision was “to deliver exceptional patient care by exceptional people”, with a mission statement “to respond quickly and safely to patients’ emergency and urgent care needs, at every stage of life, to reduce anxiety, pain and suffering.” The trust had established three strategic goals to achieve this, which had clear direction and were underpinned by clear initiatives:

- From Prevention to Intervention: summarised the trust's ambition to support a safer, more efficient and sustainable urgent and emergency care system for the future.
- Right Care, Right Place, Right Time: captured one of the trust's key initiatives that focused on ensuring patients received the best possible care, in the most appropriate place and at the right time.
- 1 Number, 1 Referral, 1 Outcome: captured the value added by the trust as a provider of NHS 111 services that were integrated with GP Out-of-Hours and 999 services.
- Local Service, Regional Resilience: recognised the dual role of the ambulance service in delivering a local service, providing individual and personalised care to patients, balanced with system-wide coverage and capacity for resilience.

We asked five members of staff of different grades within the organisation to describe the vision, which was first published in July 2014. Staff could not talk about the core aims of the strategy or describe their contribution in achieving these aims. However, one station manager described the key aims and understood his responsibilities to communicate and promote the vision.

There was a realistic strategy for achieving the priorities and delivering good quality sustainable care. The trust’s long term strategic goals and corporate objectives reflected its quality priorities. These included national priorities for ambulance trusts and local commitments agreed with external stakeholders, including the clinical commissioning groups and the trust's council of governors. The trust had four strategic goals supported by a quality strategy. The strategy was developed in consultation with both staff and patients.

The strategy was aligned to local plans in the wider health and social care economy. The organisation had engaged with a variety of external stakeholders, including those involved in the various Sustainable Transformation Partnerships (STPs) they were part of. This had also involved the development of a three-year transition plan with commissioners to help improve the organisations ability to achieve targets. The trust’s strategic goals were:

- **Safe, Clinically-Appropriate Responses**: Delivering high quality and compassionate care to patients in the most clinically-appropriate, safe and effective way.
- **Right People, Right Skills, Right Values**: Supporting and enabling greater local responsibility and accountability for decision-making; building a workforce of competent, capable staff who were flexible and responsive to change and innovation.
- **24/7 Emergency and Urgent Care**: Influencing local health and social care systems in managing demand pressures and developing new care models, leading emergency and urgent care systems and providing high-quality services 24 hours a day - seven days a week.
- **Creating Organisational Strength**: Continuing to ensure the sustainability, maintaining and enhancing financial stability.

Progress against the delivery of the strategy and local plans was monitored and reviewed. Performance and progress was reported within the trust’s integrated corporate performance
report, which was presented to the board of directors at each board meeting. We looked at minutes for these meetings and saw they were comprehensive and used data from all areas of the service to evaluate performance and drive improvements.

The trust had an implementation plan for the new ambulance response programme (ARP) standards and had switched over to the new monitoring system in November 2017. Progress against this plan was monitored daily through trust-wide operational calls and reports to the National Ambulance Advisory Council (NAAC). Managers showed us the daily report, which benchmarked all performance data from all ambulance trusts nationwide. Managers said they found it assuring to see how other trusts were performing as it gave them further assurance of their own performance when other trusts reported similar issues and data.

**Culture**

Leaders across the trust tried to promote a positive culture that supported and valued staff. Staff in the north division told us the care of patients was at the forefront of everything they did and this approach was supported and driven by senior staff. They reported they never felt pressured by managers to reduce the amount of time spent with patients and they were given the time to provide a good level of care.

Some staff felt supported and respected, however many staff we spoke with did not feel valued by the trust. There was low morale and staff felt disengaged. Staff expressed concerns over ongoing issues with overruns on shifts and with annual leave availability. The trust had an annual leave policy which required staff to book 75% of their leave before the start of the new financial year. Several staff explained that despite doing this, they frequently had their requests rejected, and many reported being allocated odd days of leave when they could not book it when they wished. Staff told us in some stations they were starting to record data about their overruns and missed breaks, although this was dependent on the manager in charge of the station and staff were unclear as to what the data would be used for.

The trust monitored additional hours worked as part of their monthly expenditure reports. Between June 2017 and May 2018, the trust paid 109,531 hours in overtime and 3,329 hours in time owed because of shift overruns and unplanned overtime.

Most staff on the frontline described how they enjoyed their job. However, shift pattern changes, overruns and increasing pressure and demand had resulted in increased sickness and people leaving the service. Some station managers believed the loss of staff was due to improved job prospects in other organisations for paramedics. However, they also acknowledged that morale was low at some stations. The change in leadership structure was hoped to improve morale, however it was too early to tell if this had been, or would be, successful.

Staff morale and motivation in the emergency and urgent care service was mixed with deteriorating scores reported in areas around manager communication, job satisfaction, effective use of staff and patient feedback, the number of staff feeling they made a difference and the number of staff recommending the trust as a place to work. In the 2017 staff survey there were five key findings where staff experiences had deteriorated since the 2015 survey:

- The percentage of staff agreeing their role made a difference to patient service users had decreased from 89% to 86%.
• The scale score (calculated by converting staff responses to questions into a score between one and five, where the higher score the better) for staff who thought the organisation effectively used patient and service feedback decreased from 3.35 to 3.22.
• The percentage of staff reporting good communication between senior management and staff decreased from 28% to 24%.
• The scale score for staff who recommended the organisation as a place to work or receive treatment decreased from 3.57 to 3.46.
• The scale score for staff who were satisfied with the quality of work they could deliver decreased from 3.84 to 3.75.

The report identified one area where staff experience had improved:
• The percentage of staff who had received an appraisal within the last 12 months increased from 76% to 82%.

The trust had produced a service line action plan in response to the staff survey, which showed broken down areas to work on by division. The action plan contained both positive and negative highlights from the survey, and showed key objectives and plans for achieving them. However, it was not clear how progress against the objectives was being measured. The trust also had a corporate action plan, which showed dates for review for all actions. Some actions contained updates, including a progress update around the increase in the number of staff failing to report errors, near misses or incidents. All these actions had clear owners and review dates.

The trust had provision for supporting staff affected by incidents, including caring for deceased patients of all ages. This was extended to all staff, including bank staff. All employees at the trust could access a staff wellbeing service called ‘Staying Well’. This offered support for physical and psychological health needs. Several staff we spoke with spoke highly of the resource and knew how to access mental health support. Managers told us how the Staying Well service had been used to support staff who had experienced post-traumatic stress disorder return to work. However, some staff felt the emotional support offered by the trust was poor following traumatic and emotionally challenging jobs. Staff described feeling pressured to become available for the next job and felt they were not given enough time to debrief following incidents.

Following highly emotional or traumatic events, the trust acted promptly to support the mental wellbeing of colleagues. Operational officers with additional training in psychological support conducted welfare checks. The officer contacted personnel to discuss the situation and assess if further support was required, which may include a referral to the staff well-being service. Staff were aware the trust used the Trauma Risk Management (TRiM) model for debrief, however three staff said this model was not followed properly and they had failed to receive a 72-hour follow up from their manager.

There was not always a strong emphasis on the safety and wellbeing of staff. Staff in the east and west divisions felt their wellbeing was not always promoted, especially around the booking of annual leave. Staff told us it was difficult to get leave agreed, especially in the school holidays. If staff worked with their partners, it was problematic trying to get time off together. However, some staff in the north division felt well-supported and told us there were systems and support mechanisms when required. This included support following work-related incidents and personal and physical support following certain injuries. Staff in the north division told us leaders were supportive and promoted a culture where staff could raise concerns with them. If staff experienced a difficult call, leaders in the north division set aside time for a debrief and additional time was set.
aside in the following weeks to review staff wellbeing. In addition, staff we spoke with across all divisions felt one of the biggest threats to their welfare and morale was the continued, significant overruns.

Staff had access to confidential support through a staying well service. This provided emotional and confidential support for staff. Support was provided for both work-related and personal needs. Staff in the north division spoke highly of this service and reported it was promoted, readily accessible and responsive to their needs. One member of staff described the trust’s wellbeing service as “incredible and proactive”. We were given examples where access to a counsellor was timely, with processes to ensure the right counsellor was available at the right time of day. Along with the counselling service, staff described good access to physiotherapists to ensure injuries obtained either in or out of work were managed appropriately. However, in other divisions some staff felt the trust needed to be more proactive rather than reactive. Others were worried if they used their allotted counselling sessions for one incident, they may need it more in the future and be denied access.

Staff received recognition for their work. Letters of praise and thanks from patients were shared with staff by email with an accompanying note from their manager. We saw thank you cards displayed in many of the ambulance stations we visited. Positive feedback received also formed part of the monthly reports created by the quality buddies. Quality buddies were staff responsible for distributing key quality information including patient safety, patient experience and risks to operational managers/county commanders, clinical hubs, urgent care and operational service managers. We also saw evidence of staff members receiving letters of commendation from senior management regarding incidents where they had performed above and beyond what was expected.

The culture was centred on the needs and experience of people who used services. Staff always acted in the interests of their patient, which we saw in all the episodes of care we observed. However, the recent 2017 staff survey showed staff felt the organisation did not respond or use patient feedback effectively. There had also been a 3% decrease in the number of staff who felt their role made a difference to patients, since the last survey.

Most staff we spoke with felt positive and proud to work for the organisation. Nearly all staff we spoke with in the north division told us they were most proud of the care they gave patients. One staff member said they were proud to put on and wear the ambulance uniform every day.

Leaders tried to encourage openness and honesty at all levels, especially around driving incidents. However, staff felt there was a ‘guilty’ culture in relation to driving incidents. Staff told us if they were involved in a driving incident while using blue lights they were suspended from driving until they had been re-assessed by the driving team. One member of staff told us they were involved in an incident that was not their fault and had to go through this process. Sometimes this review took place quickly, but other times it could take longer for the staff member to be re-assessed. However, most staff told us they were supported by their operation managers during this time.

There were mechanisms for providing staff at every level with the development they needed, including high-quality appraisals and career development conversations. Individual performance was monitored to assess for areas of improvement. Performance was assessed fortnightly by operations officers who reviewed individual key performance indicators, sickness, absence, complaints and incidents. If areas of concerns were noted, one-to-one meetings were held with the staff member.
There were not always cooperative, supportive and appreciative relationships amongst staff, and teams did not always work collaboratively to resolve issues quickly or constructively. One manager told us they would shortly be returning to their previous role as they felt they were being asked to pressurise the crews in their current role. They felt there was a great deal of goodwill shown by staff who came in early to clean vehicles and complete checks, as they were otherwise frequently sent out prior to these checks being completed. They felt this goodwill was overlooked and they were expected to discipline these same staff if problems were found which delayed them booking on with control or if they were taking ‘too long’ on scene with a patient. Other staff also reported they felt bullied by senior staff. However, in the north division staff reported they worked well with colleagues and reported incidents where staff had supported each other. Staff were willing to work extra hours to support colleagues when needed.

The organisation did not always manage organisational change well. During our inspection, we were told of a planned change to staff meal breaks. Staff were entitled to two unpaid 30-minute breaks in a 12-hour shift. Senior managers told us they wished to trial one 45-minute break in a 12-hour shift, and reducing the number of hours staff had to cover on relief weeks to cover the 15 minutes staff would lose. Senior managers said this was also a move from a station-based to a vehicle-based service (where crews used the vehicle as a base rather than a station). We spoke with staff about this proposed change and none knew about it. On the last day of our inspection, staff told us an announcement had been made through the main trade union social media page, informing members of the proposed changes. Staff told us they were unhappy about this and felt things were "done to them", rather than in consultation. Staff also expressed concerns about having to carry their food with them for the duration of the shift, without having appropriate cool storage. This was due to managers wanting them to take breaks at the nearest station, rather than return to their base station, although discussions around this issue were still ongoing with unions.

At the time of our inspection the organisation was introducing a new staff structure. Staff we spoke with reported they were uneasy and unaware about all the changes being made and the impact they would have. For example, one north division station had an operations officer to manage staff concerns and to respond to and manage incidents, such as cardiac arrests and road traffic collisions, to allow ambulance crews to concentrate on providing care. Proposed plans included removing the operations officer from this station and having them at another station. One member of staff said, "it would be worrying if you didn’t have someone to talk to", another said “I can perform my job well knowing I have an operational officer following me up the garden path”.

**Governance**

There were some effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services. There was interaction between trust management and operational staff on quality, safety and governance. There was a clear governance structure, with clear lines of reporting at senior level. Operations officers fed into the deputy county commanders and county commanders through meetings every three weeks. There were twice-monthly meetings held by the county commanders, which fed into the monthly senior leadership team meeting (executive board).

The trust had developed a programme of ‘quality buddies’. These were staff from various parts of the governance functions in the organisation who linked with operational staff to share a range of information. A quality buddy had been assigned to each operational area. Reports were generated quarterly, which gave an overview of serious incidents and themes, adverse incidents,
safeguarding referrals, duty of candour, complaints and compliments, patient engagement and a risk register overview. The scheme was developed to pick up an action from the last CQC report on the disconnect between operational managers and senior staff in relation to quality and risk. It aimed to ensure operations managers had the right support and information to brief frontline staff. This scheme linked the quality team with operations managers under the old structure and county commanders under the new structure, and to date had been very well received by senior managers. We reviewed two of the quarterly quality reports and saw they gave a comprehensive overview of incidents, safety performance and learning alongside other data such as complaint responses.

Most levels of governance and management functioned effectively and interacted with each other appropriately. Meetings were held monthly to discuss any themes from incidents, complaints, audit results, claims, inquests, risks, and to share excellent performance. However, staff had mixed levels of awareness of this.

Staff on the ground felt disconnected from the higher level of management, including the senior leadership team (executive board). They said they felt well connected with the operations officers, but less so with staff more senior of this. This meant they were unaware why decisions were made at a more senior level, and felt decisions were ‘top-down’.

Arrangements to facilitate information sharing from the board to local staff were not always effective. We heard of multiple ways in which information was shared, including bulletins, emails, posters and development days. However, staff reported they often did not have the time to read all the information. This meant they were unaware of some changes and learning across the organisation. We were informed county commanders would be carrying out twice-yearly visits to each station to enable information sharing, however at the time of our inspection this had not started.

Staff at all levels were clear about their roles and they understood what they were accountable for, and to whom. All staff we spoke with understood the importance of keeping up-to-date with clinical updates, but some did not always understand why changes had been made to a policy or guidance. Staff explained if they did not keep up-to-date with best practice and trust guidance, they risked their professional registration if they acted outside of trust policy. Previously, staff expressed concerns they did not always get enough time to read and digest clinical updates on station. It was also not clear previously if managers had oversight of staff who had not read and acknowledged clinical updates. We saw the introduction of the new Joint Royal Colleges Ambulance Liaison Committee (JRCALC) plus application allowed staff to access all clinical updates and policies on their personal mobile phones. Staff acknowledged this would make it easier for them to keep up-to-date with changes. Through the application staff acknowledged they had read updates, which gave managers a central oversight of which staff had and had not acknowledged certain updates. As the application had only just been released during our inspection, it was too soon to see if it was an effective way of monitoring staff compliance with clinical updates.

We asked a learning and development officer and five staff about feedback from audits. None were involved in conducting audits or could identify any changes in practice because of audit activity, other than failure to meet response times.

The need for learning, updating knowledge, and changes to practice had been identified by the trust. Examples included staff being made aware of how the new General Data Protection
Regulations (GDPR) affected what they recorded and stored on the electronic patient records. The Joint Royal College Ambulance Liaison Committee (JRCALC) guidance used locally by staff was updated where it was recognised changes were needed to practice following incidents or complaints. There had also been training delivered for caring for an intoxicated patient with possible underlying injuries following a Coroner’s inquest.

The trust had a system which flagged when new paramedics had completed 150 operational hours and required a one to one with their manager. There were also processes between the operations officers and the training practitioner which flagged when staff were falling behind with their coursework so help and advice could be offered to get the staff member back on track with their study programme.

There were arrangements in place and being developed for coordinated working with other services and agencies. The trust was in the process of developing a new pathway for non-injury fallers. This would involve working closely with the local fire services who would attend these calls and request an ambulance attend if the patient was found to be injured. It was hoped this service would improve ambulance availability and improve response times.

The trust ensured ambulance staff declared working arrangements outside the trust. There were systems to review staff who had secondary employment, but there was no system to monitor if staff members were working excessive hours. The trust had a policy which stated staff members had to apply if they wanted to undertake secondary employment, which would then be authorised by the county commander or their deputy. However, managers informed us they had no process of monitoring an individual’s working hours including any secondary employment. Instead they had to rely on their observation of staff performance.

Management of risk, issues and performance

The arrangements for identifying, recording and managing risks, issues and mitigating actions were not always sufficient. At the time of our inspection there were 49 risks on the corporate and directors’ risk register across all core services. Risks included incident stacking (jobs which have been taken by call takers but which are yet to be allocated a resource to be dispatched), ARP performance targets, major IT service failure, service changes and their impact, reputation, commissioner affordability, external impact on finance strategy, and 999 clinical call audit compliance.

At our previous inspection we found there had not been alignment between the recorded risks and what staff said was on their ‘worry list’. We found this was still the case with frontline staff in most stations we visited. We asked staff if they had any knowledge of trust-wide risk registers, and most responded they did not. Staff could not tell us what the top risks to the service were. We saw little evidence of discussion in relation to existing or new risks within the divisions. There was a trust-wide risk register for the operations directorate. Risks were allocated to the Executive Director of Operations. There was no requirement in the trust for risk registers to be maintained at station, sector, division or service line level (except for one held at a north division station). However, accountability for managing local risks, or corporate risks at a local level, remained unclear. We saw some discussion recorded at operations meetings in relation to meal break management and staff working beyond their contracted hours, as staff and managers acknowledged this remained an ongoing risk. We saw in two stations staff had devised a way to record all their missed breaks and overruns. However, staff told us they felt it was disappointing it
had been left to staff to organise, and did not know who would eventually look at the data they were collecting.

At our last inspection we found staff had voiced concerns over intensity of work, staff resilience, levels of staff absenteeism due to sickness, and staff turnover. We found the 2017 staff survey reflected the same concerns but also raised some other worrying staff feedback. For example, the survey showed the number of errors, near misses or incidents had increased, the number of staff experiencing violence at work had increased and the number of staff experiencing bullying and harassment had increased. We did not see any risks recorded on the corporate risk register which reflected staff welfare or resilience. Instead, operational resilience was captured in a risk around business continuity. We reviewed this risk register and the operations risk register and saw all recorded risks were well-documented. Following our inspection, the trust added a risk to reflect the potential impact of the proposed meal break changes to the operations risk register.

The trust conducted a review of the corporate and directors’ risk register before moving from spreadsheet-based risk register to a new online risk management system. This piece of work was designed to simplify the risk register and make the monitoring and challenging of assurance of risks more efficient. However, while visiting one station in the west division we asked to see the risk register to ascertain the key risks to the service in this area. We were told the register was held centrally at the headquarters in Exeter and not available locally, and the manager was unable to locate or produce the register at the time of our visit.

There were processes to manage risks within the organisation, although not all staff were aware of them. Risk registers were managed by Executive Directors or Directors and overseen by the Quality Risk Assurance Group (QRAG), who reviewed risks monthly. Risk registers were mainly held at divisional levels. The QRAG also challenged senior management. For example, senior management wanted to reduce the risk rating for call stacking, but this was overruled by the Quality Risk Assurance Group.

There were comprehensive assurance systems, and performance issues were escalated appropriately through clear structures and processes, which were regularly reviewed and improved. The trust board used a joint board assurance framework to provide a simple and comprehensive method for the management of the principle risks to the strategic objectives. It also provided a structure for the recording of evidence to support the annual governance statement. The highest rated risks from the corporate risk register were explored in more detail so the board could gain assurances the risks were being effectively managed. At the time of our inspection the trust had identified one risk with a rating over 25, and seven risks with a rating of 20. We saw that as part of the joint board assurance framework, all these risks had undergone a deep-dive and the outcome for each had been reported to the board. For example, the deep-dive of the highest risk score for the emergency and urgent care service was around the ARP performance targets. The deep-dive showed key controls currently in use, such as actions included as part of the quality performance improvement plan and the introduction of new rotas. It also identified further actions required to reduce the risk score, which included the development of new web reports to enable the review of performance against the new standards and the recruitment of additional call handlers and emergency operations centre clinicians.

There were processes to manage current and future performance, which were regularly reviewed and improved. Senior leaders were sighted on the key issues to performance which affected the service within their locality. Live performance data was available and personnel such as operations managers and officers monitored the information to make informed decisions regarding
resources and escalation processes. These performance trends were discussed daily by teleconference, weekly by on-call managers, and fortnightly at the county commanders’ meetings.

There was a systematic programme of clinical and internal audit to monitor quality, operational and financial processes, and there were systems to identify where and when action should be taken. Quarterly audit and assurance meetings took place, which discussed all current and planned audits, both internally and externally. We reviewed minutes from these meetings and saw discussion around each audit item, with actions recorded along with the owner of the action. The trust also had a 2017/18 audit schedule, which covered 13 areas of focus for the year. These included records management, infection prevention and control, and an evaluation of the non-injury faller volunteer scheme. All other audits were focussed on improving outcomes and response times for patients.

Potential risks were considered when planning services, including seasonal or unexpected fluctuations in demand. We saw how during a recent heatwave the trust worked with Public Health England and the Met Office to ensure resources were allocated to high risk areas. In addition, there were regular reviews of upcoming local events. This included an alcohol support programme where a treatment centre designed to support patients who had excessive alcohol on weekends was deployed. Street pastors and security were provided with the telephone number for this service to reduce the number of 999 calls and to reduce hospital attendances.

When considering developments to services, the impact on quality and sustainability was assessed and monitored. The senior management team were working in partnership with local commissioners to improve efficiency in the service to improve performance against ARP targets. We saw a draft action plan showing eight areas for focus, including NHS111, high intensity users, falls, healthcare professional calls, mental health, frailty, handover delays and the use of alternative pathways. Some of the areas for focus reflected concerns raised by staff at our previous inspection, especially around pathways and mental health services.

Ambulance crews understood their role in major incidents and were involved in planning and exercises. At the time of our inspection an updated major incident response plan was out for comment, and was due to be approved by the senior leadership team. A decision to review the plan had been made in response to a major incident in Wiltshire. However, we found there were some major incident cards still in circulation on vehicles which were out of date and were not in line with best practice or current standards.

On the Isles of Scilly, a table top exercise had been run in February 2018. A resilience officer responsible for the ambulance service response to a major incident on the Isles of Scilly ran the exercise. The scenario presented was that of a passenger aircraft crashing into the terminal building at St Mary’s airport, resulting in 20 casualties. During the exercise the Command, Safety, Communication, Assessment, Triage, Treatment, Transport (CSCATT&T) model was followed to target discussions around areas of response. Several areas of weakness were highlighted during the exercise and the debrief report made recommendations of further work required.

Information management

The arrangements to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems were not sufficient in areas we visited. Some patient records were not stored securely at one north division station. In the crew room each staff member had a pigeon hole and a locker to store personal items. In one of these pigeon holes we saw over 30 patient record forms which contained the patient’s name, address, date of birth and medical
interventions. There were also papers which contained patients’ personal information. Within this pile we also found a vulnerable adult safeguarding form from 2016, which contained the patient’s name, address, and a description of the abuse identified by the crew. Within the locker, which was open with the key in the lock, we saw an additional three-inch-high pile of patient records, which included a mix of patient records and patient safeguarding referrals. There was also a printed record of a vulnerable child safeguarding referral form from 2006, which contained personal information as well as the reason for the abuse being referred. We raised this with the station manager who oversaw our inspection of the paperwork and areas identified.

We informed a manager of what we found and they removed the records from the pigeon hole and stored them safely in the office. The patient records in the locker were left but the locker was secured and the key was left with the manager until the records could be managed appropriately.

Additionally, we found on one ambulance in the north division, a patient’s name, date of birth, address, observation results and medicines given written on the back of a paper pad. We raised this with the manager on site who removed it and disposed of it appropriately.

Information stored electronically was not always secure. We saw computers being left unlocked and unattended when not in use at stations which were themselves, not always secure. This meant information was accessible to members of the public. We also saw several electronic patient record devices unlocked and unattended in the back of ambulances.

There were clear service performance measures, which were reported and monitored. These included response times and patient outcomes, which were reported at all levels of the organisation, including individual monitoring and feedback. Information was used to measure improvement as well as to gain assurance of performance and safety. The organisation had recently reviewed the impact of a falls admissions avoidance pathway in one north region. The most recent results from January to December 2017 showed a drop in falls admissions from 63% to 13% overall.

The trust had systems for assessing and managing foreseeable risks, which may affect the capacity of the organisation to meet demand. A series of strategic calls escalated information from frontline crews to those making organisation-wide decisions. However, we were unable to see how decisions and information from a trust-wide perspective was communicated to operational teams, including ambulance crews.

Operations officers were responsible for the management of resources, including staffing within a cluster of locations. The operations officers participated in a daily teleconference, known as ‘bronze command’. The bronze command teleconference for the west division also included an operations manager. The aim of the calls was to evaluate performance over the previous 24 hours, assess current risks to the service, and plan for foreseeable concerns, which may arise over the next 48 hours. We listened to these calls in the east and west divisions and heard meaningful and concise discussions.

Performance data reviewed during the bronze command meeting compared actual demand against predicted demand, estimated from the previous year’s activity. At the time of inspection, the activity experienced by some areas located in the west division was 25 to 35% more than the previous year. Across the entire west division there had been an increase of 10.6% against the predicted activity. Incidents with poor response times were identified and investigated to determine if any patient harm had occurred because of delays. If patient harm was identified, this was
escalated to the higher level ‘gold command’ meeting and reported as a clinical incident via the electronic reporting system.

The performance data available to operations officers and managers included the operational status of receiving hospitals. This was used to evaluate potential threats to patient safety across a local system. For example, the number of crews waiting to handover patient care was used to assess flow and prompted a conversation between the local operational team and managers at the external provider.

To evaluate performance and foreseeable risks across the trust, a higher level ‘gold command’ teleconference meeting took place daily. The teleconference was attended by operations managers from each bronze command teleconference to allow information to flow across the organisation. The meeting was structured to allow the operations manager from each locality to report performance, resources, concerns, and actions. The gold command teleconference also received information from the National Incident Liaison Officer (NILO), who reported the current terrorism threat level and weather warnings issued by the Met Office.

There were effective arrangements to ensure the information used to monitor, manage and report on quality and performance was accurate, valid, reliable, timely and relevant. Action was taken when issues were identified. At the time of our inspection, the Met Office had issued a level two weather warning due to a heatwave. The trust had implemented a heatwave plan, which included consideration for the expected influx of visitors towards coastal areas and practicalities such as bottled water provided to frontline staff.

The information provided by those attending the gold command call was used to inform the actions taken across the organisation to maintain patient safety. We heard information regarding the expected increased use of the 111 and urgent care centres and how these may be impacted by reduced staffing in these areas. There was a focus placed on effective handovers at receiving hospitals and an emphasis on monitoring system-wide performance as demand was expected to rise over the next 48 to 72 hours. We also heard messages regarding staff welfare during the heatwave and praise for those working on the frontline to deliver a good standard of care. However, it was unclear how this information from the gold command call was shared with the wider workforce. We were told there was no structured process in place. We asked a member of staff who had not received the information about their welfare despite being operational in the hot weather.

**Engagement**

People’s views and experiences were gathered and acted on to shape and improve the service and culture. We saw discussion around safety incidents, compliments, complaints, feedback and contact from other organisations such as the Parliamentary and Health Service Ombudsman in minutes from the annual patient safety and experience report. The report identified themes from all sources of feedback, including areas for learning. However, it did not contain details of specific things which had changed because of the report. The trust’s Communication and Engagement Strategy (December 2014, due for review December 2017) was developed to support the strategic goals of the organisation through an improved interaction with key stakeholders. The organisation had established pathways for sharing information with media outlets, other NHS providers, the public and staff. However, staff we spoke with did not always feel involved or understand changes within the organisation and we were unable to identify how the staff voice was consistently heard.
at all levels of the organisation. Staff we spoke with reported they mostly relied on the yearly development day to hear about shared learning and changes to practice.

The trust attempted to engage with staff, including those working from remote locations. Within the west division, the use of social media was being used as an accessible and easy form of communication. Colleagues could join a closed group where organisational information, including learning from incidents, was shared to improve engagement. Teams could see who had viewed information and gauge the level of engagement. The team were considering spreading the use of social media to other teams as they felt it had improved staff engagement. However, there were concerns about how the trust would engage with staff working from remote locations following the organisational restructure. Operational officers were still located at the stations; however, it had not been determined at the time of our inspection where they would be located following the reduction in these staff. To help with this transition we were informed the county commander and their deputy would be visiting the stations in the short term.

Communication from the senior leadership team was cascaded via newsletters, emails, text messages, and electronic messaging to vehicles. All staff agreed communication was challenging in a large organisation where staff were spread across a wide geographical area and worked different shifts. However, we were told station or team meetings no longer occurred to help manage this challenge. Information was usually received electronically, but at times staff felt the volume of information was overwhelming, which made it difficult to identify the ‘need to know’ points. Additionally, frontline staff did not always have time to read emails at the computer. This staff group had come to rely on informal communication routes where information would be shared between colleagues. They told us they did not always feel fully informed of the latest information in the organisation.

In the absence of staff meetings and due to the ad-hoc nature of contact with line managers, staff told us there was no consistent route for them to collectively feedback their opinion on changes within the organisation. We were told there were health and safety meetings involving staff side representation from unions, but this was not a route open to all staff and not always appropriate.

It was hard for senior managers to engage face to face with front line staff. Due to the low morale found in some stations, there were plans to try and improve engagement via local forums and bulletins. These plans were yet to be put in place. One member of staff stated, “there were no human interactions from management.”

Staff did not feel actively engaged with and therefore did not feel their views were reflected in the planning and delivery of services. We asked staff how the organisation engaged with them and collected their views. Staff reported this was mostly limited to staff surveys and yearly career conversations. However, we also heard of examples of positive engagement, including a trial for staff to raise issues about their finishing times.

Some administration staff and operations officers told us they were not kept up to date on the structural changes and didn’t feel there was enough communication, or communication was received at the last minute.

People who used services, those close to them and their representatives were actively engaged and involved in decision-making to shape services and culture. This included people in a range of equality groups. We saw an online survey aimed at collecting the views of people who had accessed services while they or someone close to them was experiencing a mental health crisis. This project was still ongoing during but managers showed us how the responses gathered would
be used to inform the future of mental health services. The questionnaire was aimed to establish what patients and their families felt were their priorities when contacting the service during a mental health crisis.

Some stations held local open days, which encouraged the public to come and find out more about their local ambulance station. This was a good opportunity to educate the public about the correct use of an ambulance. It also encouraged young people into the service and taught emergency first aid skills.

The trust attempted to engage with patients in a variety of ways. These included a 'Getting in Touch' leaflet that was available on most of the ambulances we inspected. The leaflet provided patients with information about how they could contact the trust to make a complaint or give a compliment. However, we saw none of these on display and did not observe any being given to patients of relatives. The trust also had a patient engagement programme to identify and improve engagement with isolated, vulnerable or harder to reach groups of patients.

The trust engaged with patients to drive improvement. The trust had developed a 'learning from experience/excellence group'. Their role was to monitor the implementation and sharing of lessons learnt from compliments and complaints, as well as presenting a patient experience report to the quality committee each quarter. One example of this was taken from a complaint about resuscitation carried out on a patient that had a do not attempt cardiopulmonary resuscitation (DNACPR) decision. It was decided that following discussion and confirmation from the emergency operations centre, a paramedic or other ambulance crew would no longer need to see evidence of the DNACPR decision before deciding to not carry out resuscitation in accordance with the patient’s wishes.

The trust engaged with patients to assess the quality of its services. Social media platforms were also used to engage with the wider public. We saw content regarding staying well in the heatwave and celebrating success. Stories where patients had met the ambulance crews to thank them for their work were shared to inform the public about the work of the organisation.

The trust had participated in public engagement events, which were advertised through their website. Events were planned to occur throughout 2018 across Wiltshire, Somerset, former Avon, Devon and Cornwall. The type of events included open days, school visits and attendance at community fairs.

There were positive and collaborative relationships with external agencies. There had been developments with regards to joint training with the fire service and police. It was hoped by providing training in aspects such as first aid, this would increase the other organisations’ skills and reduce demand on the ambulance service.

There was transparency and openness with all stakeholders about performance. We received feedback prior to our inspection from various sources including local commissioners, patient welfare groups and other healthcare providers. We also saw the trust received and reported on responses to the quality account from each Healthwatch organisation. However, one noted although patient experience and patient engagement were said to be the best source of information, there was no mention of Healthwatch within the quality account itself.

The trust engaged with local universities to publicise the trust as a potential employer for newly qualified paramedics. The trust ran a student paramedic conference every year. The last event was for 250 people and counted as a day’s continuous professional development (CPD). The trust
had connections with several universities in the area and was actively working on converting graduates to employees. This was a new initiative that had been put in place in the last three months and had seen uptake of graduates to positions in the trust rise to 90%.

Learning, continuous improvement and innovation

Leaders and staff strived for continuous learning, improvement and innovation. The trust was working with commissioners on a plan, focused on eight measures, to improve performance and ambulance response times. Regular reports to Clinical Commissioning Groups were planned to monitor progress against the agreed trajectories. There was also a clinical development team who assessed performance and drove improvement. This included engaging with staff and commissioners on clinically-focused pathways. This team had helped in the development of the directory of services, as well as a change in the process for the management of stroke and ST-elevation Myocardial Infarction (STEMI) patients.

The trust had a Joint Royal Colleges Ambulance Liaison Committee (JRCALC) application that was accessible to staff on their personal mobile phones. The trust planned to upload this application onto the electronic patient system so the trust did not have to rely on staff using their own mobile phones. The application contained information from JRCALC along with trust policies. The application could monitor and record when staff members had accessed and read a new policy or protocol.

There was effective participation in and learning from internal and external reviews. The leadership team had commissioned an external audit of all their stations and had introduced a plan for refurbishment of those stations. One east division station was due to be modernised and updated soon.

There were systems to support improvement and innovation work, including objectives and rewards for staff. The trust recognised staff through an annual award ceremony, which awarded staff in many different categories. These included long service, outstanding achievement and excellent patient care. The trust communications directorate also referred to staff achievements in the chief executive’s weekly bulletin. This ranged from fundraising activities to local initiatives and providing excellent patient care.

Staff were not able to regularly take time out to review individual and team objectives, processes and performance. Although staff were allocated time out for debriefing and development days, there was a lack of time spent together to discuss team objectives due to the operational demands and logistics of the job.
Emergency operations centre
Facts and data about this service

South Western Ambulance Service NHS Foundation Trust and the emergency operations centres (EOCs) provide services across a large portion of England including Cornwall, the Isles of Scilly, Devon, Dorset, Somerset, North Somerset, Bristol, Bath and North-East Somerset, South Gloucestershire, Gloucestershire and Wiltshire. The trust’s area of operation covers 10,000 square miles, is predominantly rural, but also includes large urban areas such as Bristol, Plymouth, Exeter, Bath, Swindon, Gloucester, Bournemouth and Poole. The trust serves a population of 5.3 million people, which increases over the summer months due to the influx of tourists to the South West of England.

The role of the EOCs is to receive 999 ambulance calls from members of the public and other emergency services. Staff assess caller’s needs, take decisions, provide advice, and dispatch ambulances to the scene as appropriate. Staff also provide assessment and treatment or advice to callers who do not need an ambulance response, a service known as ‘Hear and Treat’. This involves staff giving advice to callers including self-care, making an appointment to see their GP, or directing them to other services. Staff in the EOCs manage requests from healthcare professionals, such as GPs and hospital staff, to convey patients from the community into hospital, or transfer between different hospitals.

South Western Ambulance Service has two primary EOCs. These are known at the trust as ‘clinical hubs’. The first is at trust headquarters in Exeter, and the second in Bristol. The new site was under development for the Bristol EOC at the time of our previous inspection in 2016. Staff moved into the new offices in November 2016. The Exeter and Bristol EOCs currently work as one ‘virtual’ hub with 999 calls routed to the next available operator, and vehicles dispatched from the hub responsible for the local area. The Exeter and Bristol hubs have both emergency medical dispatchers (EMDs) (staff trained to take and prioritise emergency calls), dispatchers (staff who managed and dispatched ambulances and other emergency vehicles) and trained clinicians (nurses and paramedics) assessing patients and giving clinical advice to the EMD, the patient or their carer. During this inspection we spoke with around 87 members of staff including emergency medical dispatchers, dispatchers, clinicians, team leaders, supervisors, duty managers, the quality and complaints team, a safeguarding named professional, and senior managers. We listened to 107 emergency calls and heard how callers were treated and responded to over the phone. We looked at and analysed data about the organisation, and information provided to us by the trust.

In this report we will refer to the EOCs as either the clinical hubs or the North (Bristol) hub or the South (Exeter) hub.

Is the service safe?

Mandatory training

Staff received effective training in safety systems, processes and practices. Compliance with mandatory training had significantly improved since our previous inspection in June 2016. Staff told us the quality of training had improved. There was a programme of mandatory training which staff were required to update every year or every three years, depending on the subject. Yearly training consisted of the ‘development day’ which included training such as resuscitation, safeguarding adults and children, and preventing radicalisation (known as PREVENT). Three yearly training included infection prevention and control, health safety and welfare, and information governance.
The majority of EOC staff overall had completed the trust’s mandatory training workbook, although the results were not equal in the two regions. The workbook took three months to complete, was completed every three years, and covered the theoretical components of mandatory training. As of 1 June 2018, compliance with completion of the mandatory workbook for the combined EOCs was 87.3%. This was above the trust’s target of 85%. However, compliance for the North (Bristol) hub was 83.8% compared to 90.5% of staff at the South (Exeter) hub who had completed the mandatory workbook. Therefore, the North hub was slightly missing the target and the average had been raised by the performance at Exeter.

Staff completed an annual development day which provided them with additional training for their role, as well as the required mandatory training. There were two separate development days for the clinical team and a separate day for non-clinical staff such as the EMDs and dispatchers. Development days were delivered throughout the year. In 2017/18, EOC staff met the trust’s 85% target for attendance at the development day with 85% of staff having attended. Topics included at the 2018/19 development day were non-accidental injury in non-mobile children, child intoxication, the Mental Capacity Act 2005. and Deprivation of Liberty Safeguards for both the clinical and non-clinical day. The clinical development day included additional topics such as head injury assessment and management. Also, a review of a maternity serious incident including the lessons learnt, and a paediatric resuscitation update. Staff told us the quality of mandatory training had improved over the past 18 months, which they felt was due to the addition of more face to face training.

**Safeguarding**

**Safeguarding training completion rates**

Staff had received effective training to keep people safe from abuse. The 85% training completion target was met for both safeguarding training modules for staff in the emergency operations centre overall, and for both qualified staff and support staff.

The breakdown of training compliance by training module for all staff working the emergency operations centre for the period from April 2017 to March 2018 is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Level 2</td>
<td>394</td>
<td>426</td>
<td>92.5%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Level 1</td>
<td>412</td>
<td>455</td>
<td>90.5%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The breakdown of compliance by training module for qualified staff (clinical team staff) is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Level 1</td>
<td>83</td>
<td>93</td>
<td>89.2%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Level 2</td>
<td>81</td>
<td>93</td>
<td>87.1%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
The breakdown of compliance by training module for support staff (EMDs and dispatchers) is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Level 2</td>
<td>313</td>
<td>333</td>
<td>94.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Level 1</td>
<td>329</td>
<td>362</td>
<td>90.9%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

*Source: Trust Provider Information Request – Mandatory training*

There were systems and processes to keep people safeguarded from abuse. The trust safeguarding policy (updated and issued March 2018) described the legislation underpinning the policy, the guidance used to develop the policy, and the principles behind the processes. People covered by the policy were described in a good level of detail, as were those staff within the organisation (“all staff and agents of the trust”) who were required to apply it. The duties and responsibilities of the trust board and its executives, through to all operational managers, were clearly described. The policy went on to describe the differences between processes for children, all of whom under the age of 18 years should be safeguarded, and adults who would be at risk from abuse. These processes followed different pathways and protocols as required by legislation and guidance.

The safeguarding policy described other trust policies, guidelines, clinical notices, and standard operating procedures to be considered alongside its requirements. This included the detailed safeguarding referral process and the training strategy. The policy also defined the trust’s duty, as with all NHS trusts, to identify named professionals for safeguarding, and described their roles. The annual report to the board listed the appointed named professionals for both children and adults as required. Alongside these staff, the service had recently appointed a senior manager to the fulltime post as head of safeguarding.

The trust understood the scope of safeguarding people at risk from abuse. It had produced and published a statement on its website recognising those people who would be subject to safeguarding, including victims of domestic abuse and radicalisation. The statement described the process we saw in policies and procedures, and staff talked with us about. This included training staff to recognise abuse, including recent changes in the definitions, and their duty to report it.

The level of safeguarding referrals had increased over the past five years. The trust recognised this as related to the impact of the clear duties laid out in the Care Act 2014, improved training for staff, and safeguarding prompts from the electronic patient care records. In 2017/18, the trust made around 14,500 safeguarding referrals from around 1.5 million contacts with patients. This was an increase of around 1,000 on the previous year, and in contrast to around 5,700 in 2013/14. There had been around a twofold rise in referrals for children, and a threefold increase for adults across the five years.

Staff understood their responsibility to report safeguarding incidents and could provide us examples of safeguarding concerns they had reported. Staff told us what sort of incidents they would report as a safeguarding. These included calls where there was a lot of background noise in the form of crying or shouting or terminated calls. There was a centralised electronic safeguarding
referral system which staff had access to at their workstations. Staff told us they would also talk through safeguarding concerns with their team leader during their shift.

Staff were sometimes provided with feedback regarding the outcome of safeguarding referrals they had made, however feedback was not routinely provided. Staff felt feedback was usually provided following the more complex safeguarding cases. We saw three examples of emails which had been sent to staff containing feedback and the outcome following the safeguarding referral which they had made.

**Cleanliness, infection control and hygiene**

Staff were aware of infection, prevention and control issues as they related to patients or environments. There were procedures for EOC staff to manage information about infection control to minimise the risk when patients were transported. Where appropriate, the prioritisation system prompted staff to ask about possible infections or hygiene issues. This was particularly the case if a patient was being conveyed from one hospital to another, and might have a healthcare-acquired infection. This information was then passed through the call record to the dispatch team, where it was then made available to the ambulance personnel attending the scene or transferring the patient.

The clinical team would provide support and advice regarding infection control issues raised during calls to the EOC. Staff told us they would approach the clinical team for advice when required, either during or after a call. The clinical advisors were also able to call the patient or person with them to get further information about possible risks.

The EOCs were not clinical areas, but hand sanitiser gel was available outside the entrance of the EOCs if staff wished to use it. There were posters on the wall about the importance of hand hygiene.

Staff working in the EOC environment followed the trust’s policy in relation to uniform rules. Trust policy stated staff wearing operational uniform, which applied to staff working at the EOC, must be bare below the elbow. The policy also required staff to wear short sleeves, no watches, no nail varnish, rings with stones or bracelets. Staff we saw at the EOCs met the trust’s policy.

**Environment and equipment**

The working environment at the EOCs was appropriate for the service being delivered. The North hub in November 2016 had moved to new premises which were much larger than the previous building. The building better accommodated the needs of the staff working from the clinical hub.

Both the North and South clinical hubs had a very similar set up. The EMDs, dispatchers and clinicians all sat together in their own areas on long desks accommodating about 10 staff. However, while the Bristol office was completely open plan, the Exeter EMDs were separated from the clinical team and the dispatchers, who were in the next room. There was mixed opinion between staff at the Exeter hub as to this separation.

Managers told us a piece of work was ongoing to see if a wall could be moved in the original office which would then increase the capacity of the office to accommodate the EMDs again. However, talks about this were in the very early stages. Team leaders and managers at the South hub told us the configuration of the office set up did not impact on their work.

Staff at the North hub had access to the ‘horseshoe’ in the centre of the open plan office. The horseshoe was the area where all the managers and team leaders sat facing their team. They felt
this was useful to see their teams so they could identify any issues or problems which may occur during the shift. Both clinical hubs also had quiet rooms where staff could go to take time out after a difficult call.

Noise levels in the EOCs were minimal which made for a safe working environment. The space available and the large desks enabled staff to sit at a distance from their colleague next to them to reduce distractions when handling incoming calls. Materials to manage and absorb noise had been incorporated into the planning and design of the new North hub. The ceiling tiles and flooring had noise absorbing properties which kept noise levels to a minimum.

The North and South hubs worked as one virtual hub and used the same prioritisation and telephony systems. The South hub finally aligned all its systems with the North hub in April 2017. The virtual hub improved the ability for the hubs to support each other in times of staffing shortages and to better manage increased call demands.

Staff in the roles at the EOC spent a considerable amount of time sitting at desks and looking at computer screens. The EOCs complied with the Display Screen Equipment (DSE) Regulations 1992 to ensure the provision of a safe environment for staff working at the clinical hubs. Staff completed their workstation assessment on starting their role. This was then reassessed on a yearly basis. There was access to specialist chairs and desks for staff who required customised equipment. This ensured the health and safety of EOC staff whilst at work. We saw staff making use of the specialist chairs and desks where required following their individual assessments.

There was a procedure for staff at the EOCs to follow in the event of an equipment failure which staff were all familiar with. The EOCs telephony and CAD system had failed at the same time in a serious incident and power failure in December 2017. In this situation, staff converted to a paper-based system. Staff had access to the prioritisation system in the form of a card deck (a paper-based set of prompts) and there were mobile telephones available for when the landline telephone systems failed. There were procedures to transfer information onto the electronic records once the systems were restored. There were dedicated IT technicians to respond to technical problems as the server equipment was located at the clinical hubs. There was also a store of back-up computers available in case of a failure in a single item of IT equipment.

However, there was no planned practice to convert to the paper based system. Managers told us when this occurred, the transition to the paper based system always worked well. The staff we asked told us the only time this was practised was during induction for new members of staff.

**Assessing and responding to patient risk**

The EOCs used approved prioritisation systems to prioritise calls based on risk and need. Patients were prioritised based on responses to questions asked by the EMDs. Coding categories determined the level of risk for the patient. There were four categories. Category one identified a life-threatening risk to the patient and therefore a specific response standard. The remaining three categories reduced in priority and response standard time in accordance with the assessed need of the patient.

The level of risk identified then determined the response which was coordinated by the dispatch team. If a caller made a further call to the service, the EMD completed a new assessment which meant the level of risk was reassessed. If appropriate, the initial designated response would be reviewed to ensure the patient received the right response.
Staff made good use of special notes or warning markers to assess and respond safely to known or potential risks. GPs or healthcare professionals could contact the service to provide key information about patients which would be added to the warning markers system. Information was received about patients who had additional needs, for example a learning disability, were receiving end of life care, a mental health diagnosis, or when patients presented with additional risks, such as aggressive behaviour. This flag was visible to all staff in the EOCs and ambulance crews attending the scene of the emergency.

However, warning markers were specific to an address rather than a patient. Therefore, if a patient with a warning marker was located at a different address, staff would be unaware of the risks associated with the patient. This was a national problem associated with all ambulance service patient record systems. National work was ongoing to see whether warning markers could be attached to the patient’s NHS number rather than their address.

Staff could raise any new risks in the patient’s record which they identified during the call which ensured risks for the patients and crew could be managed safely. EMDs had the option to record a basic or a serious warning. A basic warning included non-urgent relevant information to the crew, such as details of possible difficulties with accessing the property or locating the patient. A serious risk included, for example, if the patient was bleeding and was taking blood thinning medicine, or if the patient was currently undergoing a diabetic episode. This information was then passed to the dispatchers who would make ambulance crews aware of higher levels of risk.

Staff responded appropriately to changing risks to patients to ensure their level of need was safely met. A qualified professional, such as a nurse or a paramedic working as part of the clinical assessment team, used their clinical judgement to change the priority of calls if necessary. The clinical team could review decisions made by the EMDs and the prioritisation system. This was done by either reviewing the information within the patient’s notes as recorded by the EMD, or by calling the patient or person caring for them and getting more information. The decision could raise or lower the priority assigned by the prioritisation system depending on what information was seen or heard by the clinician. The emergency medical advisors were also able to ask advice from the clinicians if they were concerned the prioritisation system had not produced the right priority for a patient. Only clinicians from the clinical team had the authority to upgrade or downgrade ambulance responses. During the inspection, we observed clinicians upgrading and downgrading ambulance responses appropriately.

The system enabled the clinical team to listen into live calls and respond to identified risks which may have delayed patient care. They were prompted by certain keywords or triggers to listen in and give advice. We saw an example of where a clinician had listened into an urgent call. The answers provided by the caller in response to the EMDs questions did not reflect what the clinician could hear, in terms of the condition of the patient’s laboured breathing in the background. The caller’s response to the questions prompted the prioritisation system to downgrade and not respond as a category one (life threatening call). The clinician made the decision to prioritise this call as a category one (life threatening) based the risk of the patient deteriorating further if a category one response was not dispatched.

The EOCs were contributing nationally to the pre-triage questions/nature of call (PTQ/NOC) work. This work around PTQ/NOC had been proven to identify Category 1 (C1) incidents at the earliest opportunity. The EOCs were using the PTQ/NOC at the start of every call to improve EMDs ability to prioritise patients who may require an urgent response for an ambulance for a category 1 (life threatening) call. This enabled the service to provide a timelier response to the life-threatening
call. EMDs were being provided with an education programme around PTQ/NOC to enhance their skills and ability to prioritise calls more effectively.

There was a system for monitoring the welfare of patients whose ambulance response exceeded the expected timeframe. The EOCs planned to carry out welfare calls when a patient's ambulance response was delayed. The system was designed for either clinical staff of EMDs to make an initial telephone call to the patient to check on their welfare, or offer advice regarding what to do if their condition worsened. The clinician or EMD, with advice from the clinician, then determined how frequently the patient should receive subsequent welfare calls.

The trust did not routinely monitor whether welfare calls happened in the agreed timeframe or at all. However, a one-off audit was completed in the latter half of 2017, which reviewed a sample of 209 calls over a four-week sample period. The audit found that 76% of sampled calls received an initial clinical welfare call.

A system had recently been reintroduced which allowed the clinical team to reprioritise responses for patients using their expertise and skills, although it was not yet being used consistently or therefore meaningfully measurable. The clinical team assessed all calls, but prioritised calls which had been allocated as a category one or two (life threatening or urgent) priority, to ensure the level of risk associated with these calls was appropriate for the response the prioritisation system had identified. The purpose of this function was to change the response if the system had prioritised the call inappropriately. We were told there was inevitable and understandable frustration from ambulance crews when they arrived at a scene which the prioritisation system had wrongly categorised, when there were higher priorities elsewhere. The clinical intervention and reprioritisation enabled the service to improve response times, ensure resources were available for the right patient and the right time, and better support the frontline teams.

This initiative had been reintroduced recently to the clinician’s workload. However, there were varied opinions between the clinicians as to this process and the tools they had available to support this work. The clinicians had access to a system which was designed as a support tool to help them to assess low acuity patients. Some clinicians using the tool to support this work told us they felt the tool was not fit for purpose for reviewing category one and two calls. Others told us they clinically assessed patients using their knowledge and skills without using the tool.

The operational performance meeting minutes reported that the clinical lead had been to look at a different tool used by another ambulance service. However, there was no further information as to the next step of the process and whether this was an option the trust was considering. There was a lack of consistency in the approach taken to carry out this work which could make it challenging to audit and review how effective this work was. Nevertheless, we were told the frontline ambulance crews had already seen a difference as to more appropriate prioritisation of calls through the clinicians carrying out this work.

**Staffing**

**Planned against actual staff**

Staffing levels and skill mix ensure patients received safe care and treatment. The trust grouped its clinical hub staff into three categories. These included:

- NHS infrastructure support staff - EMDs and dispatchers, audit team leads, control officer and the duty manager to name a few. These staff carried out the day to day operational function in the clinical hubs.
• Qualified ambulance service staff - qualified staff working in the clinical teams, such as nurses and paramedics carrying out the daily operational function in the clinical hubs.
• Support to ambulance service staff who work in the hub setting but are not included in delivering care. This included administrators and managers who had no patient contact such as quality and safety staff and the rota administrators.

The trust reported their staffing numbers as below for the emergency operations centre as of March 2017 and March 2018 for comparison.

The overall number of staff was close to establishment at 99.7% as of March 2017, and remained close to what was planned at 99.9% as of March 2018.

The staff group NHS infrastructure support was heavily over-established as of March 2017. The number of staff at that date was 39.1% above establishment. As of March 2018, the number of staff had fallen to 17.6% above establishment.

The number of qualified ambulance service staff was 90.5% as of March 2017, but as of March 2018 the position had improved considerably, and this staff group was over-established with 104.1%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>March 2017</th>
<th>March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>WTE planned staff</td>
<td>WTE actual staff</td>
</tr>
<tr>
<td>NHS infrastructure support (EMDs and dispatchers)</td>
<td>15.5</td>
<td>21.6</td>
</tr>
<tr>
<td>Qualified ambulance service staff (qualified clinical team)</td>
<td>43.0</td>
<td>38.9</td>
</tr>
<tr>
<td>Support to ambulance service staff (members of staff not delivering care but working in the hub setting.)</td>
<td>355.2</td>
<td>352.1</td>
</tr>
<tr>
<td>Total</td>
<td>413.7</td>
<td>412.6</td>
</tr>
</tbody>
</table>

Source: Trust Provider Information Request – Total staffing

There was a plan to maintain the current level of staffing. There was a constant recruitment drive to maintain a pool of staff to replace those who left. If candidates passed the recruitment assessment, they would be offered a place on one of the training courses. Training courses were run every other month, and successful recruits were booked onto the next available course. At the time of the inspection, there was a pool of staff available, and the training courses were to be moved to being quarterly. EMD team leaders told us as soon as an EMD left the service, a new member of staff should be ready to replace them. This ensured rotas could be filled and provided a good level of staffing to cover shifts.

The hubs ran open evenings to give potential staff considering the EMD role first-hand experience as to what the role entailed. The EMD was a unique role which although could be fulfilling, staff told us, was also challenging and demanding, and recognised as not for everyone. To get as many staff through the training and into the role as possible, the open evenings showed what the work involved. Recordings of previous calls were played to give potential staff an insight into the type of
calls and the situations the EMDs managed. Managers told us this process had been successful and they had seen improved commitment from potential staff.

There were sufficient numbers of staff working for the clinical hubs to provide relief cover on duty rota for EMD staff. Relief cover was a level of staffing which enabled the organisation to release staff for training, annual leave and to maternity leave, sickness cover and unplanned absences. The newly-designed EMD rota now included relief staff cover for all shifts. This ensured there was adequate cover to enable continuation of the EOC service delivery while being able to release staff to participate in other important events such as training.

**Vacancy rates**

From April 2017 to March 2018, the trust reported vacancy rate of 1.8% for the emergency operations centre. This was lower (better) than the trust target of 5%.

The vacancy rates broken down by staff group are shown below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Annual vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS infrastructure support (EMDs and dispatchers)</td>
<td>-23.2%</td>
</tr>
<tr>
<td>Qualified ambulance service staff (qualified clinical team)</td>
<td>6.6%</td>
</tr>
<tr>
<td>Support to ambulance service staff (members of staff not delivering care but working in the hub setting.)</td>
<td>2.7%</td>
</tr>
</tbody>
</table>

The highest annual vacancy rate was for qualified ambulance service staff at 6.6%.

Clinician cover for the combined hubs was not meeting planned levels due to vacancies and sickness. This left some shifts not always having full cover. During an unannounced visit to the South clinical hub one evening, only one clinician was on duty. Their shift was due to end, which meant there would be no clinician cover for the South hub for the remainder of the overnight shift. Work for the South hub was to be managed by the North hub clinicians.

We were told clinician cover had been low at the EOCs for some time. We saw current and predicted staffing levels for clinician cover for a three-week period between 21 June to 9 July 2018. There was only one occasion in these three weeks where there was 100% cover for the combined hubs. Combined cover for the hubs over this period ranged between 65.5% and 92.7%. Messages were being sent to clinicians and bank clinicians to cover the unfilled shifts, however at the time of the inspection clinicians had not come forward. However, we were told staff had been recruited to cover the 6.6% clinical staff vacancies and were due to be in post six week following our inspection.

There was a high staffing surplus of 23.2% above establishment for infrastructure support staff. This was to ensure the service maintained a pool of staff so any vacancies which came up due to staff leaving could be covered immediately to not cause disruption to the service and their ability to meet the demand of calls coming in. There was also a relatively low vacancy rate of 2.7% for “support to ambulance service staff”.

*Source: Trust Provider Information Request – Vacancy*

**Turnover rates**

Although turnover rates appeared high, these numbers included a significant number of staff who had not passed their training or had been suitable for the role. Turnover was, nevertheless, always...
higher in EOCs that most NHS roles, and this was reflected in the trust’s expectations of around 15%. From April 2017 to March 2018, the trust reported an annual turnover rate of 26.1% for the emergency operations centre. This was higher than the trust target of 15%.

The turnover rates broken down by staff group are shown below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS infrastructure support (EMDs and dispatchers)</td>
<td>5.0%</td>
</tr>
<tr>
<td>Qualified ambulance service staff (qualified clinical team)</td>
<td>13.0%</td>
</tr>
<tr>
<td>Support to ambulance service staff (members of staff not delivering care but working in the hub setting.)</td>
<td>28.8%</td>
</tr>
</tbody>
</table>

The turnover rate for “support to ambulance service staff” was much higher than the trust target.

Source: Trust Provider Information Request– Turnover

Turnover rates appeared high. However, these figures included staff who had not completed their training successfully, staff who had developed and moved into other roles within the organisation, and dismissal for capability reasons.

To provide a more meaningful number, the North and South clinical hubs provided a breakdown of their staff turnover between December 2017 and May 2018. Out of the 25 staff leaving the North hub, eight failed their training, four had relocated, two had been dismissed and one had moved into another role. One had retired, six had left due to health reasons and three had left on capability grounds. Of the 15 staff at the South hub, one had failed training, four had moved into other roles, one had moved away, and two had retired. The remaining six staff had left due to health issues and personal reasons.

Sickness rates

Sickness rates were higher than the trust target. From April 2017 to March 2018, the trust reported an annual sickness rate of 7.1%. This was higher than the trust target of 4%.

The sickness rates broken down by staff group are shown below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Annual sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS infrastructure support (EMDs and dispatchers)</td>
<td>1.5%</td>
</tr>
<tr>
<td>Qualified ambulance service staff (qualified clinical team)</td>
<td>9.7%</td>
</tr>
<tr>
<td>Support to ambulance service staff (members of staff not delivering care but working in the hub setting.)</td>
<td>6.8%</td>
</tr>
</tbody>
</table>

Both qualified ambulance staff and support to ambulance service staff had annual sickness rates higher than the trust target.

Source: Trust Provider Information Request– Sickness

Rotas
Virtual rotas were used in both the North and South clinical hubs. Around a year ago there had been a change to the rota system for the EMDs. This was due to the clinical hubs not being able to answer calls in line with targets set for them. Also, staff rotas were not fit for purpose as they did not integrate and relief support into the rota to enable staff to be released for training or to cover for annual leave.

There were a small number of bank staff available to cover shifts at the clinical hubs. However, if cover was required, a message would be sent initially to internal staff to cover the shift. Bank staff consisted of EMDs, dispatchers and clinicians. It was the responsibility of the bank member of staff to maintain their competence in their role by carrying out one shift per month. If staff were inactive for a period of three months their contract would be terminated. This was to ensure the safety of patients. The clinical hubs no longer used agency staff to cover shifts.

The virtual hub environment made it possible for staff resources to be shared during periods of high call volumes. Calls could be answered by either hub and were picked up by the corresponding county dispatch team based at either the North or South hub.

Rotas and shift patterns were set to meet expected demand. Daily calls were held to discuss staffing issues and concerns and ‘horizon plan’ (plan staffing levels in advance). Weekly resource management group meetings were also held to look at 72-hour forward planning and horizon planning. A daily report had been introduced to the hubs one year ago which provided a weekly view of predicted demand based on historical data. This helped the hubs plan appropriate levels of staffing required, to ensure staff could safely manage and prioritise the number of calls coming in. This meeting also reviewed events which may have an impact upon demand, such as festivals held in the patch, or at the time of the inspection, an international televised football event.

Staff received adequate breaks and time off in between shifts. However, breaks did not always happen at planned times due to periods of increase demand for the service. Staff were aware of the challenge of being able to take breaks on time due to the unpredictable nature of the role. EMD staff planned their breaks at the start of their shift. Times were allocated on a first come first served basis. Staff told us it was an incentive to come in a little earlier to secure their break at the time they wanted. However, staff told us if someone was due their break, but were stuck on a call, this could then have a knock-on effect over the course of the shift and delay everyone else’s break. Staff told us they tried to be flexible to avoid this happening and where possible they looked to swap with colleagues if looked like they were not going to be able to take their planned break time to avoid the delay impacting on other members of staff.

**Records**

Patient records were managed, completed and stored appropriately and confidentially. Patient records were held electronically and staff required a password and login details to access them.

The clinical hubs used the computer aided dispatch (CAD) system to record patient details, to prioritisation calls and deploy ambulance resources. A new record was created at the start of every 999 call and patient details were recorded on the CAD system. The prioritisation systems then guided EMDs through a series of questions to identify the patient’s condition and the ambulance response required. There were also places on the record to update information as the patient’s situation developed during the call.

As part of the licence for the prioritisation system, all calls and records were recorded and regular call audits had to be carried out to identify the EMDs performance and ability to effectively use the
prioritisation system and record information the patient record. This process supported staff to recognise when they were following the right guidance, giving the right advice to the patient or caller and generating the correct ambulance response for patients.

There was a dedicated team at both the North and South clinical hubs to support EMDs to improve their performance following the outcome of individual call audits. The team would spend time with individual members of staff identifying area of their performance which required improvement and provide support advice on how to do this.

The launch of the virtual hub model in April 2017 enabled patients’ records to be shared and the North and South hubs to support each other on a day to day basis. In April 2017, the North and South hubs aligned, with the South hub transferring to using the same patient prioritisation system as the North hub. This enabled patient records to be shared between each individual clinical hub between the EMDs, dispatchers and clinicians and across both clinical hubs.

There was a dedicated team who ensured warning markers or ‘special notes’ existed within records to alert EOC staff to important information. Warning markers provided information which supported EMDs and clinicians in decision making and assisted them to manage certain patients, situations, or known risks. If EMDs identified a warning marker which was out of date, staff would report this to the team who would review the information and follow it up to get the most up-to-date information is possible.

Warning markers existed on the system and flashed up on the patient’s record (although only at a linked address) if there was an alert about the patient. Information to populate the warning markers came from healthcare professionals, GPs or the patients themselves. Alerts included whether the patient had written resuscitation decisions, a key safe code, complex care instructions or a mental health diagnosis. It covered patients with learning disabilities, living with dementia, as well as patients who might present a risk to staff, such as a history of violent or aggressive behaviour.

However, as discussed above, the information was held electronically and was connected to the patient’s address, rather than the patient’s name. If the person moved address, unless the EOC was informed, information would remain against this address, and could be inaccurate. EMDs told us there were ways to cross-reference the information with the patient’s name, which would ensure there was no delay in providing services to a patient if warning markers were no longer valid at the wrong address.

**Medicines**

There was approved clinical guidance on medicines for the clinical team to reference. The clinical team used the Joint Royal College Ambulance Liaison Committee (JRCALC) and British National Formulary (BNF) for medicines guidance. These were available electronically to ensure they had access to the most current version.

Although the advice provided to patient’s medicines at the EOCs was required to be limited, the patient prioritisation system provided the EMDs with some advice for patients. For example, the prioritisation system directed EMDs to prepare patients for a possible hospital stay. Callers were advised to gather any medicines taken regularly. This was in case the ambulance crew took the patient onwards to hospital for assessment, so the patient had their regular medication with them. The EMDs only advised patients to take medicines as instructed to do so by their GP. However, if the patient had breathing difficulties and had prescribed inhalers or nebulisers (medical equipment
and medicine to help improve breathing) the EMDs would advise patients to use these while they waited for an ambulance.

**Incidents**

Incidents were thoroughly investigated, however there were delays with the time taken to report on incidents. There was a clear incident reporting policy available for staff to access on the intranet. The policy required staff to report all adverse incidents so they could be investigated and controls arranged to avoid the incident reoccurring. Learning was also identified to improve working practices and procedures. The policy set out the role and responsibility of the staff in reporting incidents. Guidance was provided as to what should be reported as an incident and the incident reporting process. The senior management team were responsible for ensuring incidents were properly investigated, findings fed back, and learning shared with staff across the EOCs.

Staff understood their responsibilities to raise concerns, record safety incidents and near misses and report them internally. The trust had an electronic incident reporting system which all staff had access to and staff now had access to the trust’s intranet at their desks. All staff having intranet access had only been organised at the North hub since November 2016 and was a positive addition to hub working. Prior to this, staff at the North hub had to find an available computer with the intranet which were in limited supply and not always available. Staff we spoke with were familiar with the electronic reporting system, and how to use it.

There had been 1,593 incidents reported by clinical hub staff between April 2017 and March 2018. Trends and themes had been identified. Of the 1,593 incidents reported, 909 of these had been categorised as treatment delays. Other trends and themes identified from the remaining 684 incidents were to do with communication, staffing levels and crew issues.

Clinical hub staff were not always reporting specific situations of their being verbally abused by callers, which were classed as a reportable incident under the trust’s incident reporting policy. The policy required staff, under the category of security incidents, to report any calls where they received verbal abuse from a caller. Staff told us they saw this as part of the job and did not report such incidences of verbal abuse. Staff told us they would often report any verbally abusive calls to the team lead on duty during the shift. Staff felt reporting abusive calls would require a large time commitment which they did not feel they had capacity to manage. Out of the 1,593 incidents reported by the clinical hub teams, only one incident of verbal abuse had been reported. This situation had not improved from our previous inspection in June 2016.

**Breakdown of serious incidents**

In accordance with the NHS Serious Incident Framework 2015, the trust reported 22 incidents for the emergency operations centre which met the serious incident reporting criteria set by NHS England from June 2017 to May 2018.

The breakdown by incident type was as follows:

<table>
<thead>
<tr>
<th>Incident type</th>
<th>No. incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment delay</td>
<td>17</td>
</tr>
<tr>
<td>Sub-optimal care of the deteriorating patient</td>
<td>3</td>
</tr>
<tr>
<td>Major incident/ emergency preparedness, resilience and response/ suspension of services</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>22</strong></td>
</tr>
</tbody>
</table>

*Source: Strategic Executive Information System (STEIS)*
There was a formal structure for reviewing, investigating and reporting on serious incidents. Incidents classed as serious went through the weekly serious incident decision making panel. The trust’s quality team took the lead for investigating serious incidents and were trained to do so. Serious incidents were subject to root-cause analysis investigation, with reports identifying how the incident arose and the learning taken to prevent the incident occurring again in future. Staff involved with the incident were encouraged to attend serious incident review meetings. This was optional, and due to work pressures, did not always attract the member of staff involved. Any individual issues would be identified and fed back to staff and where required, they would undertake further learning or education. Serious incidents were thoroughly investigated and reported on. We reviewed two serious incidents and saw learning had been identified and action plans developed to ensure actions were implemented into practice.

Improvements were made to EOC systems and processes following the outcome from serious incidents. In the latter half of 2017, a theme from approximately 18 serious incident investigations concluded that patient outcomes could have been improved following the correct application of welfare call guidance. Actions included a review of the policy and the issue of a new standard operating procedure (VH07) for welfare call management. Guidance was introduced to increase clinical interaction and provide greater opportunity for additional clinical assessment and advice. Furthermore, this improved process would support the EOCs to better manage the risks associated with enhanced demand. However, despite this work, welfare calls were still not being carried out in a timely way, and there was no process to monitor whether they had been completed according to clinical recommendations.

Not all incidents were being investigated in the time required. Serious incident investigations had not been completed within the 60-day timeframe required by the NHS National Serious Incident Framework. Out of the 22 incidents reported, 14 of these incidents had been closed. The others were ongoing. However, only four of these 14 incidents had been closed within the 60-day timeframe. Delays were due to meetings being delayed, gathering further information, and delays in senior staff reviewing the investigations.

Not all staff were able to recall examples of learning from incidents and serious incidents. Managers and team leaders could give us examples of learning from serious incidents. For example, they described learning identified following serious incidents during the period of bad weather in February/March 2018. However, EMDs, clinical staff and the dispatchers were unable to give us examples of learning or feedback from incidents or serious incidents.

Managers told us that learning from incidents or serious incidents was displayed on the electronic information boards in the EOCs. Alternatively, information was part of the weekly staff bulletin or sent via email to staff. There was a gap between information being cascaded from managers and team leaders and staff reading it. However, during the inspection we saw an example of a change which has been made to EOC coding following a childbirth incident. This had been displayed on the electronic boards.

When required, joint reviews with other services were carried out for incidents which involved several organisations to ensure learning happened among everyone involved. There was a memorandum of understanding (a working agreement between two or more parties) between local Clinical Commissioning Groups (CCG) and NHS trusts regarding joint incident reviews. These multiagency reviews would usually be led by the local CCG, and the trust would play an active role in the multi-agency investigation process.
The trust had duty of candour guidance available on the intranet. Senior staff demonstrated an understanding of their responsibilities about the duty of candour. This is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. We reviewed two of the examples of serious incidents where the duty of candour had been applied. There was evidence of an apology as required, and a written letter to follow this up. Patients and their families were encouraged to be part of the investigation process and to have face-to-face discussions with members of the trust’s quality team following the outcome of the investigation. We were told some patients and families wanted to be involved with the process and found it beneficial to get closure following the event they had experienced.

**Is the service effective?**

**Evidence-based care and treatment**

Accredited triage and clinical management systems were used to prioritise patient care and ambulance responses. At the time of our inspection, EMDs at both locations used a licenced international integrated prioritisation and clinical management system. To use the prioritisation system, EMDs were trained to ask a series of pre-determined questions in a set order. The answers to each question led the EMD along an evidence based pathway for prioritisation of emergency 999 calls.

Call audits were undertaken to monitor the quality of the service provided by the call handlers, and to ensure that call handlers asked questions using a standardised format, followed the agreed pathway to ensure that all relevant information was gathered in the right order for the system to be able to prioritise the call safely and effectively.

The EOCs were not compliant with call performance audits. This was also a concern during our previous inspection in June 2016. Therefore, leaders did not have adequate assurance regarding the staff compliance with the evidence based protocols and pathways within the call prioritisation system. The trust was required to meet certain audit criteria to become an accredited centre of excellence (ACE) and to meet the requirements for the license agreement for call prioritisation system. The criteria included the quantity of audits completed (a target of 1% of the total call volume) which equated to 830 audits per month, and the compliance of EMDs with the standards measured in those audits (a target of 93%).

During the six months preceding our inspection, the trust had not met the 1% target for quantity of audits completed, although this situation was improving. Leaders explained that audit staff had less availability to carry out audits because they had been involved in training the South hub staff to use the new triage system which was implemented in April 2017. However, a gradual improvement towards the compliance target was evident. The table below shows the quantity of audits completed as a percentage of the target during the six-month period preceding our inspection:

<table>
<thead>
<tr>
<th>No. of random audits completed</th>
<th>January 2018</th>
<th>February 2018</th>
<th>March 2018</th>
<th>April 2018</th>
<th>May 2018</th>
<th>June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Random audit target</td>
<td>728</td>
<td>513</td>
<td>688</td>
<td>681</td>
<td>749</td>
<td>796</td>
</tr>
</tbody>
</table>

150
During the six months preceding our inspection, the trust had not met the licence requirement for call audit compliance, although this was improving. Leaders explained this was because the EMDs had needed time to adjust to the new triage system. All EMD’s with a minimum of six months experience were expected to not exceed the following levels of non-compliance: partial compliance 10%, low compliance 10%, non-compliance 7%. The table below describes the levels of non-compliance recorded in audits of the prioritisation system during the 6 months preceding our inspection.

<table>
<thead>
<tr>
<th>Audit compliance</th>
<th>January 2018</th>
<th>February 2018</th>
<th>March 2018</th>
<th>April 2018</th>
<th>May 2018</th>
<th>June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Compliance</td>
<td>36.4%</td>
<td>29.2%</td>
<td>42.8%</td>
<td>39%</td>
<td>40%</td>
<td>47%</td>
</tr>
<tr>
<td>Compliant</td>
<td>22.7%</td>
<td>23%</td>
<td>21.3%</td>
<td>22%</td>
<td>23.3%</td>
<td>23%</td>
</tr>
<tr>
<td>Partial Compliance</td>
<td>11.1%</td>
<td>12.1%</td>
<td>11.4%</td>
<td>11.2%</td>
<td>12.6%</td>
<td>10%</td>
</tr>
<tr>
<td>Low Compliance</td>
<td>4.1%</td>
<td>5.6%</td>
<td>3.6%</td>
<td>3.2%</td>
<td>3.9%</td>
<td>2%</td>
</tr>
<tr>
<td>Non-Compliant</td>
<td>25.7%</td>
<td>30.1%</td>
<td>20.8%</td>
<td>24.5%</td>
<td>20.2%</td>
<td>19%</td>
</tr>
</tbody>
</table>

Measures had been taken to increase the quantity of call audits being completed to improve compliance against the target. Managers were recruiting more auditors for the North EOC team. Auditors were given individual daily targets for completion. The audit team had recently introduced ‘live’ audits (listening to calls and viewing records as they were being taken) which were quicker to complete than retrospective audits (listening to recordings and viewing archived records).

Measures had been implemented to improve the compliance rate of call audits. During live audits, the auditors engaged with the EMDs and gave immediate feedback regarding their performance. Managers selected 12 EMDs per month for individual coaching and support. If any audit was scored as non-compliant, the auditors met face-to-face with the EMD responsible to give feedback. If they had concerns or wanted an opinion regarding a call, EMDs could request that call to be audited to receive individual feedback on their performance. EMD team leaders had also completed the audit qualification so they were able to give feedback in line with the performance standards.

Measures were taken to minimise possible discrepancies in methods or interpretations of audits. The audit manager re-audited two audits per auditor per month and gave individual feedback regarding their learning needs. All auditors were certified with the licenced triage system. Auditors from both EOCs also attended learning sessions where they all audited the same call. The outcomes were then discussed with the help of a facilitator from the company that supplied the system.

Clinical advisors assessed and re- triaged low priority patients using a clinical support tool. This system was based on guidelines published by the National Institute for Health and Care Excellence (NICE) and Joint Royal Colleges Ambulance Liaison Service Committee (JRCALC). There were regular system updates to ensure the clinical advisors had access to the latest evidence based guidance.

There was a lack of monitoring to ensure the clinical team followed the clinical support tool guidance correctly and consistently. Therefore, leaders did not have adequate assurance that staff
were making clinical decisions on evidence based guidance. The trust was required to meet certain audit criteria to meet the requirements for the license agreement for Clinical support tool. The criteria included the target for the quantity of Clinical support tool audits completed (percentage of the total call volume) annually and the target for the compliance of clinical advisors with the standards measured in those audits (%).

During January to May 2018, the trust had not met the target for quantity of clinical support tool audits completed. However, there was evidence of improvement and the trust exceeded the target in June 2018. The table below shows the quantity of clinical support tool audits completed as a percentage of the total number of calls made by clinical advisors during the 6 months preceding our inspection:

<table>
<thead>
<tr>
<th></th>
<th>January 2018</th>
<th>February 2018</th>
<th>March 2018</th>
<th>April 2018</th>
<th>May 2018</th>
<th>June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of random audits completed</td>
<td>74</td>
<td>96</td>
<td>62</td>
<td>86</td>
<td>164</td>
<td>210</td>
</tr>
<tr>
<td>Random audit target</td>
<td>172</td>
<td>172</td>
<td>172</td>
<td>172</td>
<td>172</td>
<td>172</td>
</tr>
<tr>
<td>Percentage against licence requirement</td>
<td>43%</td>
<td>55%</td>
<td>36%</td>
<td>50%</td>
<td>95%</td>
<td>122%</td>
</tr>
</tbody>
</table>

At the time of our inspection, the trust was not meeting the licence requirement for the clinical support tool audit compliance. All clinicians with a minimum of six months experience were expected to not exceed the following levels of non-compliance: partial compliance 10%, low compliance 10%, non-compliance 7%. The table below describes the levels of non-compliance recorded in audits of the clinical support tool during the 6 months preceding our inspection:

<table>
<thead>
<tr>
<th></th>
<th>January 2018</th>
<th>February 2018</th>
<th>March 2018</th>
<th>April 2018</th>
<th>May 2018</th>
<th>June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partial compliance</td>
<td>28%</td>
<td>20%</td>
<td>19%</td>
<td>8%</td>
<td>18%</td>
<td>17%</td>
</tr>
<tr>
<td>Non-compliance</td>
<td>12%</td>
<td>25%</td>
<td>19%</td>
<td>30%</td>
<td>35%</td>
<td>30%</td>
</tr>
</tbody>
</table>

The EOCs were working to increase the quantity of clinical support tool audits being completed. Clinical team leaders were expected to spend 12 hours per month carrying out audits. However, due to the demands of the role this was not always feasible. They could be paid overtime to complete these if required. However, there was no dedicated audit team for the clinical support tool audits. Trends from the analysis of audits were shared with clinicians in the form of a bulletin as they logged on to the clinical support tool system.

There were no systems to audit the interventions of the clinical advisors when they did not use the clinical support tool system. The service could not be assured there was no discrimination on the grounds of protected characteristics under the Equality Act when clinical staff made care and treatment decisions. Clinical staff assessed and re-triaged high priority calls (category one and category two) using their clinical judgement without use of an evidence based tool.
Technology was used to enhance the delivery of effective care and treatment. Clinical staff had access to an app (a computing application – especially as downloaded by a user to a mobile device or computer) on their computer screens and mobile phones that linked them to a directory of community resources such as minor injury units, community falls assessment teams. This app also included access to the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) Guidelines 2016.

All EOC staff accessed trust policies and clinical directives on the intranet which was available to them at their workstations.

Both EMD and clinical staff advised patients to call back if their condition deteriorated while waiting for the ambulance. The triage system identified ‘worsening advice’ specifically related to the nature of the call. EMDs clearly relayed this information to patients. We heard the clinical team giving advice to patients or those who made the call about what to do if the patient became more unwell.

**Pain relief**

EMDs recorded patients’ descriptions of their pain as part of the questions prompted by the prioritisation system. Clinical advisors talked to patients about their pain and, when appropriate, advised patients to use their usual preferred analgesia to relieve pain.

**Response times**

The trust monitored, recorded and measured the real-time performance of the EMDs to ensure patients calls were answered as promptly as they could be. Electronic screens visible to all staff in the EMD room displayed the number of calls waiting and the length of time the caller had waited for a response. We saw that break times were managed to avoid delays to patients during peak times.

Calls were answered on an equitable basis. The EMD teams in the Exeter and Bristol EOCs used an integrated system. This meant that if one of the EOCs experienced increased demand, the other EOC picked up the calls for that area.

The trust participated in and had been one of two ambulance trusts in England to pilot the Ambulance Response Programme clinical coding trial (ARP) in April 2016 (see explanation within the well-led report above). Under this programme, the response times to reach patients were changed.

The evidence for this report reflects two different sets of data relating to before and after the implementation of the ARP in November 2017. This is because when the trust started on the ARP in November 2017, the measures of performance were changed to reflect the new ways of working. The indicator ‘call abandonment’ was in use prior to November 2017. Since then it has been discontinued as a measure of ambulance systems performance.

**Call performance**

The trust performed better than the England average in three of the four measures of call performance and had been showing improvement in the fourth. The trust measured the time that EMDs were taking to answer the calls. This was measured using four metrics:

- Median time spent between call connect and call answer (i.e. the time below which 50% of calls were answered)
- Mean average time from call connect to call answer (i.e. total call answer time divided by calls answered)
- 95th percentile of times from call connect and call answer (i.e. the time within which 95% of calls were answered)
- 99th percentile of times from call connect and call answer (i.e. the time within which 99% of calls were answered)

As the new measures were introduced by South Western Ambulance Service on 23 November 2017, under ARP, data for the trust for that month demonstrates a partial return.

From November 2017 to April 2018, the trust’s performance as measured by the median was worse than the England performance in every month except December 2017. The trust median was two seconds in every month except December, when the median was three seconds.
From November 2017 to April 2018, the trust’s mean call answer time was consistently better than the England mean. Performance was variable but there was an improvement in trust performance from eight seconds in November 2017 to four seconds in April 2018.

From November 2017 to April 2018, there was an improvement in the trust’s performance as measured by the 95th centile. Performance improved from 38 seconds in November 2017 to 17 seconds in April 2018. Over this period the trust consistently outperformed the England 95th centile.

From November 2017 to April 2018, there was an improvement in the trust’s performance as measured by the 99th centile. Performance improved from one minute and 24 seconds in
November 2017 to 51 seconds in April 2018. As with the mean and 95th centile, over this period the trust consistently outperformed the England 99th centile.

*Source: NHS England – Ambulance Quality Indicators – System Indicators*

The trust monitored the real-time performance of the dispatchers to minimise the time that patients waited for an ambulance resource to be allocated. This was measured by two metrics. The time taken for dispatchers to allocate a resource to category one calls (target of 30 seconds) and the ambulance response times in accordance with ARP targets.

The computer aided dispatch system (CAD) captured this data according to geographical area rather than individual dispatcher. Dispatchers could see on their screens when incidents were breaching the targets. The CAD also displayed the dispatcher’s compliance with the ‘status plan’ (a plan estimating the likelihood of an ambulance resource being needed in a certain location at any given time). Every incident which breached the time targets was verified by the control manager. They checked to make sure individual dispatchers were using all resources available to them at the time of the call. The dispatcher and the control manager recorded the reason for any delay on the electronic patient care record.

**Patient outcomes**

The trust performance was worse than the national average for the proportion of patients who re-contacted 999 within 24 hours of the original emergency call being closed with telephone advice. Data for this metric was collected up to October 2017. Leaders explained this metric was unreliable because it captured information related to location and sex of the patient rather than their individual NHS identification number. In May 2018, the revised national ‘Ambulance Quality Indicator’ guidance no longer required this data to be collected.

From May to October 2017, the trust consistently had a higher proportion of patients who re-contacted the service within 24 hours following closure with telephone advice than the England average. There was an improvement in trust performance, from 10.3% in May 2017 (compared to the England average of 6.3%) to 8.6% in October 2017 (compared to the England average of 8.0%). Please note in the graph below, four ambulance trusts provided no data and are therefore not included in any England average calculations for that period.

*Source: NHS England – Ambulance Quality Indicators – System Indicators*
The trust’s performance against the new ‘hear and treat’ metric improved during the six months preceding our inspection. The data for the period from 23 November 2017 to March 2018 is shown below. The trust started submitting data to the ARP on 23 November 2017. Therefore, the trust figure for November below is based on a partial return for that month. Please note in the graph below, four ambulance trusts provided no data and are therefore not included in any England average calculations for that period.

![Hear & Treat Graph](image)

From November 2017 to April 2018, there was an improvement in the trust’s performance against this metric, from 4.7% in November (compared to the England average of 5.7%) to 5.8% in April (when the England average was 5.2%). The trust outperformed the England average in the latest two months.

*Source: NHS England – Ambulance Quality Indicators – Systems indicators*

The EOC leads aimed to increase the percentage of patients who were treated over the telephone without the need for dispatch of an ambulance (hear and treat). At the time of our inspection, the EOC leads had recently introduced an audit for the clinical team which looked at the number of calls completed by the clinicians during any given time-period. The impact in terms of quality and quantity of calls at the time of the inspection had not yet been determined.

**Competent staff**

The service ensured new starters were competent to operate the assessment and triage systems. New EMD staff participated in a comprehensive induction and training programme which lasted for four weeks. Of these four weeks, one week was spent shadowing a more experienced mentor. Staff told us they found this experience invaluable. New staff were required to pass an examination to become a certified emergency medical dispatcher (EMD) prior to taking calls. Before clinicians started to work independently, they were required to show compliance in ten clinical support tool audits.

The service made sure staff continued to be competent to carry out their roles. Teams in the South hub had recently moved over to using the same triage tool as the North hub. All EMD staff at the
South hub had participated in four-week training programme to learn how to use this new system. All EMDs held current certification to use the system and received individual feedback from call audits. Staff in the clinical team participated in one-to-one meetings with their line manager to discuss their performance on clinical support tool audits.

Dispatchers and EMDs had the opportunity to develop their skills. The training and development team organised training sessions for EOC staff and arranged an annual half-day development session. The topics for these were based upon discussions with the auditor team, with managers regarding learning needs identified in appraisals, and with staff regarding the areas of concern for them. For example, staff identified they did not feel confident dealing with a terrorist incident. This topic featured as part of the training programme at the development day.

Opportunities existed for clinical staff to develop their knowledge and skills. The clinical staff were invited to identify their own training needs during a ‘learning amnesty’ conducted in the six months prior to our inspection. For example, nurses felt they needed more confidence in the interpretation of patients’ echocardiogram results relayed to them from the scene of the emergency. Clinical staff were allocated 24 hours of paid study-time per year to undertake continuing professional development in addition to the mandatory training and development days.

Not all the clinical advisors we spoke with felt that their learning needs were being met. At the time of our inspection, the training team were developing further plans to address the learning needs of clinical staff. This included undertaking individual learning and development reviews with all clinicians at the EOCs over the coming months, and arranging an annual full day of training for clinical staff.

Not all EOC staff had participated in an appraisal. In April 2018, 72% of staff working in the emergency operations centre at the trust had received an appraisal. This was lower than the trust target of 85% and was also a deterioration from the rate of 88.3% reported for the previous year (April 2016 to March 2017). However, the EOC had been given a revised target of 70% for appraisal completion because the board had recognised that staff had been asked to address more pressing priorities, such as the transition between two different prioritisation systems.

Improvements had been made to the management of appraisals. The most recent data for May 2018 showed the overall performance had improved to 82.7%. Managers kept track of which staff had completed their appraisals and which staff were due for renewal of their appraisal. Many of the appraisals left to complete had been booked in people’s diaries.

Appraisals were comprehensive, relevant and pivotal to the career development of the appraisee. As part of the appraisal process, staff submitted evidence to show how they had met expectations in key indicators during the preceding year. These indicators were trust values and behaviours, communication, health and safety, service improvement, equality and diversity, and effective leadership. If the appraiser agreed the member of staff had exceeded expectations, they were invited to join the ‘talent pool’ which gave them opportunity to apply for certain jobs prior to the recruitment process being widened.

EMDs were encouraged to develop their leadership skills and take on more responsible roles. EMD staff who had expressed an interest were given the opportunity to shadow and be mentored by the EMD team leader. On days the team leader was absent, a member of staff being mentored could stand in for them as a development opportunity. This also provided a level of resilience for the service. During our inspection, an EMD was spending the day shadowing and being mentored by the EMD team leader.
There were other development opportunities for EMDs who could apply to become a dispatcher after two years working as an EMD. EMDs could apply to become an emergency care assistant at regular intakes throughout the year.

**Multidisciplinary working**

There was good multidisciplinary working in the clinical hubs which helped to benefit patients. A midwife was located at each of the EOCs from 8am until 8pm. Midwives were employed by local acute trusts and were available for patients in the geographical areas of Gloucester and Plymouth. The midwives coordinated a project which aimed to ensure only women in established labour were taken to or advised to go to hospital. The midwives gave advice to women who telephoned an emergency advice line. The midwives also gave advice to staff at the EOC to ensure that emergency resources were only sent to women who were in established labour. They also provided support to staff to deal with any obstetric emergencies.

The triage systems used by EOCs enabled all staff to provide a multidisciplinary approach to patient care. Each member of staff from the different teams had access to the information provided within the triaged system by the other teams. The system enabled information to flow from the emergency medical advisor through to the dispatch team to provide the appropriate response.

Dispatch teams carried out handovers to enable a transition between shifts. Senior staff confirmed the handover process was not factored into their shift pattern, so not being recognised as essential by the trust. Handovers included relevant information about the previous shift and current issues. The dispatch team told us they arrived 10 minutes early for their shift to ensure there was time to have a handover. No decision had been made as to whether the handover would be factored into the new dispatch rota.

**Health promotion**

There were pathways available to clinical staff to refer callers to other services when they were not calling with a medical emergency. The clinical advisors could access a web-based system from their computer and their mobile telephones. Clinical advisors inputted data such as the patient location, gender, age, GP and the system presented a range of options for the patient, for example, support groups and treatment centres.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Emergency medical dispatchers and dispatch staff only need to have minimal involvement in applying the Mental Capacity Act 2005 or Deprivation of Liberty Safeguards. Therefore, these staff were not required to complete training in these topics.

EOC staff were not expected to complete mental capacity assessments over the telephone. EOC staff noted any concerns regarding consent on the electronic patient care record. If required, the ambulance crew completed an assessment of mental capacity when they arrived at the scene of the emergency. Ambulance personnel were expected to act in the best interests of any patient who was not able to make decisions at the time of the emergency.

All staff in the EOCs could access detailed guidance from trust policy available at their workstations, including a clinical directive for staff outlining their responsibilities around mental health and mental capacity. All staff in the EOC’s were expected to follow the principle of the Mental Capacity Act 2005 in assuming that all patients had capacity unless they found evidence to suggest otherwise.
Clinical staff we spoke with understood the relevant consent and decision-making requirements of the Mental Capacity Act 2005 that applied to patients who did not have capacity to consent. Most staff had completed their mandatory training in this subject.

However, not all clinical staff had updated their knowledge regarding Deprivation of Liberty Safeguards. Staff in the clinical team were required to complete mandatory training for Deprivation of Liberty Safeguards and the Mental Capacity Act 2005. The breakdown of compliance for this training in March 2018 is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act</td>
<td>82</td>
<td>93</td>
<td>88.2%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Deprivation of Liberty Safeguards</td>
<td>57</td>
<td>93</td>
<td>61.3%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Source: Trust Provider Information Request – Mandatory training

Staff felt the training they received did not provide them with appropriate skills to care for patients with mental health needs and learning disabilities. Although staff received yearly training on the Mental Capacity Act 2005, staff felt training to manage callers with mental health problems or learning disabilities was limited. Staff told us the skills they had learnt to manage these callers had come from their experience of managing previous calls which they had received.

Is the service caring?

Compassionate care

There was a strong visible patient-centred culture at the EOCs. Staff demonstrated their compassion and commitment to each caller on each of the 108 calls we listened to. Staff were consistently reassuring, empathetic and kind.

Relationships between people who used the service, those close to them and staff were maintained. Staff consistently demonstrated their commitment to caring for patients. Staff showed compassion, kindness, respect and professionalism throughout each call despite at times their challenging nature. Staff remained calm and respectful. The Emergency Medical Dispatchers (EMDs) remained calm under pressure, but with confidence and assurance, and handled all calls with courtesy and patience.

Staff were highly motivated to provide to provide care which was compassionate and empathetic. EMDs provided reassurance for patients during the calls. They continually reassured callers about the situation and checked on patients when they waited on the line (if the situation required this) until the ambulance response arrived with the patient.

Emotional support

Staff showed determination to support callers and provide appropriate treatment over the telephone. We listened to a call where the caller was instructed to help a patient who was choking. The situation was fraught and the caller was very concerned for the welfare of their relative. To support the caller to help the patient, the EMD was calmly and appropriately assertive and
provided clear instruction, while also providing reassurance and support. Emotional support was then given to the caller, who had taken an active role in helping the patient. The EMD leading the call provided much needed praise and reassurance to the caller under the circumstance of the distressing situation, and informed the caller how well they had done in helping the patient. The EMD provided emotional support by reassuring the caller that their actions had saved the patient’s life.

The emotional needs of callers and patients were recognised by staff and embedded in the care they provided. EMDs provided continuous emotional support to the most unwell patients and callers when an emergency ambulance response was on its way. Where necessary, and unless other priorities took over, advisors remained on the line until the ambulance crew arrived at the scene. This provided reassurance to callers they were not alone during a possibly distressing time.

The values of kindness, compassion and empathy were embedded in service delivery. The clinical team provided empathy and compassion to an elderly patient who was unwell, lonely and who said they had given up. The clinician took the time away from carrying out their assessment by empathising with the patient about the challenges of living alone. They took the time to listen to the patient and provided a compassionate response to the information they were providing over the telephone. The clinician took a calm and sensitive approach to the situation due to recognising how mentally fragile the patient was. It was clear the clinician had an understanding about how the impact of being unwell had been so hard on this patient.

Staff demonstrated respect and empathy for callers experiencing a mental health crisis. Staff were caring, compassionate and respectful despite being restricted by the procedural demands of the system they used for prioritisation. Staff would complete the required stages of prioritisation and then offer emotional support to patients. They explained to us that the emotional support offered was a skill they developed over time and was not something they had been taught. EMDs and clinicians spoke of the need to be patient, listen and offer reassurance when people were distressed. We listened to several calls with patients experiencing poor mental health. Each EMD and clinician provided support and reassurance to the patient.

**Understanding and involvement of patients and those close to them**

Staff were committed to working in partnership with callers and patients to manage their expectations of their care and treatment. We listened to a call where the EMD took the time to engage with a caller to explain that a rapid response vehicle (RRV) had been sent to attend to the patient rather than an ambulance. The EMD explained what the RRV was to provide clarity and understanding for the caller.

Clinicians communicated with people to ensure they understood the information they were providing them with, and adapted communication to make sure it could be understood. We listened to a call carried out by a clinician from the clinical team. The clinician had a discussion with the duty manager over the telephone about the patient and carried out an assessment to identify whether the patient’s health had deteriorated. During the assessment and throughout the phone call, the clinician clearly explained information and ensured the caller understood the questions and to reduce the risk of confusion. Following the assessment and the advice provided, the clinician summarised the information for the duty manager and ensured that instructions had been understood to ensure the safety of the patient.
Staff communicated clearly and simply with callers. Call handlers provided clear instructions about how people with the patient could support them until the ambulance arrived. EMDs also explained what the patient could and could not do to ensure their safety.

EMDs clarified their understanding of the information they received from callers to ensure they had heard the information correctly. This ensured assessments were accurate to enable effective prioritisation and the most appropriate ambulance response.

Is the service responsive?

Service delivery to meet the needs of local people

Services were planned and delivered to meet the needs of local people. For example, the trust identified that patients who fell without injuring themselves were at risk of developing pressure ulcers and deconditioning. This was because they may have to wait a long time for an emergency ambulance response.

The trust had developed the role of the community first responder to better meet the needs of these patients. Community First Responders are drawn from a range of volunteers and other professional organisations to provide support often in rural or hard-to-access areas. The Community First Responder (CFR) service had demonstrated improved outcomes meeting the needs of a patient group. Community First Responders were trained to attend the scene of the incident, complete a checklist with the patient to ensure there was no risk of injury, and then help the patient to a seated position using assistive equipment. Community First Responders could telephone the clinical support desk at the EOC for advice if needed. As a result, 72% of non-injured patients who had fallen were able to stay at home without the need for conveyance to hospital.

The EOC’s were set up as one ‘virtual’ hub. This meant that staff in both EOC’s could answer calls and dispatch ambulance resources to patients across the whole region covered by the trust. In this way, peaks in demand and/or shortfalls in staffing at any one location were shared across both clinical hubs.

Meeting people’s individual needs

There were systems to ensure patients who could not communicate verbally were able to contact the EOC using alternative means. For example, patients dialled using their minicom telephone and were connected to an operator who spoke with the EMDs on the patient’s behalf. When EMDs answered silent calls, they tried to collect as much information as they could to triage the call as accurately as possible. For example, the EMDs looked at the caller history on the triage system and contacted the police.

EOC staff could access foreign language interpreters when patients were unable to communicate using English. We heard this being used effectively. Staff told us this was used as a last resort because accessing the language line caused delays to the triage process.

‘Frequent callers’ were adults who either made five or more emergency calls related to individual episodes of care per month, or twelve of more emergency calls related to individual episodes of care in three months, from a private dwelling. It was important to have a safe system for managing frequent callers to meet their needs appropriately and to make best use of scarce ambulance resources.

There were systems to manage frequent callers to the ambulance service. There was a frequent
caller team which covered Exeter and Bristol EOCs. This team were responsible for agreeing a care plan for every identified frequent caller which staff at the EOC could refer to when prioritising and dispatching ambulance resources. The frequent caller team wrote these care plans in conjunction with the individual patient and their main care provider, or their GP or mental health service. Patients who had a care plan were given a flag on their electronic care record. EMDs and dispatchers clicked on the flag to view instructions regarding how to categorise the call, and how to prioritise the dispatch of resources where appropriate. The frequent caller team implemented a staged process of escalation for managing frequent callers. These processes included letters to the patient that were copied to relevant professionals, multi-agency meetings to discuss and set up behaviour contracts and face-to-face meetings with the patient.

Unfortunately, staffing issues had impacted on what was previously a high-performing service. There was no assurance that the trust had full oversight of the performance of the frequent caller service. No audits of this service were completed during the 12 months preceding our inspection. Frequent caller team meetings were infrequent (five in the 12 months preceding our inspection). Meetings to discuss complex patients were infrequent (five in the 12 months preceding our inspection). There was no identified frequent caller lead available to monitor compliance with the frequent caller policy. At the time of our inspection, EOC leads were in the process of recruiting to this post on a temporary basis. We were told that members of the frequent caller team were not able to attend multi-agency meetings as they were short staffed. This meant that critical decisions regarding ongoing patient care were being made without input from key members of staff.

The frequent caller policy did not identify how frequently care plans should be reviewed. At the Exeter EOC there were 863 frequent callers identified on the database and 23% of these patients had a frequent caller care plan. Between 24/02/2018 and 06/07/2018, 31.3% of flag warnings at the Exeter EOC were not reviewed by a Clinician. On 06/07/2018, the oldest set review date on any warning flag was 24/02/18. At the Bristol EOC, there were 482 frequent callers identified on the database and 97% of these patients had a frequent caller care plan. Between 24/02/2018 and 06/07/2018, 14.3% of flag warnings at the Bristol EOC were not reviewed by a Clinician. On 06/07/2018, the oldest set review date on any warning flag was 22/03/18.

This meant that EMDs, the clinical team and dispatchers were making decisions about care and treatment based upon information which could be out of date. For example, the patient’s condition may have changed, they may no longer be a frequent caller, or their behaviour may have escalated.

Prior to implementation of the Ambulance Response Programme (see above), the trust was required to report data regarding the number of emergency calls from patients for whom a frequent caller procedure had been identified. However, from May to October 2017 the trust reported no data for this metric.

Source: NHS England – Ambulance Quality Indicators – System Indicators

We did not find specific evidence of harm resulting from the deterioration of the frequent caller service. However, the trust was not making best use of all opportunities to make ambulance resources available for patients who needed them. For example, the frequent caller record system was not shared to ensure patients received agreed responses from both hubs. The Bristol and Exeter EOC’s used separate databases to record individual management plans for frequent callers. Clinical staff at each EOC could only access the information in their own database. During our unannounced visit, there was only one clinician on duty at the Exeter EOC. The clinician’s shift
was due to finish meaning there would be no clinician present in the Exeter EOC for the remainder of the overnight shift. In that situation, the clinical staff in the Bristol office covered the demand for patients in the south of the region, but were unable to refer to any care plans for frequent callers.

Following our inspection, we were told that the trust planned to introduce a new frequent caller management system. The first phase of this plan was due to commence in August 2018 with testing of the system and training for all the clinical staff and frequent caller team. At the time of our inspection there was no agreed plan regarding how data would be migrated to the new system.

**Access and flow**

Ambulance resources were dispatched with reference to risk and need using the electronic prioritisation software system. EMDs asked patients questions and the answers enabled the triage system to automatically assign the call to a category of priority. Category one calls were from patients with urgent life-threatening conditions, for example cardiac arrest or serious allergic reaction. Category two calls were from patients with emergency needs, for example burns, epilepsy and stroke. Category three calls were from patients with urgent needs, for example late stages of labour, or diabetes. Category four calls were from patients with less urgent needs such as a urine infection or diarrhoea.

Dispatchers allocated ambulance resources according to the categories allocated by the prioritisation system. However, as part of the dispatch process, dispatchers considered several other factors which impacted upon their allocation of resources. These included, time to travel to the scene of the emergency, capacity of the resource to convey patients to hospital, skills of the personnel, meal breaks and shift patterns of the road crews.

The auto-dispatch function on the computer aided dispatch system (CAD) detected and dispatched the fastest available resource for category one (life threatening calls). Staff in the dispatch team checked the accuracy of the auto-dispatch function based upon local knowledge of the geographical area. If required, the resource allocation could be amended. The service was at the forefront of ambulance services using this technology. There were only two other ambulances which had recently started to use the auto-dispatch system.

The CAD system forecasted from previous information the likelihood of ambulance resources being needed in certain locations at any given time. This helped the service plan for areas in which demand may increase and help improve ambulance response times. The system communicated this to dispatchers as a ‘status plan.’ The CAD displayed the dispatcher’s real-time compliance with the status plan on their screen to remind them to move resources accordingly. Dispatchers tried to locate resources in these positions, however, at times it was not always possible to do this due to the demand for services elsewhere.

Dispatchers were mostly successful in ensuring the minimum number of ambulance resources were committed to any one incident at a time. The number of ambulance resources allocated was less than (better than) or the same as the national average for seven of the eight indicators. This was except for the number of ambulance resources which arrived on the scene of category two incidents. The table below shows the trust performance against the national average for ambulance trusts in May 2018:

<table>
<thead>
<tr>
<th>Category and resource</th>
<th>Trust performance</th>
<th>National average</th>
</tr>
</thead>
</table>

164
The EOCs took longer (were worse) than the national average time to identify category one calls. The time taken to identify these incidents was important because the right type of ambulance resource could only be dispatched once the category of incident had been identified. In May 2018, the team took a mean average of 53 seconds to identify category one incidents, compared to a national average of 47 seconds. At the 90th percentile, this task took 106 seconds, compared with a national average of 87 seconds. During our inspection, we saw how leaders of the EOC were focused on improving this indicator. At the time of our inspection, staff were attending training workshops where they learnt about the ARP pathway and the importance of the pre-triage questions in determining category one incidents.

The trust provided additional data showing performance over the five months preceding our inspection, these figures were lower because they excluded duplicate, not urgent or emergency calls, upgraded or downgraded calls and incidents that took place outside of the geographical footprint of the trust. However, we were not able to benchmark these figures against the national average.

This data (Mean time in seconds to Cat 1 identification for incidents early identified by Pre-Triage questions, What's the Problem Keyword or Nature of Call) is shown in the table below:

<table>
<thead>
<tr>
<th></th>
<th>Feb 2018</th>
<th>Mar 2018</th>
<th>Apr 2018</th>
<th>May 2018</th>
<th>Jun 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean time</td>
<td></td>
<td></td>
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Learning from complaints and concerns

Complaints were responded to well in terms of the quality and work that went into the response, but the responses had not been timely, although this was now improving. Acknowledgement of the receipt of the complaint within three days, as required, was almost 100% in the 2017/18 year. The trust target for a full response to be given following a complaint was 25 days and 35 days for a more complex complaint. The deadline of 25 days was not untypical of NHS trusts in England, but the deadline of 35 days was considerably less than in many NHS trusts, where 60 days was more characteristic.

Complaints were not being responded to in the deadlines set by the trust. In the year 2017/18, the trust had responded to just 35% of all complaints within the deadline, and for complaints about emergency operations centres, this was just 17%. The trust provided us with the latest information which showed the response for all complaints deteriorated further in the first month of the 2018/19 year (April 2018) to 18%, but by June 2018, significant progress had been made, and the response was now at 71%. 
The number of complaints made to the trust had fallen. In the year 2017/18, the trust received 1,334 complaints, comments or concerns to be investigated. This was a fall of 17% over the previous year. Several of the 1,334 complaints had more than one area of concern, which increased the number of areas of concern to be investigated to 1,665. Around 52% of these complaints related to the emergency operations centre service. From our analysis of the complaints received, almost all concerns were about ambulance delays (71%), followed by communication and the poor attitude of staff (10%).

The quality of the responses was good. During our regular engagement work with the trust we have reviewed several significant complaints. We have found them to be investigated well, with a thorough response produced. Another measure of the quality of the complaint response being high was from those that needed to be reopened following the initial response. In 2017/18, this was only 28 of the 1,334 received (2%). Another measure was from complaints escalated to the Parliamentary Health Service Ombudsman. People could complain to the ombudsman if they felt a response from the NHS had been inadequate. In 2017/18, five complaints were made to the ombudsman, and none were upheld.

The process for people to complain to the trust was straightforward. People could complete an online form on the trust website, write to the trust, or call by telephone. The instructions on the website were clear for people to follow. When staff made welfare calls, they gave patients the telephone number for making a complaint if the patient requested this.

The organisation learned from complaints. The annual report 2017/18 described some of the actions taken because of complaints made about the emergency operations centres. Just over 100 complaints were related to how calls had been triaged, and 93 reporting dissatisfaction with communication. Actions taken included conversations with call handlers about communication and a requirement for reflection, and review of the welfare calls system which was struggling in times of high demand.

**Is the service well-led?**

**Leadership**

There was dedicated and experienced leadership within the EOCs. Senior staff had been part of the ambulance service for number of years and had worked in various clinical and managerial roles before progressing into senior roles. We spoke at length with the clinical hub leader and the deputy hub leaders. They demonstrated enthusiasm for their roles and demonstrated a commitment to improving the quality of the service. Service leads were passionate about improving the service and positively engaging staff. They demonstrated integrity during discussions about areas where the service was not doing as well as they had hoped, and how they planned to improve. The head of clinical hubs and the deputy clinical hub leaders had a clear understanding the roles of the staff in the EOCs.

Leaders were motivated and proactive, and committed to improving the quality of the service. The deputy lead for the North hub had been in post many years. The deputy hub lead for the South had come in to post six months prior to the inspection, along with the head of clinical hubs. Most staff we met were confident with the leadership provided at the clinical hubs and staff spoke positively about the new style of leadership. Staff at the South hub told us they now felt more engaged in the clinical hub environment. Staff told us it had taken time to get used to the new
leadership style but described it as “refreshing” and “re-energising.” Staff at the South hub also described the new leadership as much needed “continuity and stability.”

Staff appreciated how open and transparent the new head of clinical hubs had been and how they outlined their intentions on starting the role six months ago. The head of clinical hubs wanted the teams to be more involved and was keen for suggestions. For example, one area that was recently improved was dealing with the low use of Community First Responders (CFR) in the North patch. The hub lead explained to staff about the CFR role what they did and what they were available to support. This provided staff with the confidence to make better decisions about the use of resources and there had been noticeable increase in the use of CFRs in the North. The head of clinical hubs and deputy hub leaders spoke about the importance of involving and engaging with staff to encourage them to drive improvements to improve the quality of the service.

Leaders engaged with staff to ensure they understood the EOCs strategy and were involved with driving improvements. Staff told us how the head of clinical hubs had taken the time to engage and meet with staff. Sessions were held and discussions included evidence-based explanations about what was going well and what needed to improve, along with data and proposed solutions. The session was optional, but staff who attended told us they found this session helpful and engaging.

The head of clinical hubs and deputy leaders were visible around the clinical hubs and encouraged supportive relationships among staff. Staff were aware of their line managers and who they were accountable to. The deputy leaders’ offices were also on the same floor as the EMDs and dispatchers. This ensured leaders had oversight of what was happening in the hubs and were available to provide support if required.

Managers of all levels working in the clinical hubs understood the challenges to good quality care and could identify actions required to address them. Managers told us about how they managed increasing call demand and call stacking due to the need to maintain targets and provide a consistent good quality service. They also told us how they managed staffing challenges and gave us an example of how an issue with dispatch staffing shortage was well-managed the weekend prior to the inspection. Managers told us every day was unique and they had to be flexible with the resources and staff to ensure an efficient high-quality service.

Staff felt confident to raise issues or concerns and challenge managers to improve working practices. We were given an example when an email regarding a change to a process at the hubs was not communicated to staff in a timely way. The EMD team lead took this information back to the hub deputy and lead to discuss the concerns raised by staff. We were told the hub leaders listened and accepted the feedback to ensure communication was carried out in a timely way in the future. Staff at the hubs told us there was a more open, two-way style of communication, which they appreciated.

There was recognised support for staff wellbeing and welfare. The Staying Well service supported staff with their physical and mental health. Staff spoke highly of the service and told us how they had been supported following periods of illness or following a difficult call which had had a profound effect on them. Staff praised the service for how quickly it provided support, and the level of support staff at the service continued to provide as a small team. Some EMDs gave us specific examples of the support they received from the service following calls which had affected them.

Managers told us they were particularly aware of looking after the current EMD workforce. This staff group was much younger than other members of the workforce and may not have had much
exposure to challenging and emotional situations. Staff were aware of the impact challenging and
gle unpleasant calls could have on the workforce. They were vigilant to watch out for these sorts of
calls coming in to be able to provide support for staff. There were posters available around the
clinical hubs providing information and contact details to enable staff to self-refer to the service.

Vision and strategy

The trust had a clear mission statement, vision and a set of values. The trust’s mission statement
was patient focused and centred on saving lives. The vision demonstrated a commitment to
delivering high quality services to patients, by ensuring patients received the right care, in the right
place, at the right time. The trust’s values included respect and dignity, commitment to quality of
care, and everyone counts. The values were displayed on posters around the clinical hubs and
staff were familiar with the values.

There was a clear strategy for the clinical hubs, with the focus being on performance, efficiency,
quality and building strong foundations for the core work carried out by the clinical hubs on a day
to day basis. The head of clinical hubs and deputy leaders recognised there had been a lot of
high-paced change over the past two years. These included changes in leadership, alongside the
ever-increasing demand for the service. There had been the introduction of a single telephony
system and the South hub implementing the same prioritisation software as the North hub. This
enabled the launch of one ‘virtual’ hub model in April 2017.

The North hub had relocated to new premises in Bristol, and the hubs had been part of the pilot
study for the Ambulance Response Programme (ARP) from April 2016, which had been
implemented nationally in November 2017. The ARP aimed to provide the right response to an
incident, rather than the quickest. The strategy for the hubs was to focus on consolidating the
changes, while also improving quality. The clinical hub leaders wanted to improve compliance with
call audits to improve the ability of the emergency medical dispatchers to prioritise calls effectively.
In turn they recognised this should lead improve performance and ambulance response times,
improving the overall efficiency of the service.

Staff understood the vision and values for the trust and their role in achieving the strategy. It was
clear during discussions with staff they were passionate about their role and were committed to
providing high quality care for patients in line with the trust’s vision and values. Staff understood
the importance of their role and the need to prioritise patients effectively to enable the right
response to be dispatched to the patient. Staff understood the importance of the call audit process
to identify areas of their performance which could be improved and to improve the quality of the
service. being provided. Staff were also provided with information about the strategy for the EOCs
on the electronic notice boards located in the clinical hubs.

Culture

Staff morale had improved at the clinical hubs in comparison to our previous inspection in June
2016. The majority of EMD and dispatch staff told us they had seen an improvement in morale in
the clinical hubs. They put this down to better staffing levels, improved communication and better
staff engagement. However, there were a small number of dispatch staff at the North hub, who felt
morale had not improved. They reported this was due to poor communication in the local hub, and
the wider EOC environment. Staff told us there were always going to be ups and downs in morale
due to the nature of the job, rising call volumes and pressures of the work, but on the whole
morale had improved.
Morale was low in the clinical teams in both the North and South clinical hubs. Staff told us their role had changed somewhat. They felt managers in the EOC did not entirely understand the role and function of the clinical team and they felt restricted by the clinical support decision tool.

A significant amount of work had been undertaken to reduce the cultural differences between the North and South clinical hubs. Work was ongoing to align the hubs and standardise working processes. The hubs became one virtual clinical hub in April 2017 with the alignment of telephony and prioritisation systems. Managers told us how there were daily and weekly teleconferencing meetings between the two clinical hubs and various managers meetings where they were encouraged where possible to get together face-to-face. Managers told us they knew their counterparts in the opposite hub well and were in contact with them regularly outside of assigned meetings either by telephone or email to discuss and manage issues. EMD team leaders told us it had taken time to build relationships between the hubs. Initially there had been conflict if one hub had called to report something which had not worked well. However, as time had passed and staff became familiar with each other and the way they worked, working relationships had improved. Team leaders told us they regularly communicated on the telephone during shifts.

The culture within the EOC was open and transparent and most staff felt valued and empowered to speak up. The staff survey from 2017 demonstrated that 52.3% of staff working in the EOCs felt confident to raise concerns about unsafe practice. Within EOC staff, 12.1% strongly agreed with this statement. Only 6.9% of staff disagreed with 2.3% of staff strongly disagreeing. There were some staff, 26.4%, who neither agreed or disagreed with the statement.

A member of staff told us about a situation where systems and process had not been working effectively and this had been raised with the head of clinical hubs. The hub lead had provided an alternative process. However, the member of staff did not agree with the recommendation and was able to be open about their concerns. The head of clinical hubs then took the time to have a conversation with the staff member and provide the rationale behind the recommendation. The member of staff found this to have been helpful to develop their understanding as to the benefits of the suggested system. The system was implemented and was reported to be working effectively.

There were procedures and opportunities for staff to receive support. Staff were actively encouraged to take time out after a particularly difficult call, or when the job became more overwhelming than usual. There were quiet areas for staff to use and staff were trained in trauma risk management (known as TriM) to offer support. TriM is a recognised peer-delivered psychological support mechanism to identify those that require specialist intervention. It is used by frontline organisations such as the ambulance service to prevent post-traumatic stress disorder following a disturbing event. Staff trained in TriM would be available or released from their duties to support staff who had taken a difficult call or managed a serious incident. On member of staff told us how valuable TriM was when they were provided with support by the service following a traumatic call.

Action was taken to address performance and behaviour which was not consistent with the values of the trust. If senior managers identified a concern about a member of staff and their performance, they were managed according to trust policy. This included formally meeting with the member of staff and identifying a clear action plan and targets to be achieved. Staff would continue to have regular meetings to review their performance against the action plan.

The set-up at the EOCs enabled teams to work collaboratively and in a timely way to provide the right care and support for patients. The launch of the virtual hub in April 2017, enabled the North
and South hubs to work collaboratively. We were given examples of the hubs supporting each other when they had staffing challenges. We were told of a recent situation where the North hub covered for the South hub who had a challenge with insufficient dispatch staff over a weekend. To help the South team, staff at the North hub took on the dispatch for the Somerset region at the North hub. This would usually sit with the dispatch team at the South hub. We were also given examples of how flexible the hubs had become. For example, when staff from the North hub had carried out a shift at the South hub and vice versa for various reasons. The launch of the virtual hub had also made significant incidents such as the power failure in December 2017 easier to manage. Due to the nature of the event which occurred during the power failure, staff from the South hub went up to the North hub to work to ensure there was minimal disruption to the service.

**Governance**

There was an effective governance framework to support the delivery of the strategy and good quality care. There was a straightforward governance structure where the EOCs were represented through both the clinical effectiveness group and quality governance committee. Information from these meetings was then fed into the directors’ group, who were accountable to the trust board.

There was a systematic approach to monitor and improve quality and safety in the clinical hubs. There was a bi-weekly hub huddle meeting for the North and South hubs. These fed into the clinical hub operational management meeting held monthly. There was also a teleconference meeting held on a Monday and Friday with representation from both the North and South hubs.

Forward planning was a key agenda item to ensure quality, safety and risks were managed appropriately. Staffing levels were checked to manage any significant events which were planned across the patch. There was a daily conference call to discuss any issues with staffing or problems from the night shift and to identify and issues around safety quality or performance which may develop over the course of the day. This information was then escalated to the daily trust-wide conference call which would provide a clear picture of service-wide risks which had the potential to affect quality, patient safety and performance.

Staff at all levels were clear about their role, what they were accountable for and to whom they were accountable. Staff were clear about who they reported to while on shift and were clear about the roles and responsibilities of other senior managers. Staff told us they regularly communicated with their team leaders for various reasons, for example after a difficult call or for advice.

There was interaction between trust management and operational staff on quality, safety and governance. The trust had developed a programme of ‘quality buddies’. These were staff from various parts of the governance functions in the organisation who linked with operational staff to share a range of information with staff in the clinical hubs.

Meetings were held monthly to discuss any themes from incidents or complaints, audit results, claims or inquests, risks to the organisation, and to share areas noted as excellent in performance.

The need for learning, updating knowledge, and changes to practice had been recognised from these meetings and conversations. Examples included staff being made aware of how the new General Data Protection Regulations affected what they recorded and stored on the electronic patient records. The Joint Royal College Ambulance Liaison Committee (JRCALC) guidance used by the clinical team was updated where it was recognised changes were needed to practice following incidents or complaints. There had been training around caring for an intoxicated patient with possible underlying injuries included as part of the development day following a Coroner’s
inquest. Other training on specific conditions or injuries such as Asperger syndrome and complex spinal injuries had been identified from work on incidents, complaints, and new guidance being produced locally or nationally.

Management of risk, issues and performance

There was a proactive approach to managing foreseeable risks such as changes in demand and seasonal weather issues. This was designed to manage risks associated with the increase in demand for the service and to deal with them effectively to limit negative implications for the service. One activity used to identify and manage risks was the weekly resource management group meetings. These were held to review staffing levels and look at 72-hour forward planning and long-term horizon planning (planning for future increase in demand). This enabled the EOC to be prepared to manage foreseeable risk to endeavour to ensure services were not disrupted and risk to the service was managed effectively.

There was a clear plan to manage the risks to patients from increasing call demand. The demand management plan was a support tool for managers to implement when call demand into the hubs increased. The plan provided a structured framework for dealing with risks. The plan enabled the EOCs to respond to periods of high call demand, which exceeded the capacity of the service to provide an optimal response to patients. Implementation of the demand management plan was based on the longest single wait for a category two to four incident. The plan identified which demand management level would be taken when specific triggers were met. The plan also had action cards which identified what needed to happen at each level. The control officer and duty manager had oversight of EOCs and knew when the demand management plan needed to be implemented.

Risks were managed during the carefully planned relocation of the North hub to their new premises in November 2016. This ensured there was minimal impact to the service and EOCs ability to answer calls, ensuring patient safety. Prior to the move, the new premises were set up to mirror the previous hub. This included for example, having a card deck and the paper-based system ready in case of a system failure. During the relocation, half of the staff moved to the new premises, and the remainder stayed at the previous hub to cover shifts. Once the new premises had been up and running smoothly for several days, the reminder of the staff moved to the new office.

Risks associated with EOCs were understood and managed. The trust held a risk register to identify, record and manage risks. The risk register reflected the risks associated with the EOCs which included call stacking, call audit compliance and inability to answer 999 calls. The risk register identified the controls established to reduce or limit the risk, and further actions which needed to be taken, but lacked information as to when the risk was added, a time frame in which actions needed to be completed, a named person responsible for the actions, and an update as to the status of the actions.

Risks were managed positively with risk assessments and risk management plans developed to limit risks to patients. Risk assessments had been completed in relation to the impact of being unable to meet clinical and non-clinical call audit compliance. We saw the completed risk assessments which included current actions to mitigate the risk which had been scored in accordance with a risk matrix took as to the level of the risk. There were four actions with deadlines which had passed in May 2018. There was no identification whether these actions had been completed.
There was alignment between risks recorded on the risk register and staff understanding of the risks the organisation faced. Managers and team leaders of all levels could tell us about the challenges and risks which the clinical hubs faced. Staff of all levels could tell us how they worked to manage risks in accordance with their role and level of responsibility.

There was a business continuity plan for the trust which identified procedures and processes which needed to be carried out in the event of a failure within the EOC. These failures included the loss of telephony, power, or the computer aided dispatch system. The plan contained action cards which identified the roles and responsibilities of staff and the actions required if the situation was to occur to enable business continuity. The business continuity plan was last followed by the hubs because of a power failure in December 2017.

The trust was part of the National Ambulance Resilience Unit (NARU) resource escalation action plan (REAP). The EOCs were part of the escalation plan response and the trust’s major incident plan was based on national criteria. The nature of the EOC response would depend upon the level of the threat posed, which ranged from ‘green: steady state’ through amber and red to ‘black: extreme pressure’. During the inspection, the trust was running at amber which indicated the trust was working under a moderate amount of pressure.

The EOC clinical teams had access to NARU guidance identifying their part in responding to major emergencies. EOC staff had access to emergency planning and preparedness action cards to provide further support and detail about how to manage major incidents. This would include, for example, incidents involving firearms or chemical or biological incidents. The action cards provided supporting information about what to do if a specific scenario occurred, additional questions to ask the caller and which ambulance vehicles which would attend the incident. The emergency planning and preparedness actions cards were being updated in line with national guidance to include more major incidents following recent events in the UK.

There were dedicated staff within the EOCs with specialist knowledge to provide a response to incidents. Within the EOCs were specialised teams which included the HART team (hazardous area response team), and the helicopter emergency medical services (HEMS). These teams would be used in the event of a significant or major incident.

The trust had a major incident response plan. This identified how the trust would work together with other emergency services and take a multiagency approach to managing a major incident. The plan also outlined the role and responsibilities of the EOCs in such an incident, outlining how the EOCs would respond and which EOC would lead the response. This was dependent on where the incident had occurred.

Staff at the EOC understood their role in major incidents and were involved in planning and rehearsals for major incidents. The trust followed the Joint Emergency Services Interoperability Programme (JESIP) principals to ensure effective collaborative working with other emergency services during major incidents. Managers within the EOC were undertaking training to ensure familiarity with the JESIP principles and their competence with managing multiagency responses to a major incident. Control officers and duty managers from both the North and South hubs had either completed or were due to complete the week-long training course at the time of the inspection. The training was then to be rolled out to the dispatchers working for the EOCs. All dispatchers had been booked onto the training course in October 2018.

The EOC was responsible for alerting all major parties and stakeholders for health services of a major incident. These included local clinical commissioning groups, Public Health England, local
hospitals and local authorities. The EOC would send out a message using the electronic messaging system, which stakeholders were required to respond to. Messages were returned to the incident coordination centre where plans would be made to manage the incident with other stakeholders. This last occurred in February/March 2018 due to periods of heavy snowfall within the trust’s patch.

The Bristol and Exeter EOCs had provision for rapidly establishing major incident rooms should these be required. These were set-up with radios, telephony, computer-aided dispatch systems, administration systems and information screens. The major incident plan set out which staff were required in this room in the event of a major incident.

**Information management**

Fortnightly individual clinical hub meetings for both the Bristol and Exeter hubs were held to discuss performance, quality and safety. Meeting minutes reported a rolling agenda which covered sickness, mandatory training and career conversations (appraisals), audit, quality updates and horizon planning (staffing planning). However, the meeting minutes lacked evidence that agenda items had been discussed in depth and detail, and there was no evidence of scrutiny of information or discussion of actions from the previous meeting. There was a section for quality to be discussed but the quality lead had not attended any of the local hub meetings and had not submitted any feedback to be reviewed at the meeting.

A monthly combined EOC operational performance meeting was held to discuss quality, safety and performance with the head of clinical hubs and the deputy clinical hub leaders. Minutes from February, March and May 2018 demonstrated issues around safety, performance and risk were discussed in detail, and actions were taken and assigned to a member of the team to complete. The meeting looked at serious incidents and reviewed risks on the risk register. However, complaints were not discussed to see if there any areas which required improvement within the clinical hubs. Actions from the previous meeting were not reviewed as a routine agenda item for this meeting, therefore it was unclear as to whether actions taken from the previous meeting had been completed.

Managers working in the clinical hubs had daily discussions about quality and safety. The discussions identified staffing shortages or challenges. They provided an awareness of pressures between the North and South hubs to agree actions to be taken to effectively manage pressures. There were daily conference calls between the team leaders and managers to discuss the previous day and the current working days issues. One member of the team was then selected to represent the both EOCs at the trust-wide call later in the morning. These calls were recorded rather than minutes taken.

Electronic displays in the clinical hubs kept staff informed of how the trust was performing. Some staff told us the boards were useful to understand performance which provided a better understanding of the challenges faced by the organisation and within the clinical hubs. There were also additional electronic information boards in both the North and South hubs. These provided key messages and information for staff. It was clear the hubs had done a lot of work to try and engage staff within the hubs and to keep them informed.

There were effective arrangements to ensure information used to monitor and manage quality was relevant and timely. Managers received daily resourcing reports. The reports identified staffing levels and forecasted these for the coming week. These were discussed daily at meetings.
between the hubs to ensure actions were taken so staffing met planned levels in a timely way to ensure there was no disruption or impact to service delivery.

Engagement

There was regular engagement with staff working at the EOCs. There was a weekly bulletin from the chief executive for all staff. This contained organisation news and updates, staff news, upcoming charity events and events looking for volunteers. Staff were also sent other updates, including clinical and corporate guidance usually by email.

Staff were given the opportunity to be actively engaged so their views were reflected in the planning of aspects of the service. Staff were encouraged to be part of developing change within their roles. The rota for the dispatchers was due to be reviewed and work on this was due to start in the coming months. A working group had been set up to include the managers from the North and South hubs. It also included representation from five members of dispatch staff from each clinical hub to contribute to discussions regarding the rota changes. There were also working groups to look at variations between the processes used by the North and South hubs.

The service engaged with the public in different ways to improve awareness of the work of the clinical hubs. For example, the clinical hubs invited paramedic students to spend time in the environment to get a better understanding of the role of the EOCs. There had also been engagement with local schools and scout groups to provide education about the service. The trust also reached out to patients through social media to keep people informed. The clinical hubs also worked closely with local, large organisations.

Staff were encouraged to complete the NHS Staff Survey on a yearly basis. The staff survey asked numerous questions about different aspects of the individual staff member’s role and they were asked to score each answer using a list of pre-populated statements between strongly agreeing with and strongly disagreeing with the statement. The response rate for the EOC for 2017 was 44.9%. The survey identified areas where the EOCs scored highly and the areas which required improvement. Areas where the EOCs scored highly were staff being able to contribute towards improvement work, and the organisation taking positive action towards the health and wellbeing of the staff. The EOCs scored positively on staff feeling satisfied with the quality and work and care they could deliver, and staff satisfaction with the opportunities available for flexible working patterns. There had been an action plan identified to address the areas which required improvement. Actions included addressing the ability of the staff to provide the care they aspired to provide, improve reporting of incidents of bullying and harassment and continue to promote incident and near miss reporting.

Learning, continuous improvement and innovation

The EOCs were contributing to developing national policy. A large piece of work around the Ambulance Response Programme coding had been ongoing since August 2017. The work was reviewing the level of risk across the 1,800 codes used to prioritise patients using treatment outcomes to identify a risk score. The aim of this work was to identify unnecessary ambulance attendances against specific triage codes, with a view to more effective and efficient use of resources. The service was due to take this work forwards by working with a local research and modelling organisation to make informed decision as to large scale change for the NHS ambulance services.
The EOCs were due to pilot a qualified mental health nurse/professional working with the teams. This was due to commence for a period of four months from 30 July 2018. Mental health nurses would be provided by a local mental health trust, and be located within the Bristol hub initially to support ‘Hear and Treat’ service. The hub planned to have a mental health nurse on shift during peak times of need. These included evenings and during the night. If successful, the model would be extended to the South (Exeter) hub.

The trust’s governance framework identified areas for improvement. For example, the performance improvement plan identified areas of clinical hub performance which required improvement. Areas were linked to improving performance targets with the Ambulance Response Programme, while also looking at how the clinical hub role could be developed remotely. Earlier identification of category one (life threatening) incidents had been identified as an area which required improvement. Actions taken included improved delivery of the EMD prioritisation process, additional pre-triage questions, and reviewing coding categories. Furthermore, work was ongoing to improve call answering performance. Actions taken included working with EMD team leaders to identify barriers to improving performance, and to look at better management of breaks for the EMD team during shifts.

The performance plan had identified the need to develop remote access for clinicians working for the clinical hub. There had been a recent development at six ambulance stations across the patch where clinicians could go and be able to log onto the clinical hub systems remotely. The idea of the remote access was to enable clinicians to be able to report for duty if for some reason they were unable to make it into the clinical hub. This initiative had just finished a period of testing.