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**

The North-East Ambulance Service NHS Foundation Trust (NEAS) operates across Northumberland, Tyne and Wear, County Durham, Darlington and Teesside. The trust serves a population of more than 2.71 million people and employs more than 2,500 staff including volunteers. Volunteer porters, ambulance car service drivers and community first responders provide support to patients, from helping patients to reach their appointments through to providing essential life support.

The trust provides an unscheduled care service to respond to emergency calls and a scheduled care service which provides pre-planned non-emergency transport for patients in the North East region. Since 2013, they have delivered the NHS 111 service for the region to provide urgent medical help and advice.

The emergency care, 111 and patient transport services are supported by the trust's emergency operations centres based at Newburn Riverside and Hebburn, which manage more than 1.5 million calls per annum. They also deliver specialist response services through their Hazardous Area Response Team (HART).

Locations at the trust

A list of the location areas covered by the trust is below, along with a count of locations in each area.

<table>
<thead>
<tr>
<th>Location</th>
<th>Emergency Operation Centre</th>
<th>Patient Transport Services</th>
<th>Resilience</th>
<th>Urgent and Emergency Care</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>North</td>
<td>1</td>
<td>12</td>
<td>1</td>
<td>18</td>
<td>32</td>
</tr>
<tr>
<td>South</td>
<td>0</td>
<td>12</td>
<td>0</td>
<td>12</td>
<td>24</td>
</tr>
<tr>
<td>HQ</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>2</td>
<td>24</td>
<td>1</td>
<td>30</td>
<td>57</td>
</tr>
</tbody>
</table>

The trust also has locations that deliver core training, a driver training centre and a specialist skills base where the trust delivers training on a commercial basis to both businesses and the public.

(Source: Routine Provider Information Return (RPIR) – Sites tab)

Is this organisation well-led?

Leadership

The North East Ambulance Service NHS Foundation Trust was governed by a board of directors. Records we reviewed confirmed that the board meets formally ten times a year at various locations across the geographical area.

The senior leadership team at the trust consisted of the chief executive, chairman, five executive directors and six non-executive directors:

- Chief executive
- Chairman
- Medical director
- Director of quality and safety
- Director of finance and resources
- Chief operating officer
- Director of strategy, transformation and workforce
- Six non-executive directors

The chief executive officer had been in post since October 2014 and the chairman was appointed in May 2018.

Executive directors held responsibility for the day to day running of the trust whilst the non-executive directors brought external expertise to the organisation and provided advice and guidance to the senior management team. Our discussions with members of the senior team confirmed they were engaged and worked well together providing appropriate challenge at board level. We heard of examples where non-executive challenge to directors had influenced change at board level.

The trust board of directors had a range of experience, skills and knowledge to perform its role. Evidence was seen of skills assessments completed to inform non-executive director recruitment.
An example of this was the board had identified a need to recruit one non-executive director with a medical background and one non-executive director with a commercial background, ideally of managing IT or legal services. This led to recruitment of two suitably qualified non-executive directors.

The leadership team could describe how they monitored patient safety, quality and performance and the metrics and information used to support this. Senior leaders demonstrated an understanding of the priorities and challenges facing the trust. For example, workforce and financial performance. These challenges were key to the overall strategy for the trust and were also included in the corporate risk register and Board Assurance Framework.

During the inspection we carried out checks to determine if the trust was compliant with the requirements of the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensures that directors of healthcare providers are fit and proper to carry out this important role. We reviewed five director’s files in total, of which two related to non-executive directors, two related to the newest appointments, including the chair and one included the longest servicing director. We also reviewed the trust’s Fit and Proper Person Procedure (February 2016). We found the trust was compliant with the Fit and Proper Persons Requirement.

The trust had a leadership and management strategic plan, which represented one of the strands of the Organisational Development Strategy 2016/20. This strategic plan identified the direction for the next four years and to establish a means by which NEAS would attract, identify, develop and retain managers and leaders.

The trust had a ‘Compass leadership programme’ which had been in place since April 2017 for bands 7-8b which comprised eight modules. As of 1 March 2018, 48 leaders and managers had participated in this rolling programme. A management essentials programme had begun in September 2017, which was modular and ran continuously throughout the year to ensure that managers new to the trust had the necessary skills and knowledge to undertake their role. In the 12 months prior to our inspection 31 managers had participated in learning events covered by North East Leadership Academy.

**Board Members**

Of the executive board members at the trust, 0% were Black Minority Ethnic (BME) and 67.0% were female.

Of the non-executive board members 0% were BME and 43% were female.

The diversity of the board members is outlined in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>BME %</th>
<th>Female %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive directors</td>
<td>0.0%</td>
<td>67.0%</td>
</tr>
<tr>
<td>Non-executive directors</td>
<td>0.0%</td>
<td>43.0%</td>
</tr>
<tr>
<td>All board members</td>
<td>0.0%</td>
<td>54.0%</td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) – Board Diversity tab)*
The chief executive officer and chair both acknowledged the lack of British Minority Ethnic (BME) representation on the board. There was no formal plan in place at the time of our inspection to address this. However, the newly appointed chair identified this would be one of his objectives to address.

The chief executive had carried out formal appraisals with executive directors and were linked to trust objectives. We saw evidence of this in the personnel files that we reviewed.

All staff we spoke with spoke positively about the chief executive and many said she had visited their departments. During the core service inspection, we noted that feedback from staff was much more positive regarding the visibility of the senior leadership team than on our previous inspection visit. However, in the staff survey 2017, only 19% of staff reported good communication between senior management and staff. This was part of the trust’s action plan following the survey.

There was a programme of monthly quality walk-rounds which were attended by board members and governors. The executive and non-executive directors were allocated clusters where they were responsible for board visibility for their specific areas, and regularly visited hospital sites. Additionally, board members had visibility days booked into their diaries. There was an established clinical forum and a nurse forum had been set up with a date set for the first meeting. There was a plan in place to expand the safety walk-rounds to include services which support operations.

Feedback was shared with the board with the assistant director of communications and engagement formally reporting on themes, trends and resulting actions as part of a quarterly engagement report to the public board.

The NEAS council of governors was made up of 21 public governors, four staff governors and nine appointed governors. The governors were responsible for overseeing and scrutinising business and performance. NEAS had experienced some challenges in terms of filling governor vacancies where it was felt that the associated time commitment was a contributory factor. However, the chair felt the current governors were able to hold the board to account and provide the right level of challenge.

Vision and strategy

NEAS had a robust vision and strategy. The delivery of the strategy and vision was monitored through the various governance meetings.

NEAS’s mission statement was; “Why we wear the badge”, safe, effective care for all. NEAS vision was; “Where our badge will take us”, unmatched quality of care every time we touch lives. The NEAS mission statement and vision was underpinned by “How our badge will take us there” it had six values which were; make a difference day in day out, take responsibility and be accountable, strive for excellence and innovation, respect, compassion and pride.

There was evidence NEAS values had links to recruitment, induction, appraisal, talent management and grow coaching, which was the NEAS internal skills coaching process.

The 2015/20 organisational strategy had three overarching aims which were:

1. Do what we do well
2. Look after our employees
3. Develop new ways of working
The strategy was compiled as part of a large staff consultation on the development of the mission, vision and values. This was done through a consultation exercise with staff across the organisation, stakeholders and commissioners. At the time of our inspection, the trust was in the process of refreshing the strategy and had held a senior manager workshop for all senior managers in the trust in April 2018 to discuss and invite views on the strategic direction. It was envisaged that the refreshed strategy would reflect the changes seen by the trust in terms of the implementation of the five year forward view, the changes brought in through the Ambulance Response Programme (ARP) and the new opportunities presented through the delivery of the clinical assessment service and development of new pathways for care.

We saw evidence that progress against the current strategy was regularly reported to the board as part of monitoring of the corporate objectives. The key actions from the strategy were:

1. Organisational sustainability
2. Improving Quality and Safety
3. Workforce and IIP
4. Clinical Care and Transport
5. NHS 111 and Clinical Assessment Service
6. Communication and Engagement

NEAS’s Quality Strategy 2017/20 were:

- Patient safety. The aim was to continuously seek out and reduce patient harm and have no preventable deaths
- Sign up to safety. The aim was to continue to develop an open and honest culture which ensured the organisation learned when things went wrong. NEAS wanted to ensure staff learned from excellence and that best practice was shared to improve services.
- Improving early recognition of sepsis. The aim was to lead the way in sepsis identification and management in the pre-hospital setting.
- Keeping vulnerable children, young people and adults at risk of harm safe. The aim was to ensure all NEAS staff thought about safeguarding in their every-day practice, and actioned this by making appropriate and robust safeguarding referrals
- Frailty. The aim was to recognise the complex needs of patients with frailty and only to convey those patients to hospital where it is indicated to do so, or where care closer to home is not available.
- Infection prevention and control (IPC) – excellence in practice. The aim was to maintain and improve IPC practice, through robust audit, feedback and action and to learn from areas of best practice across the region to influence our partners to adopt this
- Pressure ulcer prevention. The aim was to ensure patients at risk of developing pressure ulcers were identified and measures put in place to address this.
• Medicines governance. The aim was to have safe and robust governance arrangements for medicines and maximise the use of medicines to treat patients promptly.

• Patient experience. The aim was to deliver what mattered most by working in partnership with patients, carers, and families to meet their needs.

• Learning from complaints. The aim was to respond to all complaints in a timely and responsive way and clearly evidence actions taken to improve patient experience.

• Longest waits. The aim was to reduce the impact of ambulance delays by reviewing systems and processes to address patient safety, experience and clinical effectiveness, whilst operational staff reduced the volume of delays occurring.

• End of life care. The aim was to provide a responsive and patient focused service for those patients at the end of their life.

• Clinical effectiveness. The aim was to achieve the highest level of reliability for clinical care to achieve the best possible health outcomes for patients.

• Clinical Ambulance Quality Indicators (AQIs). The aim was to consistently be in the top three performing ambulance trusts for all quality AQI's.

• Cardiac arrest. The aim was to consistently be in the top three performing ambulance trusts for survival rates of patients who had a cardiac arrest.

• Learning from deaths. The aim was to lead the way in learning from deaths for the ambulance sector and demonstrate changes in practice because of this work.

• National audits and confidential enquiries. The aim was to take part in all national audits and confidential enquiries relevant to the service.

• National Institute for Health and Care Excellence (NICE) guidance and quality standards. The aim was to implement NICE guidance wherever possible and when investment was required to do so showing transparency with the Commissioners.

• Research and development. The aim was to lead the way for research and development in the ambulance sector.

NEAS had a quality strategy 2017/20 in place which was approved by the board in September 2017 and was aligned to the trust's mission to provide safe, effective and responsive care. The strategy had five overarching aims which were:

• No preventable deaths (patient safety)

• Continuously seeking out and reducing patient harm (patient safety)

• Achieving the highest level of reliability for clinical care (clinical effectiveness)

• Deliver what mattered most: work in partnership with patients, carers, and families to meet their needs (patient experience)

• Deliver innovative and integrated care at or closer to home, which supported and improved health, well-being and independence (patient safety, clinical effectiveness and patient experience)
Medicines optimisation within the trust was in the process of being embedded. The medicines optimisation strategy had been developed to cover 2018/21 and this had been approved by the clinical quality group. There were clear lines of governance from the pharmacy advisor up to the board to ensure key themes and concerns could be heard. The team were relatively new yet had achieved and instigated a lot of changes in a short period of time. For example, reviewed all PGDs and completed a CD locker project to ensure that storage was in line with legal requirements. We were assured that secure storage and patient group directions were in line with requirements.

The team had a clear vision and were working towards an extensive action plan. Key priorities and risks had been identified and drawn together to form a medicines risk register, however, this was held by the pharmacy advisor and not by the operational leads from the core services. Learning from medicines incidents was shared internally and attendance at local medicine safety networks and local intelligence networks ensured messages and learning was shared. The pharmacy advisor also sat on the regional senior pharmacy managers meetings as well as the ambulance pharmacist network this assisted with learning and building relationships with trusts served by the trust.

The next steps for the trust were to review effective use of medicines from a clinical view as well as embedding medicines training and development. A medicines optimisation group had been formed and had good attendance from clinical leads helping to increase the profile of medicines throughout the organisation. The purchasing of medicines was under review and a specialist company was supporting this process.

Pharmacists were also being integrated into urgent care departments. This was a collaborative piece of work with eight local trusts where staff would be working across emergency departments, out of hours services and walk-in centres. This was a new area for the trust and was in the early stages of implementation.

**Culture**

The trust’s strategy, vision and values underpinned a patient centred culture. Staff felt positive and proud about working for the trust and their team. There was a clear message around balancing quality with financial performance.

There was a relatively stable workforce. The board members, governors and senior management team worked well together with constructive challenge and mutual respect. There was a drive to improve the health and care of patients within the local area.

Most staff we spoke with during our inspections said they felt positive and proud to work in the organisation. Action was taken to address concerns highlighted by the staff groups and to address behaviour and performance that was inconsistent with the vision and values of the trust. Staff spoke of feeling valued and being part of something worthwhile within the region. They also talked about the ability to build positive relationships with directors who were approachable and as a team everyone was committed.

Following the inspection in April 2016, NEAS were given a must do action in relation to Regulation 18 of the Health and Social Care Act to ensure all staff received an appraisal and were supported with their professional development. At the last CQC inspection, overall 70.8% of staff had undertaken an appraisal between April 2015 and March 2016. At this inspection we found that, from April 2017 to March 2018, the overall appraisal rate was 70.7% which was similar to the last
inspection and significantly lower than the trust target of 95%. There was an action plan in place to improve this and we heard how the appraisal system had recently been changed to be aligned to reflect the trust’s vision and values and this was subsequently being rolled out with a trajectory to meet the trust target by April 2019.

Staff Diversity

As of 31 March 2018, North East Ambulance Service NHS Foundation Trust employed 2,987 people, of which:

- 41.2% were women
- Across the trust 1.2% of staff were from Black Minority and Ethnic communities.
- 5.8% of staff had disclosed that they considered themselves to have a disability, 80.9% of staff have told us they don’t consider themselves to have a disability with the remainder either unknown or have chosen not to disclose
- 81.8% of staff had disclosed as Heterosexual and 3.3% as Lesbian, Gay or Bisexual with the remainder unknown or chose not to disclose.
- 52.4% of staff considered themselves Christian, 18.9% as Atheists and the third biggest group at 6.3% choosing to define their religion as ‘Other’. Furthermore, 14.3% chose not to disclose their religion or belief.

(Source: Routine Provider Information Request (RPIR) – Equality Annual Report 2017/18)

The trust provided the following breakdowns of staff by staff and ethnic group (the ethnicity for North East region as at 2011 Census is also included for context). The trust stated that 93.3% answered a question about ethnicity on their staff record.

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>Medical and dental staff (%)</th>
<th>Nursing and midwifery staff (%)</th>
<th>Additional Clinical (%)</th>
<th>Admin and Clerical (%)</th>
<th>*AHP (%)</th>
<th>North East region (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White – British</td>
<td>42.9</td>
<td>100.0</td>
<td>92.9</td>
<td>91.4</td>
<td>81.1</td>
<td>93.6</td>
</tr>
<tr>
<td>White – Irish</td>
<td>0.0</td>
<td>0.0</td>
<td>0.4</td>
<td>0.0</td>
<td>0.8</td>
<td>0.3</td>
</tr>
<tr>
<td>White – Any other White background</td>
<td>7.1</td>
<td>0.0</td>
<td>0.3</td>
<td>0.0</td>
<td>6.8</td>
<td>1.3</td>
</tr>
<tr>
<td>Mixed White and Black Caribbean</td>
<td>0.0</td>
<td>0.0</td>
<td>0.2</td>
<td>0.0</td>
<td>0.0</td>
<td>0.2</td>
</tr>
<tr>
<td>Mixed White and Black African</td>
<td>0.0</td>
<td>0.0</td>
<td>0.1</td>
<td>0.0</td>
<td>0.1</td>
<td>0.1</td>
</tr>
<tr>
<td>Mixed White and Asian</td>
<td>0.0</td>
<td>0.0</td>
<td>0.2</td>
<td>0.0</td>
<td>0.1</td>
<td>0.3</td>
</tr>
<tr>
<td>Any other mixed background</td>
<td>0.0</td>
<td>0.0</td>
<td>0.3</td>
<td>0.0</td>
<td>0.3</td>
<td>0.2</td>
</tr>
<tr>
<td>Asian or Asian British – Indian</td>
<td>14.3</td>
<td>0.0</td>
<td>0.1</td>
<td>0.3</td>
<td>0.0</td>
<td>0.6</td>
</tr>
<tr>
<td>Asian or Asian British – Bangladeshi</td>
<td>7.1</td>
<td>0.0</td>
<td>0.0</td>
<td>0.3</td>
<td>0.0</td>
<td>0.4</td>
</tr>
<tr>
<td>Asian or Asian British – Pakistani</td>
<td>0.0</td>
<td>0.0</td>
<td>0.2</td>
<td>0.0</td>
<td>0.3</td>
<td>0.8</td>
</tr>
<tr>
<td>Asian or Asian British - Any other Asian background</td>
<td>7.1</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.5</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
</tr>
<tr>
<td>Black or Black British - Caribbean</td>
<td>0.0</td>
<td>0.0</td>
<td>0.1</td>
<td>0.3</td>
<td>0.1</td>
<td>0.0</td>
</tr>
<tr>
<td>Black or Black British - African</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.3</td>
<td>0.0</td>
<td>0.4</td>
</tr>
<tr>
<td>Chinese</td>
<td>0.0</td>
<td>0.0</td>
<td>0.1</td>
<td>0.0</td>
<td>0.0</td>
<td>0.6</td>
</tr>
<tr>
<td>Other</td>
<td>7.1</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.4</td>
</tr>
<tr>
<td>Unknown / Not Stated / Not specified</td>
<td>14.3</td>
<td>0.0</td>
<td>5.2</td>
<td>6.9</td>
<td>10.4</td>
<td>-</td>
</tr>
</tbody>
</table>

*AHP* - Allied Health Professional
(Source: Routine Provider Information Request (RPIR) – Diversity tab; Equality Annual Report 2017/18)

The chief executive officer for NEAS was the ambulance sector national lead for equality and diversity and the workforce race equality standard (WRES) lead for North East and Cumbria.

In 2018, NEAS were ranked as the top performing health and social care organisation in the Stonewall Workplace Equality index and the top performing foundation trust, ambulance service and emergency service in the north east of England. NEAS were striving to make continued improvements to become an inclusive organisation and create a workplace that was inclusive of lesbian, gay, bisexual and transgender (LGBT) people. We saw evidence of work that had been undertaken to support transgender and non-binary people in the workplace and, when they access services, developing resources and training for employees.

In the 12 months prior to our inspection, the trust had assessed themselves against the job centre plus disability confident scheme and had been awarded the ‘employer’ status. They had worked with a range of organisations to develop a communications guide for front line employees to support them to communicate with patients with a variety of communication needs. NEAS had also adopted a system on their website which made information more accessible. It allowed the website information to be changed into a range of languages and accessibility tools. There was an accessibility button which brought up a range of options and did not require an additional download of software. The system could talk to the user in their chosen language and play back the text in the language specified.

The trust had worked with local partners to develop a system wide strategy to improve the experience of LGBT staff. Examples of this include an LGBT and BME staff network. However, there was no disability network established at the time of our inspection. NEAS had worked with a BME group who had identified they had struggled to access language line interpreters. However, this remained a challenge for NEAS at the time of our inspection, which has recently been identified as a root cause of a serious incident. HM Coroner had issued a regulation 28 to prevent future deaths notification just prior to our inspection which related to a difficulty in a call handler not being able to source an interpreter and subsequently prioritising the call incorrectly, resulting in a serious incident investigation. The trust was in the process of updating their policy in relation to this but it remained outstanding at the time of our inspection. In the week following our inspection, the trust issued a memorandum to all staff to identify the expectation on staff when an interpreter could not be sourced. The Communications Support Guide provided all front line staff access to language line directly. The trust was also reviewing its contract arrangements in terms of interpreter services.
NEAS had developed standard images for people with learning disabilities to identify pain which had become a valued resource for paramedics and was linked to the electronic patient report form (EPRF).

NEAS had been shortlisted through Equality North East for an award in relation to improving access to services following work with the BME community. The result will be known by the end of October 2018.

Prior to any policy being approved and implemented, an equality impact assessment was completed. A yearly audit was completed on the quality of this process, which identified that at least 90% of these were good. Equality impact assessment training was delivered to all managers with the support from an external organisation.

NEAS had an equality strategy for 2016/20 with a vision which was, ‘unmatched quality of care, every time we touch lives’. It had been developed under the requirements of the Equality Act (2010), their public-sector equality duty and encompassed the national NHS Equality Delivery System 2 (EDS2) and other mandated responsibilities.

The equality objectives in the strategy were to:

- Improve the consistency and accessibility of services and information for patients.
- Encourage patients from all diverse groups to provide feedback on their experiences of our services and improve positive responses.
- Promote equality and inclusion through enhanced involvement of the community and stakeholders.
- Develop a modern and diverse workforce that was inclusive and representative of the patients NEAS delivered services to.
- Ensured NEAS leadership is committed to creating an environment that promoted and valued equality and diversity which would be embedded in all aspects of the service.

NEAS had a communications support guide which provided staff with information to make them aware of cultural and disability issues to be considered when dealing with calls. All of these areas are in fact covered in the NEAS diversity fact sheets.
The trust has 24 key findings that exceeded the average for similar trusts 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 and support for development</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KF11. % appraised in last 12 months</td>
<td>82%</td>
<td>81%</td>
</tr>
<tr>
<td>KF12. Quality of appraisals</td>
<td>2.78</td>
<td>2.65</td>
</tr>
<tr>
<td>KF13. Quality of non-mandatory training, learning or development</td>
<td>4.00</td>
<td>3.90</td>
</tr>
<tr>
<td><strong>Equality and diversity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>* KF20. % experiencing discrimination at work in last 12 months</td>
<td>15%</td>
<td>19%</td>
</tr>
<tr>
<td><strong>Errors and incidents</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>* KF28. % witnessing potentially harmful errors, near misses or incidents in last month</td>
<td>31%</td>
<td>35%</td>
</tr>
<tr>
<td>KF29. % reporting errors, near misses or incidents witnessed in last month</td>
<td>85%</td>
<td>82%</td>
</tr>
<tr>
<td>KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents</td>
<td>3.52</td>
<td>3.41</td>
</tr>
<tr>
<td>KF31. Staff confidence and security in reporting unsafe clinical practice</td>
<td>3.61</td>
<td>3.49</td>
</tr>
<tr>
<td><strong>Health and wellbeing</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>* KF17. % feeling unwell due to work related stress in last 12 months</td>
<td>43%</td>
<td>48%</td>
</tr>
<tr>
<td>* KF18. % attending work in last 3 months despite feeling unwell because they felt pressure</td>
<td>57%</td>
<td>62%</td>
</tr>
<tr>
<td>KF19. Org and management interest in and action on health and wellbeing</td>
<td>3.57</td>
<td>3.25</td>
</tr>
<tr>
<td><strong>Working patterns</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>* KF16. % working extra hours</td>
<td>81%</td>
<td>85%</td>
</tr>
<tr>
<td><strong>Job satisfaction</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KF1. Staff recommendation of the organisation as a place to work or receive treatment</td>
<td>3.66</td>
<td>3.44</td>
</tr>
<tr>
<td>KF4. Staff motivation at work</td>
<td>3.78</td>
<td>3.65</td>
</tr>
<tr>
<td>KF7. % able to contribute towards improvements at work</td>
<td>49%</td>
<td>45%</td>
</tr>
<tr>
<td>KF8. Staff satisfaction with level of responsibility and involvement</td>
<td>3.68</td>
<td>3.59</td>
</tr>
<tr>
<td>KF14. Staff satisfaction with resourcing and support</td>
<td>3.28</td>
<td>3.16</td>
</tr>
</tbody>
</table>

**Managers**
<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient care and experience</td>
<td></td>
<td></td>
</tr>
<tr>
<td>KF5. Recognition and value of staff by managers and the organisation</td>
<td>3.19</td>
<td>3.01</td>
</tr>
<tr>
<td>KF10. Support from immediate managers</td>
<td>3.68</td>
<td>3.44</td>
</tr>
<tr>
<td>Violence, harassment and bullying</td>
<td></td>
<td></td>
</tr>
<tr>
<td>KF2. Staff satisfaction with the quality of work and care they are able to deliver</td>
<td>4.03</td>
<td>3.81</td>
</tr>
<tr>
<td>KF3. % agreeing that their role makes a difference to patients / service users</td>
<td>90%</td>
<td>88%</td>
</tr>
<tr>
<td>KF23. % experiencing physical violence from staff in last 12 months</td>
<td>3%</td>
<td>2%</td>
</tr>
<tr>
<td>KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months</td>
<td>44%</td>
<td>48%</td>
</tr>
<tr>
<td>KF26. % experiencing harassment, bullying or abuse from staff in last 12 months</td>
<td>21%</td>
<td>28%</td>
</tr>
<tr>
<td>KF27. % reporting most recent experience of harassment, bullying or abuse</td>
<td>41%</td>
<td>38%</td>
</tr>
</tbody>
</table>

Note: For most of the Key Findings presented in the above table, the higher the score the better. However, there are some Key Findings for which a high score would represent a negative score. For these Key Findings, marked with an asterisk, the lower the score the better.

**NHS Staff Survey 2017 – results worse than average of ambulance trusts**

The trust has one key finding worse than the average for similar trusts 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>Violence, harassment and bullying</td>
<td></td>
<td></td>
</tr>
<tr>
<td>KF23. % experiencing physical violence from staff in last 12 months</td>
<td>3%</td>
<td>2%</td>
</tr>
</tbody>
</table>

(Source: NHS Staff Survey 2017- link)

We saw evidence NEAS had developed an action plan following the 2017 staff survey. The action plan had an overall aim to improve the overall staff engagement score.

The action plan was split by 11 themes with key actions, action owners, progress update date and dates for completing actions as follows:

- Leadership and Management: To continue to make improvements in leadership and management scores throughout survey.
- Errors and incidents: Continue to ensure that all staff were aware of the policy for raising concerns about unsafe practice and that their concern would be treated seriously, openly and transparently. Ensure that all staff involved in an adverse event were treated fairly and consistently.
- Job Satisfaction: Increase trust scores relating to involvement of employees in important decisions and acting on staff feedback. Work directly with staff groups to understand why some would not recommend the organisation as a place to work or receive treatment.
• Appraisals and Support for Development: Maintain and build on completions of appraisals. Make improvements to the quality and effectiveness of staff appraisal/performance reviews;

• Communication between Staff and Managers: Improve scores around communication between senior management and staff. Involve staff in important decision-making processes.

• Health and wellbeing: Continue to improve scoring in relation to staff health and well-being questions.

• Patient care and experience: Increase the percentage of staff who receive regular feedback on patient experience.

• Violence, harassment and bullying: Reduce the percentage of staff/colleagues reporting most recent experiences of harassment, bullying or abuse

• Equality and diversity: Increase the percentage of staff believing that the organisation provided equal opportunities for career progression or promotion. Analyse the actual numbers of staff who felt they had been discriminated against. Identify areas that had increased numbers and take action e.g. training on policies

• Working patterns: Provide more opportunities for flexible working patterns to improve scores.

• Quality and improvement: Implement the involvement of staff at all levels in improvement work where appropriate.

At the time of the inspection many of the actions were yet to be completed.

The staff survey identified that only 33% of staff were satisfied with the opportunities for flexible working patterns. This was also identified as an area for improvement by the chair in terms of recruitment and retention. Predominantly front-line staff worked 12 hours shift patterns but it was felt that, potentially if more family friendly short shift patterns were available recruitment and retention would improve.
**Workforce race equality standard**

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 Black and Minority Ethnic (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.

In order to preserve the anonymity of individual staff, a score is replaced with a dash if the staff group in question contributed fewer than 11 responses to that score.

<table>
<thead>
<tr>
<th></th>
<th>Your Trust in 2017</th>
<th>Average (median) for ambulance trusts</th>
<th>Your Trust in 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF25</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months</td>
<td>White 41%</td>
<td>50%</td>
<td>40%</td>
</tr>
<tr>
<td></td>
<td>BME 43%</td>
<td>39%</td>
<td>37%</td>
</tr>
<tr>
<td>KF26</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months</td>
<td>White 20%</td>
<td>27%</td>
<td>24%</td>
</tr>
<tr>
<td></td>
<td>BME 30%</td>
<td>32%</td>
<td>32%</td>
</tr>
<tr>
<td>KF21</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion</td>
<td>White 72%</td>
<td>71%</td>
<td>71%</td>
</tr>
<tr>
<td></td>
<td>BME 82%</td>
<td>48%</td>
<td>73%</td>
</tr>
<tr>
<td>Q17b</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues?</td>
<td>White 9%</td>
<td>10%</td>
<td>11%</td>
</tr>
<tr>
<td></td>
<td>BME 19%</td>
<td>18%</td>
<td>21%</td>
</tr>
</tbody>
</table>

(Source: NHS Staff Survey 2017 – link)

For three of the four questions above, the trust performance was worse for BME staff when compared to White staff:

- **KF25.** Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.
- **KF26.** Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.
- **Q17b.** In the last 12 months have you personally experienced discrimination at work from manager/team leader or other colleagues.

The trust felt this reflected the very small numbers of staff from a BME background and the figures were misleading as a result of this.
Friends and Family test

The 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.

The trust scored above the England average for recommending the trust as a place to receive care with regards to it’s see and treat activity and its patient transport service from August 2017 to July 2018.

The response rate for the trust’s see and treat Friends and Family test ranged from 0.14% to 2.04% for the period August 2017 to July 2018. This was generally better than the England average response rate which ranged from 0.07% to 0.16% for the same period.

The response rate for the trust’s patient transport service Friends and Family test ranged from 0.08% to 0.59% for the period August 2017 to July 2018. This was generally worse than the England average response rate which ranged from 0.38% to 0.60% for the same period.

(Source: Friends and Family Test)
Sickness absence rates

The trust’s sickness absence levels from April 2017 to March 2018 were consistently higher than the England average. The trust’s sickness absence levels had also been higher than the trust’s own sickness absence rate target of 5.0% for the period April 2017 to March 2018.

(Source: NHS Digital)

We spoke with the Freedom to Speak Up Guardian at the trust, who had been in post as company secretary since 2015 and had previously held responsibility for whistleblowing. The guardian had a good understanding of the role, had received relevant training to undertake the role and continued to attend national guardian’s office conferences and attended regional group and the ambulance network. The director of quality and safety was the executive lead and the guardian was directly line managed by the chief executive officer. The Freedom to Speak Up Guardian formally reported to the trust board twice per year and bi-monthly to the workforce committee. There were 10 champions trained within the organisation at the time of our inspection with encouragement ongoing in an attempt to attract more interest into the champion role. In 2017/18, eight staff members had raised concerns under the Freedom to Speak Up policy. To October 2018 there had been two concerns raised. Compared with other trusts this was a low figure.

We were told that in 2017/18 the trust had eight cases reported under ‘Raising Concerns’ (six of these were via the guardian and two were anonymous). To June 2018 there had been two concerns raised, one through the guardian and one anonymous. Compared with other trusts this is a low figure.

The trust had developed an action plan following the Freedom to Speak Up Guardian survey 2017 which was published by the National Guardian's Office. The action plan included the establishment of a network of Freedom to Speak Up champions.
Governance

The trust had effective structures, systems and processes in place to support the delivery of its strategy. Each committee reported directly to the board. The committees included:

- Quality committee
- Finance committee
- Workforce committee
- Audit committee
- Charitable funds committee
- Nomination and remuneration
- Executive risk management group

Leaders regularly reviewed these structures and each committee completed a yearly self-assessment to give assurance of its effectiveness. Staff we spoke with at all levels were clear about their roles and understood what they were accountable for, and to whom. There were working groups under each of the committees. For example, the serious incident review group and the clinical advisory group were managed by the quality committee. Each committee had a non-executive chair and members with the executive members in attendance. There was clear accountability within each board committee.

During inspection, the minutes of the private board of directors meeting for March, April and May 2018 were reviewed. All meetings were well attended. There was a set agenda covering assurance from board committees, performance, strategy planning and policy and regulatory. After the set agenda, other business items were discussed.

The trust had developed a CARE platform, which was implemented in September 2018 across the operational services for paramedics. The platform enabled almost real-time feedback on key patient safety issues by enabling individual feedback on a range of areas such as compliance with care bundles, self-assessment of skills to support learning and development, performance relating to time on scene and turnaround times and reflective practice. This had been well received by staff and managers.

There was a trust-wide systematic programme of clinical and internal audit to monitor quality, operational and financial processes, and systems to identify where action should be taken. Actions identified from clinical audits were monitored by the quality committee which reported to the trust board. Actions from internal audit were monitored by the trust’s governance team and audit committee to ensure implementation and review.

National data shows that NEAS were the third highest reporting ambulance trust in England for incident reporting.

A recent report looking at productivity and performance in English NHS ambulance trusts (September 2018) showed that NEAS was the best performing ambulance trust for response times for the category 1 calls (calls from people with life-threatening illnesses or injuries) and in the top three ambulance trusts for the category two calls (emergency calls), meeting the national target for both. However, NEAS performed consistently worse than other ambulance trusts and the national standard for the category three calls (urgent calls).
All senior managers and board members told us response times was their top worry area for the trust. There was a four-year plan in place to address this and to meet ambulance response programme (ARP) targets and this was on the board assurance framework.

There was a quality dashboard in place which provided data on aspects of quality and looked to triangulate some quality metrics with performance, workforce and finance. The trust’s data warehouse gave managers opportunities to examine capabilities from the dashboard in all areas of quality and allow for local level information and performance on key quality and safety metrics the clinical care managers attended the patient safety group, patient experience group and clinical effectiveness group where quality and safety measures were discussed.

Although not mandated to so, at the time of our inspection, the trust had commenced learning from deaths reviews. The trust had recently implemented a learning from deaths policy on 1 October 2018. However, the policy did not have clear lines of responsibility within it. Additionally, we reviewed three learning from deaths reviews which were not thorough or consistent in their approach. For example, the policy made reference to there being a template to use, which was not included in the policy and none of the cases we reviewed utilised a template. Following our inspection, the trust made relevant amendments to the policy to identify lines of responsibility.

**Board Assurance Framework**

The trust provided their Board Assurance Framework, which details six strategic objectives each and accompanying risks. A summary of these is below.

<table>
<thead>
<tr>
<th>Ref</th>
<th>Strategic Objective</th>
<th>Explanation</th>
</tr>
</thead>
</table>
| CO1 | Organisational sustainability | Achieving the Financial Plan - Delivering against monthly use of resources rating agreed with NHSI  
Supporting development of Integrated Care System (ICS) and associated integrated care partnerships - influencing ICS objectives and governance arrangements and working towards delivering emerging structures  
Strengthening relationships with commissioners - meeting their information needs and developing key messages covering performance and progress against strategic priorities.  
Review outcomes for the Ambulance Improvement Programme / Carter Review - Assess opportunities following release of information |
| CO2 | Improving Quality and Safety | Delivery of key milestones in the Quality Strategy - delivery of stretch targets, further develop an open and honest culture  
Develop a quality improvement hub to support clinical improvements and innovation  
Driving improvements against the CQC Fundamental Standards. |
| CO3 | Workforce and Investors in People | Develop and deliver the Workforce Strategy - including a focus on the delivery of the education & training plan, the OD plan, E&D plan, workforce plan and Health and Wellbeing plan. |
Strengthen organisational health and wellbeing - including improving the management of sickness absence.

**CO4**

Clinical Care and Transport

Unscheduled Care Service Transformation - translate ORH report into shift patterns. Delivery of new rosters to release efficiencies and improve response performance.

Scheduled Care Review - identification of potential efficiencies and delivery of an effective communications solution.

**CO5**

NHS111 and Clinical Assessment Service

Mobilisation of NHS111 and the IUC CAS ready for the new service going live on 1 October 2018.

Development of the North East Provider Alliance aligned to the mobilisation plan.

**CO6**

Communications and Engagement

Driving improvement of internal communications - delivery of a formal communications structure, a new intranet site and a social media policy.

Continued focus on external communications to educate stakeholders on the changing role of the ambulance service.

Development of a communications strategy.

The table of accompanying risks is below:

<table>
<thead>
<tr>
<th>Risk Ref</th>
<th>Description</th>
<th>Committee/Group</th>
<th>Target risk score (Consequence x likelihood)</th>
<th>Current risk score (Consequence x likelihood)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CR1</td>
<td>Organisational sustainability is compromised by the Trust's ability to meet its financial plan and / or contractual commitments, including an inability to meet the challenging cost improvement target. This would impact negatively on the ability of the Trust to meet its regulatory requirements and efficiency targets, with potential impacts on patient care, reputation and the ability to recruit / retain staff.</td>
<td>Finance Committee</td>
<td>3x4 (12)</td>
<td>4x3 (12)</td>
</tr>
<tr>
<td>CR2</td>
<td>Pressures on performance, workforce and finance, coupled with a number of changes in the local and national health economy and structures may place significant risk on the ability of the Trust to achieve national quality standards and deliver the Quality requirements</td>
<td>Quality Committee</td>
<td>3x2 (6)</td>
<td>4x3 (12)</td>
</tr>
<tr>
<td>CR3</td>
<td>Failure to develop and maintain a strong workforce and culture will result in poor retention of staff, increased pressure on existing employees and a weak organisational culture, ultimately impacting upon the desirability of the Trust in respect of employment, investment and sustainability.</td>
<td>Workforce Committee</td>
<td>3x2 (6)</td>
<td>3x4 (12)</td>
</tr>
<tr>
<td>CR4</td>
<td>Inability to implement a front-line delivery model that enables the Trust to deliver an integrated, responsive quality service, resulting in poor performance, care which is not appropriately tailored to patient needs and potential damage to our reputation.</td>
<td>Quality Committee</td>
<td>3x3 (9)</td>
<td>4x3 (12)</td>
</tr>
<tr>
<td>CR5</td>
<td>Inability to deliver an effective and efficient NHS111 and CAS (either through ineffective management or through loss of contract) impacting on the sustainability of the Trust and its ability to win new business and negative impacts on reputation and recruitment</td>
<td>Finance Committee</td>
<td>2x2 (4)</td>
<td>3x3 (9)</td>
</tr>
<tr>
<td>CR6</td>
<td>A lack of effective communications and engagement will result in disaffected and disengaged employees; a lack of compliance with key requirements which may impact on patient safety; inability to meet corporate objectives; loss of opportunity for the Trust to build market share; poor external reputation; and poor relationships with stakeholders. Ultimately the Trust will be unable to progress and develop, thus impacting upon sustainability.</td>
<td>Executive Team</td>
<td>3x2 (6)</td>
<td>4x3 (12)</td>
</tr>
</tbody>
</table>

(Source: Trust Board Assurance Framework)

The board assurance framework (BAF) and organisational risk register set out the strategic risks that could impact on the delivery of the trust’s objectives. The BAF and organisational risk register were reviewed by the trust board and the executive team to provide assurance that the strategic risks and the controls in place to mitigate the risk were appropriate and effective. Individual risks on the BAF were also reviewed by sub-committees of the board for oversight.

There was evidence each issue had been risk assessed and managed appropriately with a clear audit trail of accountability. Meeting minutes confirmed that the board assurance framework was
reviewed by executive leads and non-executive directors through governance meetings, on a regular basis. During the well led inspection, the board assurance framework was reviewed and the inspection team were assured that it provided a framework for strategic direction.

The BAF linked key risks to the strategic objectives. For each risk it identified; sources of assurance, potential or actual origins of the risk, gaps in assurance key controls, gaps in controls, forms of assurance, and action plan with deadlines. Each strategic risk had a risk rating score, identified executive leads and the committee through which the risks would be managed.

The board assurance framework linked key risks to the strategic goals. Each risk had a numerical rating (likelihood versus consequence) and was red, amber, green (RAG) rated. The highest rated risks related to financial performance, staff recruitment and achieving the transformation plan. Each identified risk included details of controls, positive assurance as well as gaps in assurance and controls. Each risk was assigned to a responsible executive lead and an associated board subcommittee.

Management of risk, issues and performance

NEAS had a quality and risk framework which was supported by a number of key meetings including:

- Quality governance
- Serious incident review group
- Patient safety
- Experience complaints litigation incidents PAL’s
- Clinical effectiveness
- Clinical advisory group
- Executive risk management group
- Finance committee
- Information governance
- Workforce planning and development

NEAS had a comprehensive crisis management plan (CMP) to deal with the immediate consequences and aftermath of a major emergency situation which would have had significant impact on NEAS. The CMP complimented NEAS’s Business Continuity Plan. The objectives of NEAS Crisis Management Plan were to:

- Protect human life;
- Put in place arrangements required to manage the crisis including the identification of responsible senior managers and their deputies who would be charged with managing NEASs response to the crisis;
- Protect NEASs reputation;
• Maintain business continuity by securing NEASs critical services, infrastructure and facilities; and

• Return NEAS to normal business operations as soon as possible and handover responsibility to NEAS Board.

The plan was effective from 14 February 2017 and due for review 17 January 2020.

We saw evidence NEAS had a business continuity strategy. The strategy had been developed to support achievement of the objectives identified in the NEAS Business Continuity Policy.

The strategy was effective from 24 November 2017 and due for review 11 October 2020.

The business continuity management system was designed to ensure that key business services could continue to deliver their statutory responsibilities.


The policy had responsibilities for staff with defined roles. The plan was effective from 25 August 2016 and due for review 25 August 2020.

NEAS held clinical review meetings, however, these meetings were not minuted. Any cases brought individually to the clinical review group were updated on a clinical review template. The meeting was a forum whereby the facts of each case would be discussed and agreement reached if the case met the criteria to be recorded as a serious incident. The rationale for the decision was also recorded.

Each department had its own risk register, with an overarching directorate risk register. The monthly executive risk management group was chaired by the chief executive officer. Directorates presented their risk registers on a cyclical basis, with the group also reviewing new risks with a score of 15 or over for escalation to the organisational risk register. The group reviewed the board assurance framework each quarter, along with the board.

The serious incident annual report was received by the quality committee in July 2018. There was a total of 31 serious incidents reported by the trust in both 2016/17 and 2017/18. Incorrect triage (10 serious incidents) and ambulance delay (11 serious incidents) were the highest reported serious incidents for 2017/18. This was similar to the findings of the themes for serious incidents reported in 2016/17, where incorrect triage (nine serious incidents) and ambulance delay (14 serious incidents) were the top two reporting incidents.

From April 2018 to the time of our inspection, there had been 11 serious incidents reported, two of which had been downgraded as a serious incident by the relevant commissioner and a further one was under review. Incorrect triage remained the highest reported serious incident with five of these nine being investigated under this category. However, there had been no serious incident from April 2018 to the time of our inspection for ambulance delays which demonstrated a significant improvement with the measures that had been put in place.
Any patient safety incidents which were recorded as moderate harm and above had a high-level review, including the duty of candour requirements and the relevant information was updated live on a NEAS computer system.

In the 12 months prior to our inspection, NEAS reported there had been 19 occasions where the principles of the duty of candour had been applied. During inspection we reviewed 12 incident reports where the duty of candour principles had been applied which demonstrated staff understood their responsibilities in relation to this.

**Finances Overview**

<table>
<thead>
<tr>
<th>Financial metrics</th>
<th>Historical data</th>
<th>Projections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>£117.6m</td>
<td>£121.8m</td>
</tr>
<tr>
<td>Surplus (deficit)</td>
<td>(£2.3m)</td>
<td>£1.6m</td>
</tr>
<tr>
<td>Full Costs</td>
<td>(£119.4)</td>
<td>(£120.2m)</td>
</tr>
<tr>
<td>Budget (or budget deficit)</td>
<td>(£3.5m)</td>
<td>(£3.0)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Finances Overview tab)

Finances were reviewed monthly at the finance committee and trust board. The board had a sound understanding of the current financial position and the challenges and risks to it both in this financial year and going forward for the next four years.

Financial risks were actively identified and mitigated by the trust. Senior leaders identified that the cost improvement/efficiency plans were developed from the budget holders upwards and were clinically driven. There was ongoing monthly monitoring of efficiency plans.

Financial outcomes were being delivered in line with plans and national requirements. In 2017/18 the trust reported a favourable variance of £0.1m against its control total target of £2.1m deficit resulting in an outturn excluding the sustainability and transformation fund of £2.0m. For 2018/19 the trust (via trust Board commitment) has accepted its pre-determined control total of £1.7m deficit and was on track to meet this at the time of our inspection.

Feedback from board members indicated that financial decisions were made in the context of understanding how the quality of services may be affected. Non-clinicians we spoke with on the board had a good understanding of the clinical services and financial pressures verses quality and performance. Board members gave examples of where quality had taken precedence over financial implications.

A monthly delivering consistency meeting was held where the directorates presented how they were delivering against finance, indicators and performance. There was a two-way challenge at these meetings on areas of overspend.
We saw NEAS’s Budgetary Control Guidelines and Framework 2018/19 document. The purpose of the document was to explain how NEAS would monitor, report and explain variances of actual expenditure and income against set plans or budgets.

The guidelines explained effective financial management was achieved by examining individual expenditure or income headings and identifying significant variances, even if a particular cost centre may have compensating over and under spending.

**Trust corporate risk register**

Within the organisational risk register provided by the trust, seven strategic risks were detailed which have a residual risk score of nine or over. These are detailed below.

<table>
<thead>
<tr>
<th>Risk Ref</th>
<th>Description</th>
<th>Latest review date</th>
<th>Initial risk score</th>
<th>Residual risk score</th>
<th>Target risk score</th>
</tr>
</thead>
<tbody>
<tr>
<td>FM17</td>
<td>Insufficient reductions in Unscheduled Care overtime and third party costs, if not on target with the performance improvement plan. Impact: Unfunded financial pressures</td>
<td>12/10/18</td>
<td>12</td>
<td>16</td>
<td>9</td>
</tr>
<tr>
<td>CE11</td>
<td>Ability to achieve adequate NHS Improvement compliance in challenging times in accordance with the requirements of the Single Oversight Framework (quality, performance, finance, well-led and strategic progress). Potential for regulatory action, particularly in relation to our financial position and subsequent risk rating under the new Single Oversight Framework, given our control total and operational performance.</td>
<td>05/11/18</td>
<td>20</td>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td>ORR-41</td>
<td>Failure to deliver all Ambulance KPI's in relation to response times for category 2 and long waits for category 3 and 4 Patient safety and financial penalties applied. Reputational risks/damage to the Trust. Inability to meet expectations of regulators. Cannot reach a balance between quality and finance</td>
<td>24/10/18</td>
<td>20</td>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td>ORR-55</td>
<td>The inability to develop, spread and embed a robust Quality Improvement culture within NEAS in order to drive continuous improvement and innovation in patient safety, effectiveness and experience</td>
<td>20/09/18</td>
<td>16</td>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Date</td>
<td>Priority</td>
<td>Recommendation</td>
<td></td>
</tr>
<tr>
<td>-------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------</td>
<td>----------</td>
<td>----------------</td>
<td></td>
</tr>
<tr>
<td>ORR-57</td>
<td>Innovation and improvement is stifled resulting in poor growth and development of staff and service provision.</td>
<td>05/11/18</td>
<td>16</td>
<td>12</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Inability to recruit in line with the workforce plan for the trust for Scheduled Care, Unscheduled Care, Operations Centre and Corporate Services.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- inability to meet regulatory and stakeholder expectations</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- inability to deliver a quality and safe service to patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- inability to deliver performance trajectories due to vacancies</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- incurring significant third party costs due to inability to recruit</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>157</td>
<td>Proposed removal of £1.3million pound from the 999 clinical hub from April 2019</td>
<td>05/11/18</td>
<td>20</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Patient safety impact due to reduced re-triage capability of patients awaiting an ambulance, reduced hear and treat resulting in the increased requirements to dispatch and ambulance therefore further increasing ambulance waits.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IG103</td>
<td>(IGWG) Multiple departments across the Trust, including Procurement, Contracting, IT and Estates have contracts in place with 3rd party providers, these are being reviewed to determine if they meet the new GDPR regulations. A definitive list of commercial and clinical suppliers/contractors is being compiled.</td>
<td>07/08/18</td>
<td>16</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Article 28 of the GDPR require binding contracts to be in place with all 3rd parties who process personal data on behalf of NEAS.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: Data request: Organisational Risk register)
(Source: Trust Board Assurance Framework)

We reviewed the organisational risk register and found this was up to date and completed appropriately. The risk register included a summary section showing changes to risk ratings and a detailed section where the risk, controls and actions taken to address the risk were recorded. Risks included date of addition to register and review dates. Each risk was assigned to a board committee, an executive director and an operational lead. The mitigating actions were frequently updated to record the activities taken to mitigate risks. Risk scores were updated and appeared to be consistent with the level of risk and mitigating actions recorded. The risks detailed in the register were reflective of those highlighted to us by staff and broadly correlated with our findings during the inspection.
Information management

NEAS had an information governance policy which was effective from December 2017 and due for review in December 2020. Staff we spoke with were aware of the policy and how to access it through the NEAS intranet site.

The policy outlined NEAS’s intentions and approach to fulfilling statutory and organisational responsibilities in relation to information governance. The information in the policy enabled staff to make informed decisions, comply with relevant legislation and help deliver NEAS’s aims and objectives. The policy complied with the applicable laws and standards.

NEAS had a records management policy which had been effective since March 2018 and was due for a review in March 2021. Managers we spoke with were aware of the policy and how to access it through the NEAS intranet site. We saw evidence the policy was followed in relation to the quality assurance systems which included security of patient records and how information was limited to key staff who had access to offender flag information. The flags did not refer to an offence but provided an overview on the risk e.g. knives, drugs, alcohol.

The policy outlined the approach to records management. The aim of the policy was to ensure that the record in whatever form it took was accurate, reliable, ordered, complete, useful, up to date and accessible whenever it was needed.

The policy covered the management of records and not the detailed requirements of what a record should contain for either corporate or clinical use. The policy covered all sites and systems operating and utilised by NEAS and applied to any individual employed, in any capacity, by NEAS and any volunteer or contractor who held a NEAS domain account.

NEAS had a records management initiative linked to ‘strive for excellence’ by streamlining the process and initiating a number of cost saving measures. It also improved patient experience and aided in serious incidents investigations, thereby facilitate learning. During inspection we reviewed the records management status reports for May, July and September 2018. The reports highlighted progress toward the overall aim of the project.

Engagement

Records we reviewed confirmed that members of the trust board held a monthly public meeting, which was held 10 times per year. At this meeting key issues affecting the trust were discussed such as its performance, finances and where they make decisions about service development and operational strategy.

NEAS were working with staff and unions to design new rosters which would enable staff to have a direct input into their future shift patterns to overcome the difficulties previously encountered. NEAS utilised the support of a rostering company, who had experience in implementing roster changes, particularly in ambulance services.

At the time of the inspection, senior leaders told us the consultation process had concluded and proposed shift patterns resulting from the consultation had been shared with staff to receive feedback before seeking final agreement.

In 2017, the trust engaged in events and activities with the local communities, schools and organisations in the north-east region. These were promoted by online events calendar and through local groups and organisations. These events provided people with the opportunity to
discuss a range of service and employment issues and give people the opportunity to ask questions.

In December 2016 and January 2017, NEAS held 10 events focusing on the BME community to explore service access issues for patients and recruitment opportunities for the trust. Additionally, the trust attended four regional Pride events in 2018 where service feedback was collected. We saw evidence of many events that NEAS took part in and received feedback from during 2017 and 2018, including MELA, Pride and BME events both to raise awareness of NEAS but also to engage with the local community in relation to service improvement. We saw actions were taken as a result of these events with further work planned.

NEAS regularly met with the regional Healthwatch groups through the ambulance Healthwatch Forum. Over the 12 months prior to our inspection topics explored within these meetings included sepsis, the trust’s quality report, patient transport service eligibility criteria, NHS 111, falls and Paramedic2 trial. NEAS had a range of social media platforms where it interacts with members of the local community.

Learning, continuous improvement and innovation

There were well developed systems in place to support improvement and innovation work, including objectives and rewards for staff, data systems, and processes for evaluating and sharing the results of improvement work. Leaders and staff we spoke with were proud to work for the trust and provided us with many examples of continuous learning, improvements and innovations. The trust participated in appropriate research projects and recognised accreditation schemes.

The trust won the ‘enhancing patient dignity’ category for its end of life services in the Nursing Times Awards 2017. The end of life service provided a responsive and timely patient transport across the north-east region for patients with palliative/end of life care needs, enabling them to be cared for and die in the place of their choice. The service was piloted for six months and was formally operational in June 2016 with funding from commissioners. During 2016/17, 2294 requests for transport were made, of which 95% were fulfilled.

NEAS were awarded the most innovating NHS education provider award as part of the Bright Ideas in Healthcare Award for their falls training. As part of the 2016/17, urgent and emergency care vanguard, NEAS was funded to deliver falls and initial response skills training, which enabled the trust to develop a project to primarily improve the experience of older people in residential and care homes, ensure older people received the best possible care, increase skills and confidence of care home staff and reduce overall pressure on healthcare services. The training was designed to empower front line teams within care homes, to reduce the risks and outcomes associated with falls.

The trust was taking part in research (one study academically led, the other NHS led) regarding ‘being open’ in how they dealt with incidents, to support implementation of the ‘just culture’ guide produced by NHS Improvement and how they develop ‘Always Events’.

Complaints Process Overview

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months.
<table>
<thead>
<tr>
<th>Question</th>
<th>In days</th>
<th>Target performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your internal target for responding to complaints?</td>
<td>3 working days after receipt of complaint</td>
<td>99.4%</td>
</tr>
<tr>
<td>What is your target for completing a complaint</td>
<td>Individually agreed</td>
<td>88%</td>
</tr>
<tr>
<td>If you have a slightly longer target for complex complaints</td>
<td>As above</td>
<td>-</td>
</tr>
<tr>
<td>*Number of complaints resolved without formal process in the last 12 months?</td>
<td>551</td>
<td>01/06/2017 to 31/05/2018</td>
</tr>
</tbody>
</table>

* Without formal process defined as a complaint that has been resolved without a formal complaint being made. For example, PALS resolved or via mediation/meetings/other actions.

(Source: Routine Provider Information Request (RPIR) – Complaints Process Overview tab)

We saw evidence that the complaint reports were a pro forma so each investigation was corporate. All patient experience finalisation letters were signed off by one of the executive team. The patient experience team was part of the national patient experience teams network. The network allowed sharing of best practice for local devolvement.

Each month the patient experience team presented a patient story to the trust board which could be a negative or positive experience. This allowed the board to gain an understanding as to what was happening at a personal level with NEAS’s interaction with the public.

The chief executive officer had overall responsibility for complaints and the director of quality and safety had delegated responsibility for patient experience which included the trust’s complaints process and was therefore the Executive Lead. The non-executive director lead was the chair of the quality committee.

The patient experience team produced a weekly report to the chief executive, directors and relevant mangers which detailed out of time or near out of time complaint investigations. The director of quality and safety produced a monthly quality governance report shared with the board and bimonthly with the clinical quality review group (external stakeholders). Additionally, an annual report was produced by the patient experience team to highlight any progress which summarised themes and trends from complaints and appreciations as well as the team’s overall performance in relation to complaints during that financial year. This report was reviewed by the quality committee and quality and governance group.
Number of complaints made to the trust

The trust received 436 complaints from June 2017 to May 2018. The Emergency and Urgent Care service received the most complaints with 269 (61.7%).

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency and Urgent Care</td>
<td>269</td>
<td>61.7%</td>
</tr>
<tr>
<td>Patient Transport Services</td>
<td>93</td>
<td>21.3%</td>
</tr>
<tr>
<td>Emergency Operations Centre</td>
<td>58</td>
<td>13.3%</td>
</tr>
<tr>
<td>Unassigned</td>
<td>10</td>
<td>2.3%</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>1.1%</td>
</tr>
<tr>
<td>Resilience</td>
<td>1</td>
<td>0.2%</td>
</tr>
<tr>
<td><strong>Trust Total</strong></td>
<td><strong>436</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

The trust reported a year on year reduction in the number of complaints received since 2014/15, from 730 to 526 in 2017/18. In 2016/17, there were 128 complaint elements relating to staff attitude and this reduced to 107 in 2017/18. Staff attitude featured in the top three areas for complaints in both 2016/17 and 2017/18. The trust subsequently conducted a deep dive into a review of complaints regarding staff attitude, which was reported to the quality committee.

Compliments

From June 2017 to May 2018, the trust received a total of 987 compliments. A breakdown by core service can be seen in the table below:

<table>
<thead>
<tr>
<th>Core service</th>
<th>Number of compliments</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency and Urgent Care</td>
<td>730</td>
<td>74.0%</td>
</tr>
<tr>
<td>Emergency Operations Centre</td>
<td>133</td>
<td>13.5%</td>
</tr>
<tr>
<td>Patient Transport Services</td>
<td>113</td>
<td>11.4%</td>
</tr>
<tr>
<td>Unassigned</td>
<td>11</td>
<td>1.1%</td>
</tr>
<tr>
<td><strong>Trust Total</strong></td>
<td><strong>987</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Compliments)

The trust reported that compliments were fed back directly to the individual staff involved; compliments were also received by the way of staff and patient stories to the board on a regular basis. All compliments were recorded in a weekly 'summary' that was sent out to staff. Themes have shown the compassion and kindness and skill of staff is what matters most to patients at the trust.
Ambulance services

Emergency operations centre

Facts and data about this service

The EOC is run as a virtual centre currently across two locations Bernicia House, Riverside Newburn and Russell House, Hebburn. The service functions 24 hours a day, 365 days a year. In October 2018 an additional third site will come online in the south of the region to support the increase in clinical activity specified for the newly awarded 111 contract that commences in October 2018.

Functioning within the EOC are the scheduled and unscheduled care services for 999, 111 services and a clinical advisory service (CAS). The CAS supports both 999 and 111 calls and workflow and delivers two out of hours contracts in the South of Tyne area.

In addition to the health advisors and clinicians who directly manage the calls that come into the services the staffing within the EOC includes a dispatch team, workforce management team, special patient notes team, training team and a systems administration and business continuity team all of whom are supported by the EOC administrative and senior management team.

(Source: Trust Provider Information Request - The North-East Ambulance Service NHS Trust- Emergency Operations Centre)

During the inspection we spoke with 53 staff, listened to 65 calls, reviewed 60 call taker audits, 32 dual call taker audits and 17 call taker pathway audits.

We reviewed 20 staff appraisals, five staff action plans, six staff records on the live training alert system and five complaints.

We reviewed 12 patient records, ten sets of patient notes which had NEWS scores, 12 duty of candour applications, ten NEAS07 incident reports, five inappropriate ambulance response evaluations, five potential unsafe call reviews, eight clinical review meeting records, 14 planned and eight live business continuity plan test reports.

Is the service safe?

Mandatory Training

Mandatory training completion rates

Following the last inspection NEAS were given a must do action by CQC to ensure all staff had completed mandatory and role specific training relevant to their role.

The information below highlights the levels of mandatory training and role specific training levels staff had achieved. NEAS had set target of 95% for completion. The provider had failed to achieve 10 of the 14 mandatory training targets and failed to achieve three of the five safeguarding training targets. In the staffing groups where 95% had not been achieved, in the main, the completion rate was within 2-3 % of the target. At the previous inspection the completion rate was noted as 85% against a 95% target, therefore the completion of mandatory training had improved at this inspection.
The service had systems and processes in place to ensure staff could access mandatory training and staff we spoke with confirmed they had enough time to complete mandatory training.

Mandatory training completion was monitored centrally.

We saw evidence NEAS had a five year statutory and mandatory training spreadsheet covering 2016-2023. The spreadsheet had 40 mandatory and 19 statutory courses. The spreadsheet outlined the delivery method, frequency of training, the time taken to deliver the course and how it would be delivered.

Staff we spoke with told us they received mandatory training, however, it was difficult to get support to attend external courses which were not part of mandatory or statutory training.

With reference to the tables below, we spoke with managers about the compliance rates with mandatory training shown regarding the staff groups. Managers assured us that the compliance figures would improve as the year progressed and so patient safety was not at risk.

NEAS dual train many call handlers in 999 and 111 services so EOC personnel were unable to be broken down into working exclusively in either core service. The breakdown of training compliance by training module for staff in the emergency operations centre for the period from April 2017 to March 2018 is shown below:

**All staff groups**

<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>1</td>
<td>1</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution (NHS England)</td>
<td>3</td>
<td>3</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling Level 1</td>
<td>466</td>
<td>482</td>
<td>96.7%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention and Control Level 1</td>
<td>464</td>
<td>482</td>
<td>96.3%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>454</td>
<td>482</td>
<td>94.2%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety</td>
<td>454</td>
<td>482</td>
<td>94.2%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fraud Awareness</td>
<td>453</td>
<td>482</td>
<td>94.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality, Diversity and Human Rights</td>
<td>453</td>
<td>482</td>
<td>94.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Display Screen Equipment</td>
<td>452</td>
<td>482</td>
<td>93.8%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Business Continuity Management</td>
<td>451</td>
<td>482</td>
<td>93.6%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality, Diversity and Inclusion</td>
<td>442</td>
<td>482</td>
<td>91.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>439</td>
<td>482</td>
<td>91.1%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Preventing Radicalisation Level 1 and 2 (Basic Awareness)</td>
<td>438</td>
<td>482</td>
<td>90.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent WRAP Level 3</td>
<td>0</td>
<td>1</td>
<td>0.0%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>
The 95% training completion rate was not met for 10 of the 14 mandatory training for which staff in the emergency operations centre were eligible. The overall completion rate for mandatory training for staff in the emergency operations centre during this period was 93.6% and all but one training course (Prevent WRAP Level 3) had a completion rate of over 90.0%.

NEAS provided a breakdown of mandatory training completion split by staff group. The breakdown of training compliance by training module and by staff group for staff in the emergency operations centre for the period from April 2017 to March 2018 is shown below:

**Emergency call handlers/dispatchers**

<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>1</td>
<td>1</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution (NHS England)</td>
<td>3</td>
<td>3</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling Level 1</td>
<td>378</td>
<td>392</td>
<td>96.4%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention and Control Level 1</td>
<td>377</td>
<td>392</td>
<td>96.2%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety</td>
<td>371</td>
<td>392</td>
<td>94.6%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality, Diversity and Human Rights</td>
<td>370</td>
<td>392</td>
<td>94.4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>369</td>
<td>392</td>
<td>94.1%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fraud Awareness</td>
<td>368</td>
<td>392</td>
<td>93.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Display Screen Equipment</td>
<td>367</td>
<td>392</td>
<td>93.6%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Business Continuity Management</td>
<td>367</td>
<td>392</td>
<td>93.6%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality, Diversity and Inclusion</td>
<td>359</td>
<td>392</td>
<td>91.6%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>357</td>
<td>392</td>
<td>91.1%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Preventing Radicalisation Level 1 and 2 (Basic Awareness)</td>
<td>354</td>
<td>392</td>
<td>90.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent WRAP Level 3</td>
<td>0</td>
<td>1</td>
<td>0.0%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>
**PTS – coordinator**

Staff in this job role are part of the operations centre dispatch team or contact centres management or dispatch teams.

<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>Information Governance</td>
<td>40</td>
<td>40</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling Level 1</td>
<td>40</td>
<td>40</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fraud Awareness</td>
<td>39</td>
<td>40</td>
<td>97.5%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality, Diversity and Inclusion</td>
<td>39</td>
<td>40</td>
<td>97.5%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention and Control Level 1</td>
<td>39</td>
<td>40</td>
<td>97.5%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Display Screen Equipment</td>
<td>39</td>
<td>40</td>
<td>97.5%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Preventing Radicalisation Level 1 and 2 (Basic Awareness)</td>
<td>39</td>
<td>40</td>
<td>97.5%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality, Diversity and Human Rights</td>
<td>39</td>
<td>40</td>
<td>97.5%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>39</td>
<td>40</td>
<td>97.5%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety</td>
<td>39</td>
<td>40</td>
<td>97.5%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Business Continuity Management</td>
<td>38</td>
<td>40</td>
<td>95.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**NHS infrastructure staff**

<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>Manual Handling Level 1</td>
<td>48</td>
<td>50</td>
<td>96.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention and Control Level 1</td>
<td>48</td>
<td>50</td>
<td>96.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>46</td>
<td>50</td>
<td>92.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Business Continuity Management</td>
<td>46</td>
<td>50</td>
<td>92.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Display Screen Equipment</td>
<td>46</td>
<td>50</td>
<td>92.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fraud Awareness</td>
<td>46</td>
<td>50</td>
<td>92.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Preventing Radicalisation Level 1 and 2 (Basic Awareness)</td>
<td>45</td>
<td>50</td>
<td>90.0%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>
Safeguarding

At the last inspection there were high levels of compliance with safeguarding training at levels one and two however not all relevant staff had been trained at level three. The data for level three safeguarding at this inspection showed once again not all relevant staff had been trained at level three with four of the 19 eligible staff still requiring to be trained.

With reference to the tables below, we spoke with managers about the compliance rates with safeguarding training shown regarding the staff groups. Managers assured us that the compliance figures would improve as the year progressed and so patient safety was not at risk.

Safeguarding training completion rates

NEAS set a target of 95% for completion of safeguarding training. The breakdown of safeguarding training compliance by training module for staff in the emergency operations centre for the period from April 2017 to March 2018 is shown below:

All staff groups

<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 Adults Level 1</td>
<td>115</td>
<td>124</td>
<td>92.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 1</td>
<td>115</td>
<td>124</td>
<td>92.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>287</td>
<td>358</td>
<td>80.2%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 2</td>
<td>271</td>
<td>339</td>
<td>79.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 3</td>
<td>15</td>
<td>19</td>
<td>78.9%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

The 95% completion rate for safeguarding training was not met for any of the five mandatory training courses for which staff in the emergency operations centre were eligible.
NEAS also provided a breakdown of safeguarding training completion split by staff group. The breakdown of training compliance by training module and by staff group for staff in the emergency operations centre for the period from April 2017 to March 2018 is shown below:

**Emergency call handlers/dispatchers**

<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 Adults Level 1</td>
<td>62</td>
<td>63</td>
<td>98.4%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 1</td>
<td>62</td>
<td>63</td>
<td>98.4%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>262</td>
<td>329</td>
<td>79.6%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 2</td>
<td>246</td>
<td>310</td>
<td>79.4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 3</td>
<td>15</td>
<td>19</td>
<td>78.9%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

**PTS – coordinator**

Staff in this job role are part of the operations centre dispatch team or contact centres management or dispatch teams.

<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 Adults Level 1</td>
<td>38</td>
<td>40</td>
<td>95.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 1</td>
<td>38</td>
<td>40</td>
<td>95.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**NHS infrastructure staff**

<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 Adults Level 2</td>
<td>25</td>
<td>29</td>
<td>86.2%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 2</td>
<td>25</td>
<td>29</td>
<td>86.2%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>15</td>
<td>21</td>
<td>71.4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 1</td>
<td>15</td>
<td>21</td>
<td>71.4%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Trust Provider Information Request – Mandatory training)

NEAS had a policy for the Safeguarding of Adults at Risk. The policy became effective in January 2016 and was due for review in February 2019. The policy outlined the statutory duty of NEAS to ensure it planned to safeguard and promote the welfare of children and young people, to protect adults at risk of abuse. The policy demonstrated compliance with the local and national agenda for Safeguarding Adults at Risk.
NEAS had a policy for safeguarding children. The policy became effective in March 2016 and was due for review in March 2019. The aim of the policy was to ensure children were protected from abuse and exploitation and that NEAS carried out their responsibilities under the Children’s Act (1989).

Staff we spoke with could explain the internal safeguarding reporting procedures and gave examples of referrals they had made and the feedback they had received.

NEAS had a procedure called Call Audit Raising Safeguarding Concerns. The procedure became effective in March 2016 and was due for review in February 2019. The procedure enabled NEAS to identify and report all safeguarding concerns to the appropriate authority, taking all reasonable steps to mitigate any further risk to the patient and provided a safe service.

The procedure outlined, as part of the routine call auditing process, it was the responsibility of the quality and performance officers to be vigilant in identifying calls where there may be a safeguarding concern.

The quality and performance officer would review the call notes created for an episode of care to check the call handler had noted their concerns in the cleric record which was the NEAS computer based recording system.

The quality and performance officer would also check an appropriate referral had been made through the logistics officer in relation to the patient.

In the event there were no notes in the cleric record, the quality and performance officer would email the safeguarding officers to confirm a possible safeguarding incident had been identified through the call audit process and requested they perform a search to determine if the referral had been made.

The safeguarding officer would advise if a referral had been made to the appropriate services and could request further information to enable them to relay the information to social services. If this did occur, the quality and performance officer would email all the requested details to the safeguarding team and then enter a retrospective note into the cleric notes stating the matter had been passed to safeguarding.

The quality and performance officer would email the call handler’s team leader and section manager advising this had been identified and managed retrospectively and the call handler should receive coaching in relation to the fact they failed to identify the matter they dealt with was a safeguarding concern or they had not followed the procedure.

During inspection we reviewed a flow chart for staff which explained how to submit a safeguarding referral. The information was dated July 2018. The flow chart provided staff with guidance as to how to report a safeguarding matter.

NEAS had a procedure for managing calls from children. The procedure stated if a call taker considered there was any concern over the vulnerability of the child a safeguarding referral should be made.

During inspection we reviewed seven adult and seven child safeguarding referrals. All the fields in each referral had been correctly filled in, there was a clear explanation why the referral had been made and the referrals demonstrated staff had adhered to NEAS safeguarding policy and guidance.

We saw evidence that safeguarding assessments had been carried out when calls passed between health advisors and clinical advisors.
The annual safeguarding report for 2016/17 demonstrated that there were mechanisms in place to safeguard children and adults at risk and to investigate and learn from concerns raised by NEAS through safeguarding processes.

The report identified key areas for improvement drawn from audit, assessments and review which were; the need for enhanced safeguarding supervision arrangements for frontline staff, the recruitment of a Band six safeguarding adult advisor to manage the Deprivation of Liberty Safeguard (DoLS) process; improved data sharing across all boroughs via CP-IS and the use of a robust flagging system. NEAS had developed an action plan with a programme of activity for 2017/18 in relation to this.

We saw evidence NEAS carried out checks at the time of recruitment of staff and on an ongoing basis where appropriate. Disclosure and Barring Service (DBS) checks were undertaken where required. DBS checks identify whether a person had a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. We looked at a sample of eight recruitment records and found all appropriate checks had been carried out.

**Cleanliness, infection control and hygiene**

Staff we spoke with were aware of infection prevention and control issues and took this into account when dispatching crews and/or giving advice to callers. Ambulance crews were provided with as much information as possible about possible infection issues which enabled a risk assessment to be carried out and decisions made such as the wearing of personal protect equipment (PPE).

EOC staff and ambulance crews could seek advice and support regarding infection control matters through clinical supervisors.

**Environment and equipment**

During the inspection we assessed the fire safety plans at Bernicia House and Russell House. Both buildings had a fire risk assessment, service evacuation plan, evacuation plans and details of fire training for staff. The control panels of the fire equipment and fire extinguishers were checked and seen to be in date.

Both premises were free from fire hazards and there were clear evacuation paths in communal areas, hallways, corridors, bedrooms, meeting rooms, dining rooms and kitchens.

The fire exits were clearly, signposted, and accessible and staff we spoke with were aware of the protocol for emergency procedures.

We saw copies of electrical wiring certificates, evidence of portable appliance testing (PAT), fire equipment checks (e.g. extinguishers and alarms) and a test record. We saw the contingency plans for fire/floodutility failure/IT failure/exceptionally poor weather.

There was evidence of personal evacuation plans and maintenance arrangements and supporting records.

During the inspection we noted the differences in the working environment between Bernicia House and Russell House. When we inspected Russell House we found the noise levels were
high during busy periods. During the inspection we saw action had been taken to improve noise levels; a specialist contractor had reviewed the premises and had made suggestions to help reduce noise. Several options had been tried, some had not been successful, but others had helped, including installation of desk dividers and staff being provided with dual headsets. However, when we visited the site we found the noise levels were still relatively high compared to Bernicia House. Some of the staff we spoke with did tell us the levels of noise in Russell House was a problem for them.

Assessing and responding to patient risk

The North East Ambulance service had collaborated with the acute hospitals through the Regional Sepsis Group to promote the use of a common screening tool across the hospital environment. The purpose of the sepsis alert guideline was to provide the optimum level of pre-hospital care for patients presenting with sepsis including providing the emergency department with a pre-arrival notification to facilitate rapid assessment and treatment of patients with sepsis.

A flow chart using National Warning Score (NEWS) and guidance was available for staff to use. During inspection we reviewed 10 sets of patient notes which had NEWS scores. All had been fully completed with the relevant information.

We spoke with the head of risk and the health and safety advisor about the special patients notes process. We were told if a crew encountered violence, aggression or anything else other crews and the service should be aware of, including safeguarding issues, they would fill out an on-line form which would allow a temporary flag to be placed on the address attended to reduce the risk to NEAS staff, other public services and the public. The flag outlined what the risks were.

We also saw evidence of other flags, for example, safeguarding concerns (unborn babies, social services have alerted), do not attempt cardio pulmonary resuscitation (DNCPR), laryngectomy flag (when a patient could not speak), general medical category of flag (on oxygen, anything where a GP pointed out they required different treatment as well as caution flags (violent, drugs).

The temporary flags were reviewed by the risk management team. A temporary flag could be put in place for three months by the EOC duty manager from the date of incident to allow the background information to be reviewed.

Any report of violence and aggression resulted in either an extend 6 months or 12 month flag. Intelligence was used and shared with the police, GP practices using EOC call history and from the Health and Security National Meetings.

We saw evidence staff were encouraged to carry out dynamic risk assessment and not to be totally reliant on the information on the flag.

We reviewed an operational memo dated 9 January 2018 which provided staff with information to assist them in updating the patient flag before contacting the police.

Staff were asked to consider the demeanour and words the caller used and add this to the ambulance notes using exactly what was said by the patient, for example, “Caller being aggressive” was open to interpretation. Call takers were advised to use, “Caller was being verbally aggressive, but this was in frustration to the number of questions asked, no threats made towards attending crews” or “patient’s mood was changeable during call from being calm to making threats to assault crew when they arrive”.
This information was used by ambulance crews to carry out a dynamic risk assessment.

NEAS attended joint quarterly multi-agency meetings to discuss issues linked to flagged addresses. If an issue arose an extraordinary meeting would be convened.

We were told there were approximately 800 flags at present. NEAS were working hard to remove redundant flags across 111 and 999 and were looking to have one flag rather than three flags across the system to have all the relevant information in one place.

NEAS had a letter based on NHS protect template to warn patients if they had displayed violence or aggression toward staff consideration would be given prosecute them and withdraw the service.

Staff told us of an example of a frequent caller who was making multiple of 999 calls per day and was banned from multiple services. They had been sent a letter from NEAS explaining if their behaviour continued consideration would be given to withdrawing services.

We were told of another example where a warning letter had been sent to a member of the public who had verbally abused a member of staff on the phone.

NEAS had agreements with local police forces for joint attendance at identified flagged addresses where the risk of violence or aggression toward staff was considered high.

Any incidents where a flag was generated this was reported using a NEAS 07 incident report form.

We saw evidence the risk and health and safety team had devised a flow chart to guide staff as to what to do if a member of staff experienced or witnessed violence, aggression or was subject to an assault.

The safer care manager, working within the quality and safety directorate, sat on a special patient notes working group but currently this was not a national forum to meet and share best practice.

During inspection we reviewed ten sets of patient notes relating to elderly people who had fallen. The notes were all complete and contained appropriate advice for the person who made the call and the patient. The information obtained by the call taker enabled the correct grading of the call.

During inspection we reviewed four sets of patient notes relating to bariatric patients. The information was recorded on a patient movement and handling assessment form. The information included the height and weight of the patient, where they resided including potential risks and hazards which could be encountered when moving the patient. This information would be used on attendance by ambulance crews and if there were any future calls.

We saw evidence of a current NHS pathway document in relation to the recent Novichok Police investigation dated 7 September 2018 which had been circulated to EOC staff. The pathway explained the process for staff to follow should they receive a call from the public with suspected exposure to Novichok.

**Staffing**

During inspection we saw a copy of NEAS`s Resource Escalation Plan(REAP)/ Escalation policy. The document had a departmental owner, date approved, date the policy became effective, when the policy was due for review and version control.

All ambulance trust providers, as Category 1 Responders, under the Civil Contingencies Act 2004 (CCA), must ensure they embraced best practice national guidance. Each ambulance trust
provider must have a Surge/Resource Escalation Plan (REAP) which is a clinical plan designed to ensure that an appropriate response is maintained at times of unexpected increases in demand.

There were four levels of escalation utilised within REAP which aided ambulance services to integrate into the wider NHS surge or escalation framework. The levels were used to determine what actions were necessary to protect the core services and supply the best possible level of service with the resources available. REAP was reported nationally as well as utilised within NEAS dynamically each day to guide escalation planning.

REAP was in operation always and was used as part of a forward looking planning process that forecasted performance and service delivery over seven days by assessing the likely impact of the key influencing factors.

The EOC manager supervised four section managers, one was a NHS 111 manager who did not manage any staff the other three did. There were 22 team leaders (WTE of 20.2), each of them had around 15 people on their teams.

There were the health advisors and we were told the senior health advisors were moving into a new team with their own rota working exclusively with a team leader.

We spoke with the EOC manager who told us the budget was for 72 WTE 999 call handlers and 133 WTE 111 call handlers. The manager told us if the staff were not dual trained and multi-skilled the service would require an additional 20 to 30 advisors. Currently, approximately 61% of staff were multi-skilled.

We saw evidence the shift forecasting was done using a computer system which could forecast five years ahead using historical data. Shifts would be scheduled accordingly taking account of training and sickness.

During inspection we reviewed the five-year forecast document which commenced April 2015. It was noted between April to August 2018, on average, the staffing levels dealing with 999 calls were 1.19% above the demand that had been predicted. This demonstrated the accuracy of the forecasting tool to enable resources to be planned to meet demand.

During inspection we reviewed the weekly forecast documents for weeks commencing 1 October and 8 October 2018. Both documents showed the staffing levels had been matched to the predicted demand.

The manager we spoke with told us accuracy in forecasting 999 calls was more difficult due to factors outside the control of EOC. The 111 calls were easier to forecast.

The EOC call takers worked on a six week shift pattern. Leading on from the five year forecast demand was forecasted a month ahead looking at call volumes and projected service levels. The forecast was reviewed at four, three and two weeks ahead, 10 days ahead, one week ahead to take account of sickness and the forecast would be adjusted accordingly. The day ahead of the shifts commencing the intra-day team reviewed the forecast and adjusted skill sets, the integer, adjust break times, to minimise impact to patient and maximise availability.

During inspection we spoke with the dispatch manager who told us the dispatch section had five rotational teams consisting of 15 staff in a team working 12 hour shifts starting 7am-7pm and 7pm-7am. The shifts were covered by a duty manager and a communication officer.

The manager told us during shift as calls came in if there was a backlog of 111 calls and the 999 calls were manageable dual trained staff would switch from 999 to 111 to deal with the demand and vice versa.
Staff we spoke with told us the dispatch section was better staffed than it had been previously. At the end of 2017 staffing was reviewed and the numbers of staff revised. There was evidence of more use of overtime rather than using bank staff.

During inspection and due to severe weather, there had been an unexpected peak in 999 calls. The increase over and above the forecast was 13% for the day overall. In response the EOC adjusted the skill sets with dual trained handlers prioritising 999 calls.

Due to the high call volume and despite having enough dual trained staff on shift the EOC did not achieve service level agreement of 95% achieving 85% on 999 and 82% on 111. The team leaders were involved in dealing with calls and a floor walker was used to provide additional support. The EOC had organised a de-brief to identify what we could have been done differently. At the time of the inspection no conclusions had been reached.

During inspection we reviewed the NEAS Emergency Demand Predictor 11-15 December 2017. The purpose of the report was to ensure NEAS could maintain service delivery and provide resources in the event of untoward incidents arising. The Emergency Demand Predictor (EPD) in the report gave a forward view of demand and potential capacity which could be faced. The predictor also detailed contingency arrangements in place for escalation purposes. The demand predictor report included; forthcoming events, NEAS staffing, a weather summary, NEAS staff forecast, national and regional issues including terrorism and health intelligence, NEAS on-call arrangements and the previous weeks demand profile.

### Planned vs actual

NEAS had reported their staffing numbers below for emergency operations centre as of March 2018.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>WTE planned staff</th>
<th>WTE actual in post</th>
<th>Fill rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified ambulance service staff</td>
<td>34.0</td>
<td>30.6</td>
<td>90.0%</td>
</tr>
<tr>
<td>Support to ambulance service staff</td>
<td>417.0</td>
<td>370.9</td>
<td>89.0%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>451.0</td>
<td>401.5</td>
<td>89.0%</td>
</tr>
</tbody>
</table>

(Source: Trust Routine Provider Information Request– Total staffing)

**Note:**

The trust had a clinical advisory service (CAS) that supported the 111, 999 and OOH services which was staffed by GP’s, pharmacists, advanced practitioners from both paramedic and nurse backgrounds, senior clinical advisors and clinical advisors.

The rest of the EOC Staff groups included:

- Service advisors
- Health advisors
- Senior health advisors
- Dispatch officers
- Communication officers
- Communication support officers
• Dispatch supervisors
• Dispatch duty managers
• Dispatch managers
• Section managers
• Team leaders
• Clinical section managers
• Service line managers
• Workforce management manager
• Workforce management team
• Palliative care team
• Special patients note team
• Team administrator
• Strategic head of EOC

**Vacancy rates**

Following the last inspection NEAS were given a must do action by CQC to ensure at all times there were sufficient numbers of suitably skilled, qualified and experienced staff. The information below highlights NEAS have enough suitably skilled, qualified and experienced staff and were over establishment.

From June 2017 to May 2018 NEAS reported an annual vacancy rate of -9.3% for call handler and dispatch staff working in the emergency operations centre. This is an over-establishment of staff compared to what NEAS had planned for. NEAS was unable to breakdown their infrastructure staff down into core service level for this data. NEAS target vacancy rate was 1.46%.

Note: NEAS dual train many call handlers in 999 and 111 services so EOC personnel were unable to be broken down into working exclusively in either.

(Source: Trust Routine Provider Information Request – Vacancy)

NEAS told us the higher vacancy rate was due to clinician gaps in CAS, which had been included in the EOC risk register.

We were told management were working closely with the recruitment team to ensure the recruitment plan was achieved and the vacancies filled.

**Turnover**

From June 2017 to May 2018 NEAS reported an annual turnover rate of 26.0% for call handler and dispatch staff working in the emergency operations centre, which is worse than NEAS target of 10%. NEAS was unable to breakdown their infrastructure staff down into core service level for this data.

Note: NEAS dual train many call handlers in 999 and 111 services so EOC personnel were unable to be broken down into working exclusively in either.

(Source: Trust Routine Provider Information Request – Turnover)
The EOC manager told us many call handlers left EOC to work in operational roles in the urgent and emergency care element of NEAS. The attrition rate was approximately 16%. We were told 10 staff were leaving from 7 January 2019 to become clinical care assistants. Managers acknowledged this did put pressure on EOC but viewed the turnover rate as positive attrition because most leavers remained in NEAS which saved money elsewhere in the organisation because of reduced training costs for example, for staff entering new operational roles.

**Sickness**

From June 2017 to May 2018 NEAS reported an annual sickness rate of 7.9% for call handler and dispatch staff working in the emergency operations centre, which is worse than NEAS target of 5.0%. NEAS was unable to breakdown their infrastructure staff down into core service level for this data.

Note: NEAS dual train many call handlers in 999 and 111 services so EOC personnel were unable to be broken down into working exclusively in either.

*(Source: Trust Routine Provider Information Request– Sickness)*

NEAS told us several long term absences had been ended due to staff leaving NEAS and there had been a high level of pregnancy related sickness. Some actions to tackle these issues had been implemented including a new “health and wellbeing” notice board in EOC, the impact of which had yet to be measured and assessed.

**Records**

Following the last inspection NEAS were given a must do action by CQC to ensure that clinical records were stored securely. During this inspection we found patient records were computer based and were stored securely.

During inspection we reviewed 12 sets of patient notes viewing them as to how they presented to operational staff on data terminals. The information fields were all completed and would be used to inform ambulance crews as to any issues they would need to consider.

Managers we spoke with told us ambulance crews completed the patient care record on scene and updated the dispatch team with any relevant information if it needed to be documented, for example, updating an existing flag.

**Medicines**

During the inspection we listened to two 999 calls, a nurse giving clinical advice and spoke with nine members of staff in relation to medicines. We also reviewed the self-assessment provided to us by NEAS in relation to their audits.

Staff in the emergency operations centre (EOC) followed NHS pathways in relation to medicines. Advice regarding over the counter medicines was provided using the direct care advice on the NHS Pathways system. For example, on one call we listened to advice given regarding paracetamol and instructions were given on how to take this safely.

We spoke with a senior clinician who could give advice on over the counter medicines and if patients had prescribed medicines they would be advised to take them as per instructions. Any other queries about medication would be passed on to a doctor for advice.
The clinical pathways profiled where to direct patients to for further advice. We saw evidence directing patients to a community pharmacy appeared above attending a GP surgery if the problem could wait 24 hours.

We saw evidence call takers used interim care and advice on the pathways at the end of the call, for example, advice on taking paracetamol and ibuprofen, advice about contra indications in relation to pregnancy and chicken pox when taking ibuprofen and advice in relation to stomach problems, the pathway stating not to take nonsteroidal anti-inflammatory drugs (NSAIDs).

The call handlers we spoke with told us they felt confident in following the clinical pathways and if they were unsure they could contact a nurse for further advice. Staff told us the system regarding providing callers with advice in relation to medicines was ‘fool proof’.

The call takers had three calls audited monthly by managers who provided feedback to ensure the advice provided on the call was safe and the clinical pathways had been followed.

**Incidents**

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, NEAS reported 10 incidents for the emergency operations centre which met the reporting criteria set by NHS England from May 2017 to June 2018. All 10 of these were treatment delays meeting SI criteria.

(Source: Strategic Executive Information System (STEIS))

Following the last inspection NEAS were given a should do action by CQC to ensure staff were supported and encouraged to report incidents and feedback provided to staff on the outcomes of the incident investigation. During this inspection all the staff we spoke with told us they were encouraged to report incidents and they did receive feedback and what the outcome of the investigations were.

NEAS had a Reporting and Management of Serious Incidents (SIs) policy which was effective from November 2015 and due for review in November 2018.

The purpose of the policy was to set out the process for the reporting and management of SI’s. The policy recognised looking at what was wrong in the system helped organisations to learn lessons that could prevent the incident recurring.

The policy endorsed the recognised approach applied within the NHS in relation to root cause analysis investigation. The policy had defined roles, responsibilities and reporting procedures clearly outlined.

During inspection we reviewed the NEAS Retrospective Review of Serious Incidents to Identify Themes and Trends report shared at the March 2018 Quality Review Group meeting. The review identified the four top themes including insufficient resources, call handler error, failure to escalate to clinician and poor crew documentation. The review also identified positive factors which included an open and honest culture, good call handling and good general communication. The overarching observation from the report reviews were the number of investigations where no positive factors were recorded. However, for every serious investigation undertaken, NEAS had offered the affected family, a family liaison officer.

The report concluded there were insufficient resources which was an expected output. There was significant ongoing work to improve staffing levels and progress was being made.
The theme of ‘failure to escalate to clinician’ was reported by senior managers in EOC as a local and national discussion point for call handling. The report identified it was difficult to differentiate between experience and individual competence and for setting criteria when complexity should trigger clinician involvement. At the time of the inspection NEAS were carrying out collaborative work to further explore any additional actions to reduce risk of calls which had not been escalated to a clinician.

During the previous inspection within EOC there were 117 open incidents over the NEAS response time targets of 28 days or 14 days depending on the severity of the incident. These incident reports were in progress but over NEAS timescales for completion.

During this inspection there were 102 open incidents relating to EOC, of these 52 were overdue, 45 related to patient safety incidents and seven related to non-patient safety incidents. Although this was an improvement on the levels found in the previous inspection, there was not a system in place to immediately identify overdue incidents which could be serious matters requiring immediate action or were near misses.

We spoke to the quality risk and safety manager who told us NEAS produced an annual serious incident report which summarised the key issues.

Last year NHS Improvement asked NEAS specific questions in relation to triage. NEAS produced a report and reviewed if there were any trends, issues or concerns in their processes. The report identified there were no specific issues or trends.

Serious incidents were monitored each month. NEAS were the second highest reporting ambulance trust in the country.

Serious incident information was recorded on the quality dashboard which had high level overview of incidents submitted to the executive board.

NEAS produced an annual learning report (April 2018) to identify any issues or themes. This was shared through the governance structure and externally.

We saw evidence individual cases were looked at by a clinical review panel every Thursday. Attendance at the panel varied but generally it was attended by the head of patient safety, someone from the patient experience team if there is a complaint, patient safety, clinicians, control room staff and EOC staff.

Notes were recorded and a decision made if the incident fitted the national framework for a serious incident. If the matter under consideration was a SI this was reported to StEIS/NRLS and managed through the NEAS computer safeguarding system that had time trackers which provided dates when certain actions must be completed by.

If required a route cause analysis (RCA’s) investigation would be conducted. Each RCA had an RCA panel which was arranged on a needs basis. When a SI was reported, timescales for RCA meetings were included. The RCA panel debriefed the staff and, if the incident had been traumatic, the debrief included team leaders and staff from the quality risk and safety team, occupational health and counselling services.

We saw evidence the finalised RCA’s were signed off by the serious incident review group.

To maintain an overview of safety each call handler had five calls audited each month. The quality risk and safety manager only reviewed the calls if there were concerns raised by supervisors or if NEAS was doing a specific piece of work in relation to issues identified in previous audits.
The provider had reviewed their systems following incidents where call takers had been unable to obtain an interpreter. Before the review, call takers had discretion as to how the call response was graded. Post review, a memorandum was sent to all call handlers identifying changes in practice in terms of categorising calls, the default grading being Cat 2 when an interpreter could not be sourced. However, there was a significant delay in this information being given to staff.

The patient safety manager was aware of some problems with language line identified in the investigation of SI’s when staff had been unable to obtain an interpreter which delayed the ability to triage the patient. We saw evidence of an audit following a SI where there had been some involvement with language line. The audit showed staff had complied with NEAS policies.

Staff we spoke with on inspection knew how to report incidents using a NEAS07. Staff told us they received feedback from what they had reported and what the outcome had been. Staff survey results showed staff felt safe, happy and competent in reporting incidents. During inspection we reviewed ten NEAS07s, one submitted by a clinical services manager, six call takers and three dispatchers. All the forms had all the fields correctly filled out with relevant information.

We saw evidence NEAS had a Reporting and Investigation of Adverse Events policy (including being open and duty of candour) effective from 23 November 2017 and due a review 23 November 2020. The policy provided staff with the information to ensure adverse events were reported in a timely manner and appropriately managed, investigated and practice-change implemented within NEAS to improve safety for patients, staff, visitors and contractors.

The policy offered advice on how to communicate with patients, their families and carers under the guiding principles of ‘being open’. The policy outlined specific roles and responsibilities.

There was evidence NEAS had systems and processes to comply with the obligations required under duty of candour. NEAS used a computer based safeguard system for recording and managing all incidents falling within that category. Once identified the individual case was assigned to a dedicated person who reviewed the information and ensured the duty was fulfilled. If the case was classified as a serious incident NEAS appointed a family liaison officers (FLOs) to deal with the case. In such cases the FLO acted as a single point of contact for the patient or family offering additional support and guidance.

Reporting and compliance with duty of candour was conducted via NEAS’s governance structure and ultimately up into NEAS board of directors via the quality dashboard.

During inspection we saw evidence learning was shared across the teams using internal intranet systems, learning posters displayed quarterly and discussion of RCA’s at team meetings.

The patient safety manager described two SI reviews which resulted in a change in NEAS policy. One was a change to policy on ring backs. The case was linked to significant ambulance delays which led to authorisation for additional resources.

The other example was a crew being delayed attending a call due to safety markers. The SI review resulted in an escalation process being introduced and changed how NEAS communicated and shared information with other organisations such as the police.

We saw a bulletin dated 26 January 2018 making staff aware of an issue identified with the coding where some cases for adults were identified which had been coded as a Cat 1 when they should not have been. Staff were provided with specific information as to how to overcome this.
NEAS had added a fix to their computer recording system regarding the early exit issue by greying out the early exit button until an age and gender had been selected which prevented the calls from being coded incorrectly.

NEAS provided data in relation to what percentage of calls resulted in a SI within EOC relating to 999 and 111 triage, the figures were as follows:

2017/2018 = 14 cases divided by 1632737 (calls) multiplied by 1000 = 0.0085%
2016/2017 = 11 cases divided by 1389966 (calls) multiplied by 1000 = 0.0079%

We discussed with the quality risk and safety manager the fact several SI’s were caused because of human error. We were told some of the reasons for this, which had been identified in SI investigations were; wellbeing bias where elderly patients tended to downplay their condition while younger people play up their condition, staff complacency due to dealing with high levels of difficult calls the seriousness of what call takers were being told is not identified or reduced.

**Is the service effective?**

**Evidence-based care and treatment**

NEAS had standard operating procedures (SOPS) for emergency dispatch staff. SOP had been subject to frequent reviews the most recent being in September 2018.

The SOP was version 10 of the dispatch standard operating procedures and was up-to-date at the time of the inspection. There was evidence the procedures had been produced in conjunction with other NEAS policies and procedures. Each member of the dispatching team had been provided with the SOP to ensure they had clear guidelines for their role and what could be expected in their performance.

Staff we spoke with were aware of the policy and told us if a caller used a female name but the call history showed previously they had used a male name for the purpose of that call they would be called by the female name. Staff told us they would ask specific questions if it was relevant to their pain and the reason for it, for example, abdominal pain questions would be asked if the caller was in their transition as this would alter how NEAS would need to respond medically.

Dispatch managers we spoke with told us mental health concerns were progressed using the same dispatch categories as physical health concerns. We saw evidence from the calls we listened to that staff were provided with information such as; the patients name, age, conditions, brief history, mental state and, if they could be aggressive.

During inspection we observed staff spoke to patients in a very calm, clear manner on all calls providing clear instructions for what to do during the call, the expected time for a response and what to do should their condition change.

**Pain relief**

We saw evidence during inspection that staff in EOC assessed pain remotely using the clinical pathways and provided information to patients, carers and ambulance crews involved in the call. Dependent upon the clinical pathway followed patients could be provided with advice to take pain relief medication or not. Ambulance crews were informed of this.
Response times

NEAS started on the new ambulance response programme in October 2017.

All measures of ambulance system’s performance were changed to reflect the new ways of working introduced.

Results were available against the historical standards up to this date, and against the new ambulance response programme measures from this date onwards.

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

The indicator “call abandonment” was in use prior to November 2017. Since then it had been discontinued as measures of ambulance systems performance.

Please note that for the graph below, from August 2017 to October 2017, as part of the implementation of the ambulance response programme by the various ambulance trusts, North West, East Midlands, Yorkshire and West Midlands ambulance services provided no data and are therefore not included in any England average calculations for that period.

Call abandonment

This indicator is designed to ensure that ambulance services are not having problems with people phoning 999 and not being able to get through. This indicator measures the percentage of 999 callers who have hung up before their call was answered in an emergency control room.

From July to October 2017 NEAS consistently had a lower proportion of calls abandoned before being answered than the England average. Trust performance varied between 0.4% and 0.6% whereas the England average varied between 1.7% and 2.1%. Therefore, NEAS was performing better than the England average.

(Source: NHS England – Ambulance Quality Indicators – System Indicators)
Ambulance systems (AmbSYS) indicators introduced under the NHS England Ambulance Response programme (ARP):

Time to answer call

The time to answer each call is the time between call connect and call answer.

Prior to the ambulance response programme, time to answer calls (emergency and urgent) was previously measured by median, 95th percentile and 99th percentile.

As a result of the ambulance response programme this indicator now includes the mean average time. The three existing measures are unchanged.

The four metrics now used to measure time to call answering are:

- 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)

From November 2017 to June 2018 NEAS median time to answer call had been slightly lower than the England average, remaining constant at 1 second.
From November 2017 to June 2018 NEAS mean time to answer calls had been consistently lower than the England average. Trust performance varied from 2.0 to 5.0 seconds whereas England average varied from 5.9 to 22.6 seconds during this period. Therefore, NEAS was performing better than the England average.

From November 2017 to June 2018 NEAS 95th centile time to answer call had been consistently lower than the England average. Trust performance varied from 7.0 to 20.0 seconds whereas England average varied from 30.9 to 96.7 seconds during this period. Therefore, NEAS was performing better than the England average.
From November 2017 to June 2018 NEAS 99th centile time to answer call had been consistently lower than the England average. Trust performance varied from 25.0 to 51.0 seconds whereas England average varied from 90.6 to 164.8 seconds during this period. Therefore, NEAS is performing better than the England average.

(Source: NHS England – Ambulance Quality Indicators – System Indicators)

Patient outcomes

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

The indicators re-contact rate and frequent caller were in use prior to November 2017. Since then they have been discontinued as measures of ambulance systems performance.

Please note that for the two graphs below, from August 2017 to October 2017, as part of the implementation of the ambulance response programme by the various ambulance trusts, North West, East Midlands, Yorkshire and West Midlands ambulance services provided no data and are therefore not included in any England average calculations for that period.

Re-contact rate

This indicator measures the proportion of patients re-contacting 999 within 24 hours of original emergency call which was closed with telephone advice; the following calls are excluded from the numerator:

- Re-contact for different patient
- Patients transported after first attendance on scene
From July 2018 to October 2017 NEAS re-contact rate had stayed stable at around 13% and had been consistently worse than the England average.

(Source: NHS England – Ambulance Quality Indicators – System Indicators)

Frequent callers

Emergency calls from patients for whom a frequent caller procedure is in place should be reported by NEAS. Frequent caller procedures should be locally determined; these procedures should relate to individual patients and be agreed with that individual and the main care provider (e.g. GP, Mental Health Service).

From July 2017 to October 2017 trust performance was better than the England average and improved steadily between July and October 2017.

(Source: NHS England – Ambulance Quality Indicators – System Indicators)
Ambulance systems indicators

NEAS started on the new Ambulance Response Programme (ARP) in November 2017. The following measures were amended for this trust in that month to reflect the new way of working under the ambulance response programme.

Calls closed with telephone advice / hear and treat

Prior to the ambulance response programme (ARP) this measure related to all calls to the emergency operations centre that did not receive a face to face response. In practice it was a measure of incidents with no face to face response, regardless of reason (which could be a decision not to respond due to capacity issues, etc.).

Following the ambulance response programme this measure had been amended and now relates to all calls to the emergency operations centre that are resolved through telephone advice or by referring to another service and where an ambulance is not dispatched.

NEAS’s performance against the new metric for the period from November 2017 to June 2018 is shown below.

![Graph showing percentage of incidents resolved without face to face response](image)

From December 2017 to June 2018 there had been a decrease in proportion of incidents resolved without face to face response. In December 8.1% of incidents were resolved without a face to face response (England average 6.7%) and in June 2018 this had dropped to 4.9% (England average 5.5%).

(Source: NHS England – Ambulance Quality Indicators – Systems indicators)

During inspection we spoke with the clinical services manager for the integrated urgent care clinical assessment services. They told us NEAS had an internal baseline for hear and treat at 11% and nationally between eight and nine percent was considered good. To improve performance a new performance dashboard had been introduced in February 2018 which provided more accurate individual data. Peer reviewing of calls had been introduced to compliment end to end audits of calls. Individual performance in this area was discussed during staff 1:1’s.

From August 2017 to June 2018 the proportion of incidents closed as “see and treat” was 25% the England average for the same period as 30.1%
Competent staff

Appraisal rates

Following the last inspection, NEAS were given a must do action by CQC to ensure all staff received an appraisal and were supported with their professional development which included support to maintain the skills and knowledge required for their job role. Overall 70.8% of staff had undertaken an appraisal since April 2015 to March 2016.

From April 2017 to March 2018 71.7% staff working in EOC had received an appraisal compared to the trust target of 95.0%.

The breakdown by staff group is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Number of staff eligible</th>
<th>Number staff completed</th>
<th>Appraisal rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTS - Co-ordinator</td>
<td>40</td>
<td>38</td>
<td>95.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Emergency Call Handlers/Dispatchers</td>
<td>374</td>
<td>278</td>
<td>74.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>NHS Infrastructure Staff</td>
<td>53</td>
<td>19</td>
<td>35.8%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

To note: NEAS dual train many call handlers in 999 and 111 services so EOC personnel were unable to be broken down into working exclusively in either core service. NEAS was unable to assign the majority of their infrastructure staff to core service level.

(Source: Trust Provider Information Request – Appraisals)

The trust collected monthly performance data for EOC which included appraisal rate. The trust reported that in March 2018 EOC had an 80.0% appraisal rate which had deteriorated to 68.3% in July 2018. This did not meet the trust appraisal rate target of 95%.

(Source: DR60 – EOC Performance Report)

Despite the target appraisal rate not being achieved at the previous inspection and not achieved at this inspection there was no evidence of an action to achieve the 95% NEAS target.

During inspection we reviewed 20 staff appraisals of both call takers and dispatch staff. All the appraisals had reference to the NEAS values the NHS six C’s; care, compassion, competence, communication, courage and commitment.

The provider had a welcome to NEAS induction policy. The policy had been subject to a full re-write due to a review and redesign of the NEAS induction process. The draft policy was approved in full by Joint Consultative Committee Sub Group in October 2017. The policy had a lead executive director as owner, when the policy was effective from and when it would be next reviewed.

The policy explained the purpose, scope and duties including roles and responsibilities of NEAS staff. The content of the policy explained the four-stage induction programme.

During inspection we reviewed the NEAS induction document for new staff. The document was extensive in its detail covering; bring NEAS’s values to life, the role of CQC, the fundamental
standards at NEAS, duty of candour, the previous CQC inspection of NEAS, HR, policies and procedures, delivering quality patient care, managing attendance, fraud awareness, information governance, resuscitation awareness, staff wellbeing and occupational health, equality and diversity, making a difference, making every contact count, dementia friends, local induction and elearning and how to stay up to date.

Monthly data monitoring reports were produced for managers through the NEAS Oracle Learning Management System (OLM) to ensure compliance had been achieved for all stages of the welcome to NEAS induction policy by new staff.

During inspection we reviewed the NEAS training alert system which recorded the levels of staff training compliance. Six staff records were checked live on the system. Four records showed 100% compliance and two showed 90% compliance. There was a traffic light system to alert supervisors to the compliance levels, red was non-compliant, amber indicated 60 days before becoming non-compliant and green which was complaint. The staff we spoke with told us monthly reports were generated from the system so supervisors could check levels of compliance and if required they could book protected learning time for staff.

We spoke with the caller taker manager who explained new staff were trained on the route to competence using mandatory and statutory training and 1:1 meetings which provided assurance of competence.

Staff were assessed in terms of productivity in how they dealt with calls including the time taken, not ready time, behaviours identified in call audits and identification if a member was struggling in a specific area.

During inspection we reviewed a selection of EOC staff call audits. The audits were colour coded;

- Green: Full achievement: this meant the indicator was demonstrated to an excellent standard or that the indicator did not apply to the circumstances of the call.
- Amber: Partial achievement: this meant the indicator was adequately demonstrated and that any issues identified in relation to this indicator did not affect the overall safety and/or quality of the call.
- Red: Not achieved: this meant the indicator was not adequately demonstrated and the issues identified detracted from the overall safety and/or quality of the call.

We reviewed 60 999 call taker audit records which had 11 areas coded red with an explanation of how to prevent a reoccurrence. We also reviewed 32 dual call taker audit records which had three areas coded red with an explanation as to what the error was and how to prevent a reoccurrence.

During inspection we reviewed 17 call taker clinical pathway audit records which were colour coded in the same way as call audits. There were no areas coded red.

We saw evidence NEAS completed regular call auditing of all staff and there was a specific competence on effective communication. During inspection we reviewed the July 2018 audit which showed 92% of 202 call handlers achieved full competence and 7% achieved partial competence in the following competency indicators:

- Communicates sensitively, professionally and with appropriate warmth
- Adapting the approach according to the needs of the situation
- Negotiates where appropriate and does so effectively
We saw evidence the EOC had a call quality management process which complemented existing policies and provided a framework to assess the quality of staff and how that could be managed. The staff we spoke with were aware of the process and we saw a copy of it on NEAS`s intranet site.

The programme for call handling audits provided detailed scrutiny and established a coaching, education and performance management process which had good governance and auditable documentation would reduce call handler error.

We saw evidence of a process for any instances where a health advisor may have triaged incorrectly and it had been identified after the ambulance crew arrived and assessed the patient face to face resulting in a downgrading of the response.

EOC managers told us if the dispatch duty manager or another senior manager reported a high volume of C1 calls in a single day, shift or any instance of a potential delay in reaching the disposition they could ask a call handling section manager to review the calls.

We saw evidence the last request came from the deputy chief operating officer, who queried why there were a high number of C1 calls on Sunday 26 August that were delayed in reaching the final outcome. There were seven calls reviewed by the EOC manager and a team leader. The review demonstrated none of the calls were found to have triage errors made by the health advisor therefore none were recorded as requiring a call for review.

If any of the road staff reported a concern with an incorrect triage via Ulysses on a NEAS07 then the ‘Calls for Review’ process began.

During inspection we reviewed the five most recent inappropriate ambulance response evaluations which were reviewed. Two calls had been graded as C3 which should have been C2, one was inappropriate advice regarding medication, one was repeated call backs where the type of chest pain had not been established and one did not have enough questions to establish if the patient was breathing regularly. In every case the call taker had received individual feedback.

During inspection we reviewed five potential unsafe call reviews. The reviews were carried out by clinicians. In four reviews issues were identified which lead to the staff involved being provided with advice as to how to prevent a reoccurrence. In one review staff received complimentary feedback as to how they had dealt with a difficult call and clearly followed the clinical pathways.

If a member of staff was not performing and the decision was to instigate a formal process information from the call quality management process would be used. The manager we spoke with told us this would be a last resort and had been used twice in recent years.

The manager told us if a member of staff was struggling to cope with the stressful nature of the calls they could be deployed to the patient transport services call handling which was simply transactional.

Managers told us all staff started on 111 and it was made clear the expectation was that in the future staff would train on 999 dependent on performance, attendance and competence. After nine months as a competent 111 call taker NEAS would train staff to deal with 999 calls after reviewing call audit results, the ability to handle calls appropriately, any complaints and any unsafe calls to get a picture of the staff members whole performance.

The manager told us the other considerations when assessing suitability to take on the 999 call taking role was whether staff showed empathy and sympathy during calls. Staff were also spoken
to individually about the differences between 111 and the potential for every 999 call being an emergency call and if they could cope with that level of stress.

The dispatch manager told us there was dedicated training for dispatchers, a corporate induction and full training package. Trainers used a training room which replicated the dispatch centre which enabled staff to use computer systems in a training environment and shadow a crew. Staff applied for a specific role as a dispatcher or call handler. NEAS held open evenings for potential applicants to provide them with a wider understanding of the role.

We saw poor and variable performance was identified by the dispatch manager sitting with each member of staff to monitor and audit calls and to provide feedback confidentially. The purpose of the audit was to establish if the staff member had communicated efficiently, identified resources and dispatched them correctly.

We saw evidence if there had been individual learning following an SI an improvement plan devised and additional training would be included in the individual’s appraisal.

During inspection we reviewed an early exit lesson plan delivered to EOC staff. The aim of the input was to ensure staff used the appropriate early exit function. The overall objectives were for staff to be able to; explain the different options within early exit, demonstrate when each early exit option should be used and utilise early exit appropriately.

During inspection we reviewed five staff action plans. The plans covered the task, standards required, concerns and issues to date and action to be taken. All the plans clearly outlined the issues for the member of staff and what was required to overcome them. Each plan was signed and dated by the member of staff the plan related to and the supervisor who had devised the plan.

Within the internal computer based system the learning issues had corporate themes attached to them which included updated training sections. An example of learning was introduction of Threat, Risk, Investigation, Vulnerability and Engagement (THRIVE) with Northumbria Police. All EOC staff had undertaken THRIVE training. The knowledge of THRIVE in addition to the clinical pathways helped staff appropriately triage calls.

During inspection we saw evidence in 2017/18 NEAS had trained a further 20 members of staff to undertake family liaison officer duties and they had undergone a five day education programme to prepare them for this important role. During 2017/2018 NEAS supported NHS Resolution to showcase the FLO role and presented at two national events in Manchester and Newcastle. NEAS had also worked with other trusts to share experiences and processes to identify best practice.

NEAS had sought feedback from managers in relation to enacting the duty of candour requirements and had undertaken initial training of frontline clinical managers during 2017/18 to support new managers coming into post.

We saw evidence NEAS had introduced a new appraisal document. The appraisal asked for examples of performance linked to NEAS values, and staff objectives were aligned to NEAS strategy.
Multidisciplinary working

NEAS began a process several years ago to consider 24/7 operation within EOC of the patient transport service referred to locally as ‘Scheduled care’. This was developed with commissioners so that a 24/7 service was available in those CCGs where it is commissioned.

The on-call arrangements for NEAS meant there was access to management support across all levels at all times 24/7.

As part of NEAS`s clinical care and transport project, the two previous service lines emergency care and patient transport service were merged into one service, clinical care and transport. This followed a management restructure that reflected this integrated structure.

For the core service, all patients were planned to be taken to hospital on time for their appointment (between 45 minutes early and 15 minutes late) and collected no more than 60 minutes after notification was received that they were ready. Contractual performance was managed through a central commissioning team. NEAS held a monthly sub-group meeting with commissioners specifically focused on the care and transport discipline.

In addition, NEAS’s care and transport service was commissioned to provide dedicated mental health transport services to Northumberland Tyne and Wear (NTW) NHS Mental Health Foundation Trust.

The County Durham and Darlington discharge service was setup in 2016 to provide a responsive discharge service for the two main Durham hospital sites. This service had specific performance targets to ensure a responsive discharge of patients ensuring patient flow across the Durham and Darlington hospital sites.

We saw evidence NEAS met regularly with police forces at the joint demand reduction group which included fire and rescue staff regionally. The services did joint debriefs from each SI to collectively share learning. If it was considered necessary GP practices and acute trusts and care homes were invited to be involved in the process.

Staff we spoke with told us of some of the difficulties they had in obtaining help from the mental health crisis teams because of availability due to being short staffed. Some of the other difficulties in obtaining services from the mental health crisis teams was because of the need to have the patient on the call and they would not call them back and they would not talk to people who were under the influence of alcohol. Some patients did not want to speak to the crisis teams and if there were no crisis teams available then the pathway would be to take the patient to the accident and emergency department.

The duty manager in EOC told us of cases involving patients living with mental ill health who were triaged before being passed to dispatch. The call would then be assessed before allocation to the appropriate team which would usually be a double crewed ambulance. Part of the assessment included identification of appropriate routes, availability of the crisis teams, possible need for police assistance and possible attendance of a GP to support the transfer.

During inspection we listened to several calls with police, fire service and on one call the coast guard, where information was shared.
Health promotion

We saw evidence NEAS had engaged with local communities in a variety of ways to promote health and what the service provided, for example, staff had attended local events, such as Pride and the Mela.

NEAS had worked jointly with other local NHS trusts to develop posters and resources with similar branding across the region in relation to health promotion.

NEAS had completed community based work on the text relay service and British sign language (BSL) relay service in local communities. Staff had carried out 10 events with deaf communities and created awareness of the services offered on 999 and 111 and supported those attending to register for this service.

We spoke with the head of quality risk and safety and the health and safety advisor about how frequent callers were identified and supported to access other services. They told us the flags were different to special patient notes.

NEAS used the national definition which were five calls per month or 12 calls in three months. NEAS worked with local general practices to reduce the call volume. It had been identified most of the frequent callers had alcohol or drug related issues rather than mental health related problems. Part of the work with GP’s was to signpost patients to support services.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

MCA training completion

NEAS set a target of 95% for completion of Mental Capacity Act (MCA) training. Within the emergency operations centre there was only one member of staff who was eligible for the training and this person had completed the training between April 2017 and March 2018.

<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>1</td>
<td>1</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

(Source: Trust Provider Information Request – Mandatory training)

We saw evidence NEAS had a capacity to consent to examination or treatment guidance document for staff who were involved in the care, treatment and support of people who were incapable of making some or all decisions for themselves at a specific time in relation to their care or treatment.

NEAS recognised patients had a fundamental, legal and ethical right to determine what happened to their own bodies. Valid consent was therefore essential in all forms of healthcare.

The guidance document was effective from November 2015 and due for review November 2018. The document outlined roles, responsibilities and duties, scope, policy content, mental capacity and how the guidance would be monitored.
Staff we spoke with told us if a caller was deemed to possibly lack capacity the call would be passed to a nurse who would do a telephone capacity assessment. The outcome of the assessment would be relayed to the caller which ensured they understood it and could recite it back including what the outcome was, for example, could be if NEAS staff did not attend the call, what the consequences may be. Staff told us the same process was in place for patients that declined treatment. There was an option of having a doctor to call the patient to identify what could be done for them in their own home.

Staff we spoke with were aware of the flagging system which was in place for violent or high risk patients. The flags could direct staff to certain actions including ringing a community nurse, crisis team or community psychiatric nurse (CPN). If there was a flag for a frequent caller there was an order of care to go through before considering escalation.

We saw evidence if the option for “mental health emergency” had been selected and a health professional had made the call the system generated a prompt to ask if restraint would be required, however, staff were aware of the need to carry out a dynamic risk assessment to identify if use of restraint would still be appropriate.

Staff we spoke with told us NEAS did not transport any patients sectioned under the Mental Health Act and showed us a document about transportation of patients detained under MHA date approved April 2016 which outlined that.

Informal patients could be transported by the crews and there was the ability to take multiple patients per transfer for scheduled care. The provider requesting the service would be informed that, if they absconded, NEAS staff would be unable to stop them. If the patient had an escort NEAS could do a joint transfer. Staff told us the usual transfers were hospital to hospital or hospital to care home. NEAS also did day requests most of which were pre-planned transfers.

Managers told us EOC staff had training and some understanding of the Mental Health Act 1983 and the Mental Capacity Act 2005 but it was most relevant to the operational crews who were patient facing.

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**Is the service caring?**

**Compassionate care**

We listened to 65 live calls in the emergency operations centres. During those calls the staff were observed to be calm, professional and considerate of the patient’s needs. We heard staff interact with people in a respectful and considerate way while ensuring they asked specific questions to follow the clinical pathway and assess the patient. We listened to calls where staff took time to ensure questions were answered, where possible, by the patient rather than supporting family members or carers to ensure the information was accurate.

Staff provided regular reassurance to patients throughout the calls we listened to. Some examples included, staff informing patients help had been arranged, staff explained and managed expectations of ambulance response times and informed patients if their condition changed or got worse to call back.

During the calls we listened to staff who were sensitive and receptive while they provided encouragement and support to those who used the service. We listened to calls where staff showed compassion and resilience with patients who had been in distress and in physically
challenging situations. We listened to a call with a patient whose safety was under threat because of where they were located. Staff stayed on the call talking to the patient providing reassurance until other emergency services arrived on scene.

**Emotional support**

During the calls we listened to, staff were observed to be confident in delivering advice and supporting the caller.

Staff provided accurate and clear information to patients and callers about their condition as they followed the clinical pathways. We observed staff being respectful, using statements such as, “I don’t want to cause offence, but I need to ask these questions”. This reassured patients and enabled the necessary information to be obtained so the call could be triaged.

Staff showed kindness, respect and compassion to those experiencing difficult circumstances. We observed examples of staff staying on the call with patients or family until help arrived. Staff showed empathy during calls and were sensitive to the needs of people who used the service.

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

During the calls we listened to, staff demonstrated they understood the importance of involving patients and those close to them during their interactions with them on the call. For example, we observed staff speak to patient’s directly and other people involved in their care.

We observed examples of staff calling patients back on mobile devices so the device could be next to the patient so a continuous dialogue could be maintained and when this had not been possible, staff provided clear, step-by-step instructions to the caller to go to the patient and gain accurate information.

Staff recognised the various cultural needs of their patient groups and gave examples which confirmed their understanding including people speaking staff of the same gender or staff liaising with other agencies instead of the patient when appropriate.

Staff had access to language line and could request interpreting services for 228 different languages through conference calling allowing them to triage patient’s appropriately.

Staff also had access to a British sign language (BSL) translation service and text relay service for those with hearing impairments.

We saw an effective process which managed a persistent caller which included providing wellbeing support for them.
Is the service responsive?

Service delivery to meet the needs of local people

NEAS used a shift projection system to ensure appropriate deployment of staff including non-ambulance service responders.

The shift projections were planned to meet EOC capacity to cope with the differing levels and nature of demand in different localities. The review systems at regular intervals enabled staffing to be adjusted to meet unexpected demand.

Meeting people’s individual needs

During inspection we reviewed the NEAS Mental Health Summary for August 2018. The data showed NEAS had attended 117 calls from CCG’s there were 21 incidents generated from the calls. NEAS attended on average 13 calls per month which resulted in the patient being taken to A&E and one call per month which was a non-A&E call.

The report identified the three main reasons for the calls were; patients with a worsening known mental health problem, patients with mental health problems and patients with behaviour changes. Any issues where an incorrect coding had been used was shared with staff to make them aware of the issues and to avoid them in order to ensure the needs of the patient was met.

Staff we spoke with told us if English was not the caller’s first language then language line would be used. If communication could not be established because of a lack of a translator the call would be transferred to a clinician or team leader. They would attempt a clinical assessment based on background noise, tone of voice, obvious signs of upset or pain. Staff had received THRIVE police training to support this. We found evidence of this during inspection on the calls we listened into.

During inspection we reviewed the language line flow chart for 999 call takers which guided staff through the process of obtaining an interpreter.

NEAS had a standing operating procedure with the provider of language line. There is no pathway in NHS Pathways for the need of translation services.

We also reviewed the NEAS supporting diversity guide. The document provided staff with general communication information, communicating with people who had a visual impairment, people with a hearing impairment, people who were deaf and blind, how to guide people through a call, people with assistance dogs and faith and cultural issues covering healthcare, when entering a home and customs around death. The document also had links to language line and the unique codes/ pin numbers staff could use for various languages to obtain an interpreter.

Patients who had speech or hearing difficulties were flagged with directions for staff as to what to do when they called EOC or when ambulance crews attended a call.

We spoke with staff who had done work in relation to the accessible information standard.

NEAS had done joint work with NHS trusts to develop posters and resources with similar branding across the region. They had developed yellow cards to give to patients to identify their communication needs.

NEAS had contracts with Becoming Visible in relation to British Sign Language (BSL) and the Royal National Institute for the Blind (RNIB) to accessible format information. In addition, brail
documents could be supplied. This enabled blind or visually impaired with the ability to access information to contact the EOC and make follow up phone calls.

We saw evidence on the rear of all publications the information was in different formats and in five of most common languages in the local area.

NEAS had a text relay service for patients which had been developed with BSL relay service and there was evidence that work had been done promoting this to communities. NEAS had carried out 10 events with deaf communities in 2017 and created awareness for 111 and 999 call takers.

NEAS were active in contacting physically supported people to register for the text relay service.

There was evidence a lot of work had been done around the communication support guide which had been developed 19 months ago with feedback from the deaf community, learning disability groups and people with languages other than English.

We saw evidence on a system called Recite me on the NEAS website which made all information more accessible. It allowed the website information to be changed into a range of languages and accessibility tools. The website had an accessibility button which brought up a range of options which did not require an additional download of software. The system allowed users to change back ground colours, text size, text style, add a screen ruler and change the information into over 100 different languages. The system had been tested and although the changing of information into different languages was never 100% accurate the accuracy was regularly 85%.

The system could talk to the user in their chosen language and played back the text in the language specified. The user could download the information in audio format directly from the site or could do text only.

The feedback from users was the information on the NEAS website was now much more accessible without the need to request specific support or information.

**Access and flow**

NEAS had a revalidation of C3 and C4 cases on a dispatch Stack procedure document which was effective from March 2018 and due for review in May 2019. The purpose of the procedure was to provide staff with information which enabled the safe management of the calls that were on the dispatch list. Welfare and re-assessment was done on C2 calls if the service were unable to send a resource within the ARP standard to review the patient and manage any associated risk to safety.

Ambulance cases were generated following a triage by either a call handler or clinician. During periods of high demand there could be periods where crews could not be allocated to cases within the timeframe recommended, those cases sat within the dispatch list in the EMS 999 system.

When there were more than two clinicians on duty in the operations centre, the staff would divide the dispatch list into geographical areas and each clinician would be responsible for the call back of all patients waiting for ambulances coded as C2/C3/C4 only, C1 cases were not to be revalidated.

For C2, C3 and C4 cases, the EOC clinician was responsible for contacting the patient/caller as soon as possible after the cases appeared on the dispatch list so that the information provided in the initial call could be revalidated. The purpose of the call was to establish if the patient’s condition had deteriorated which may have necessitated an upgrade to a higher level of response or if the patient’s condition had improved, in which case an alternative pathway of care may have
been arranged. From this revalidation, alternative transport options may be considered if safe and appropriate to use.

During inspection we reviewed a revised system for patients booked in by General Practitioners (GPs) and other health care professionals (HCP) which went live in May 2018. NEAS identified the majority of the calls came in between 12pm and 3pm and there were not sufficient resources to send a double crewed ambulance with a paramedic to all the calls. Many of the patients were suitable for alternate forms of transport especially if no interventions were needed on route to hospital.

NEAS aimed to improve responses to HCP urgent requests by prioritisation through use of additional triage information and reduction in waiting times for patients and by using transport options other than double crewed ambulances. We saw evidence that PTS vehicles were used as an additional resource to transport low acuity patients thereby freeing up urgent and emergency care ambulances.

Learning from complaints and concerns

Summary of complaints

Following the last inspection NEAS were given a must do action by CQC to continue to address the complaint and incident backlog and ensure systems and processes were put in place to prevent a re-occurrence.

During this inspection we found no evidence of a backlog of complaints which were being managed using systems and processes that had been put in place since the last inspection to prevent this. From June 2017 to May 2018 NEAS reported 58 complaints for the emergency operations centre at NEAS. The breakdown by subject and average number of days to complete and close is below:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Number of complaints</th>
<th>Average number of days taken to close</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Care</td>
<td>44</td>
<td>34</td>
</tr>
<tr>
<td>Values &amp; behaviours (staff)</td>
<td>14</td>
<td>22</td>
</tr>
<tr>
<td>Total</td>
<td>58</td>
<td>31</td>
</tr>
</tbody>
</table>

NEAS took an average of 31 days to close complaints related to the emergency operations centre. NEAS had stated that they have no trust wide target for closing complaints and close times are agreed for each individual complaint.

(Source: Trust Provider Information Request – complaints)

The Patient Experience Annual Report 2017/18 and Outlook Report 2018/19 were reviewed during inspection. The reports highlighted the highest volume of complaints were recorded by the EOC 999 hub. This service also received the lowest amount of formally logged appreciations.

EOC 999 received a total of 232 complaints and 27 appreciations for the financial year 2017/18. The most common theme of the complaints was timeliness of response. This related to where the complainant felt that the response time did not meet their expectations.
The EOC PTS service received a total of 71 complaints and 13 appreciations for the financial year 2017/18. The category of the complaints received most frequently was the timeliness of the response. No complaints for the EOC PTS service were in relation to quality of care provided.

EOC received a total of 83 complaints and 52 appreciations in relation to the 111/Northern Doctors Urgent Care. Quality of care was identified as the most common concern. Overall the main themes were around quality of care, quality of communication and staff attitude.

The lessons learned from the EOC complaints across all specialities showed that training refresher and human behavioural factors were the main reasons why complaints were made.

Specific call audits highlighted areas of concern and areas where a training refresher was required, both individually and for all the EOC staff. Along with one to one training refresher sessions, lessons learned were added to the NEAS intranet site for the whole of the EOC to see. This also included any training needs, clarity for any questions/supporting information errors, or to refresh the call handlers with the relevant information required to rectify the common mistakes.

During 2017/18 NEAS had implemented several organisational, departmental and individual changes because of learning from complaints. Listed below are several examples:

Urgent ring back standard operating procedure within EOC was re-written

THRIVE training (Threat Harm Risk Investigative Vulnerability Engagement) had been delivered to the EOC which allowed call handlers to assess the situation the patient was in and triage the response appropriately.

As a result of reported complaints linked with 111 triages, there was an increased number of clinicians in the EOC to attempt to cope with the surge in demand. This increased the level of ‘hear and treat’ to maximise appropriate ambulance usage.

As a result of reported incidents/complaints linked with 999 triages, call scripts had been initiated for the support of patients in making decisions about waiting for transports during periods of high demand. This was supported by the clinical hub.

To try and tackle demand, a team of Accident and Emergency consultants had been working with the EOC and provided additional support to those patients out of hours. They worked between the hours of 1600 and 2200 in the evening and at weekends.

A communications support guide was developed using NHS easy read images to assist staff when communicating with patient encountering communications difficulties.

A new process was developed to ensure that the batch trace on each service line (emergency care, patient transport and 111) was now matched to all the other service lines.

Secondment of a mental health lead ensured NEAS had a three year trust strategy, training and education plan and a sustainable model in relation to the management and support of patients living with mental ill health and enabled NEAS to continue to improve the support provided to patients and staff on an ongoing basis.

Improved complaints handling awareness for managers was delivered through essential management training.

A new “Complaints Handling Policy” had been developed which was much shorter and streamlined than the old one. This clearly set out what the intent and objectives behind the policy were and how NEAS planned to achieve them. The new policy, which was implemented in June
2017, was supported by a single, clear and user friendly procedure which had substituted the numerous procedures in force in the past.

Proactive cooperation between NEAS and the patient advisory and liaison Service (PALS).

During inspection we spoke with the patient experience manager who told us complaint performance information was included in NEAS’s quality dashboard. In addition, a monthly summary report was submitted to the quality and safety committee to review. We saw evidence of this.

The performance dashboard for August 2017 to August 2018 showed the percentage of complaints acknowledge by the patient experience team within three days was 98.3%. The percentage of complaints completed by the agreed date was 88.9%.

The patient experience team received complaints from numerous sources, recorded them on their computer based systems and identified an investigating officer, dependent upon which part of the service the complaint related to. The appointed investigating officer had to agree with the complainant a date for completion of the investigation and responding back to them with their findings. The patient experience team monitored and flagged any complaint response times which were over two months from the date the complaint was recorded on their systems. The purpose was to identify if this was in accordance with the wishes of the complainant and to identify if the extended time was because of the work capacity of the investigating officer and, if this was the case, to consider reallocating the complaint.

During inspection five completed complaint investigation files were reviewed. Four had been finalised and the complainant responded to before the agreed date. The other complaint had information that the agreed date had been extended in agreement with the complainant. The complaint had been finalised and the complainant responded to before the agreed revised date.

The patient experience manager told us of some recent work that had been undertaken in relation to complaints generated from EOC. It had been identified the two main reasons for complaints were timeliness responses and staff attitude. This information was shared with EOC staff and they were given a script to include at the end of each call to manage caller expectations. The result was a 30% drop in those type of complaints.

We saw evidence the complaint reports were a pro forma so each investigation was corporate. All patient experience finalisation letters were signed off by one of the executive team. The patient experience team was part of the national patient experience teams network. The network allowed sharing of best practice for local devolvement.
Is the service well-led?

Leadership

We saw evidence on a spreadsheet of the visibility of the NEAS chair and the six non-executive directors between April 2017 and June 2018 which showed their attendance at national events, attending various meetings and departments within NEAS including EOC.

We saw evidence in the quality improvement report 2017/18 that, following discussion with the board of directors, the council of governors, patient representatives and clinicians, a number of priorities for 2018/19 had been set. Consideration had been taken of the feedback received from patients, staff and the public. Presentations had been made at a range of forums providing the opportunity for those attending to comment on priority topics.

The report also outlined how progress against the priorities would be monitored through the quality governance framework and reported to the quality governance group and quality committee.

We saw evidence NEAS had a fit and proper persons procedure which outlined how NEAS would apply the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 5: Fit and Proper Persons (Directors).

The regulation applied to executive and non-executive directors, including permanent, interim and associate positions. The procedure had been effective since February 2016 and was due for review by February 2019.

Vision and strategy

NEAS had a robust vision and strategy across all the services they provided including EOC. We saw evidence EOC managers were involved in delivering the vision and strategy at an operational level. The delivery of the strategy and vision by EOC is monitored through the various governance meetings.

There was evidence NEAS values had links to recruitment, induction, appraisal, talent management and grow coaching, which was the NEAS internal skills coaching process, within EOC.

The NEAS five strategic priorities and three strategic aims for 2017/19 were included in the governance of EOC.

The NEAS quality strategy supported the strategic aims by ensuring delivery of high quality patient focused care, by staff who were skilled and supported in their role and that the best models of care had been developed to meet the needs of patients, particularly around delivering care at or closer to home.

The Quality Strategy had five overarching aims which managers in EOC were aware of and were responsible for delivering. The aims were:

- No preventable deaths (patient safety)
- Continuously seeking out and reducing patient harm (patient safety)
- Achieving the highest level of reliability for clinical care (clinical effectiveness)
• Deliver what mattered most: work in partnership with patients, carers, and families to meet their needs (patient experience)

• Deliver innovative and integrated care at or closer to home, which supported and improved health, well-being and independence (patient safety, clinical effectiveness and patient experience)

NEAS had four priorities for improvements for 2018/19 which were also areas EOC managers had incorporated into the auditing and quality reviews of calls. The four priorities were:

• Early recognition of treatment of sepsis. The aim of this priority was to build on the progress made as part of the 2017/18 sepsis quality priority to improve the early recognition of sepsis; particularly in children and pregnant women and to continue to improve awareness amongst clinical staff of the signs of sepsis and enhance the clinical effectiveness of care provided through adherence to the sepsis care bundle.

• Cardiac Arrest. The aim of this quality priority is to improve the support provided to clinicians on resuscitation and therefore improve the quality and outcomes for patients.

• Longest Waits for patients who fall. The aim of this priority was to ensure that those patients over 65 years who have fallen and were in the C4T response category did not come to harm because of the wait and their experience of the service was positive.

• Improving the care of patients with mental health needs, through improving staff knowledge and skills. The aim of this priority was to improve the knowledge and skills of frontline paramedics when dealing with mental health issues by providing high quality education and information to support them in practice.

We saw evidence NEAS had a Clinical Strategy 2016/20 produced by the medical director and consultant paramedic with contributions from the director of quality and safety as well as other directorates. The aim of the strategy was to:

• Provide the best care in services.

• Provide care based on the patient’s individual needs.

• Make it easier, as well as quicker, to access emergency and urgent care

• To get the right balance between highly specialist care where it was needed and more local care where appropriate

• Have a role in encouraging healthier communities and individuals

Within the strategy there was specific reference to specialist practitioners (operations room) who were nurses or paramedics working in the EOCs within both the 999 and 111 services which provided support both to staff managing challenging or complex calls, and to staff who were with a patient where care needs are complex.

Culture

NEAS had an equality strategy for 2016 to 2020 with a vision which was, ‘unmatched quality of care, every time we touch lives’. It had been developed considering of NEAS under the requirements of the Equality Act (2010), their public sector equality duty and encompassed the national NHS Equality Delivery System 2 (EDS2) and other mandated responsibilities.

The equality objectives in the strategy were to:
• Improve the consistency and accessibility of services and information for patients.
• Encourage patients from all diverse groups to provide feedback on their experiences of our services and improve positive responses.
• Promote equality and inclusion through enhanced involvement of the community and stakeholders.
• Develop a modern and diverse workforce that was inclusive and representative of the patients NEAS delivered services too.
• Ensured NEAS leadership is committed to creating an environment that promoted and valued equality and diversity which would be embedded in all aspects of the service.

NEAS had a diversity fact sheet which provided staff with information to make them aware of cultural and disability issues to be considered when dealing with calls. The guide covered; carers, age, ethnicity and culture, language, marriage and civil partnerships, pregnancy and maternity, faith, religion and belief, sexual orientation, gender reassignment, assistance dogs, disability, mental health, deafness/hearing impairment, blindness/visual impairment, learning disability, autism and dementia.

Staff we met were positive about the culture in NEAS. Staff spoke of feeling valued and being part of something worthwhile within the region. They also talked about the ability to build positive relationships with directors who were approachable and as a team everyone was committed.

Staff we spoke with told us NEAS supported their well-being. We were told of a mental health awareness week where there was a different element each day. Operational staff expressed some concerns that events were aimed at headquarters staff and they weren’t given time to attend.

Staff spoke positively about occupational health, quote, “They are fantastic”.

Staff told us team leaders supported them and asked if they needed some time out after a difficult call and, if clinicians realised staff were on a C1 call, they would come over and stand them down and provide support.

NEAS had a HR helpline which was available Monday - Friday 8am - 5:30pm where staff could access information, help and support.

Staff told us there was no halal food in the canteen and chips and the pork sausages were cooked in the same pan. We were told one Muslim member of staff did not know this and ate the chips. Staff expressed a view that NEAS needed to be more aware of diversity.

**Governance**

The EOC sat within the operations directorate. The strategic head of the EOC reported into the deputy chief operating officer alongside the strategic heads of operations for north and south. All three strategic heads met bi-weekly to ensure smooth operational delivery and to discuss cross area issues. All three also met monthly with the deputy chief operating officer with representatives from support services at a joint monthly business meeting.

The strategic head of the EOC also sat on NEAS senior management team, called “The Huddle”, which met weekly after the executive team meeting to ensure that the work priorities aligned with the corporate plans and strategic direction agreed by the executive team and trust board.
A weekly EOC senior management meeting was held every Tuesday, where support services such as HR, patient experience, finance and the information management team attended to discuss and work through issues relevant to the EOC service lines and to pick up any issues brought forward from “The Huddle”.

The section managers met weekly with a standard agenda. Each section manager was required to provide an overview of progress against KPI’s, items for discussion, items for assurance and issues that needed to be escalated to the risk register.

The output from these meetings informed the EOC report to NEAS’s monthly delivering consistently meeting, attended by representatives of the senior management team. This meeting was an opportunity to share, with the directors, progress against key objectives and highlight areas of concern that needed to be escalated.

During inspection the minutes of the private board of directors meeting for March, April and May 2018 were reviewed. All the meetings were well attended and included representation from EOC managers. There was a set agenda covering assurance from board committees, performance, strategy planning and policy and regulatory. After the set agenda other business items were discussed.

We saw evidence the terms of reference of the clinical advisory group (CAG) had been regularly reviewed the last time being March 2018. The document outlined the aims of the meeting which were:

- To provide assurances to the quality committee of NEAS board that best evidence was applied in clinical protocols, guidelines and practices.
- Members would provide medical opinions and advice to NEAS, maintaining an essential clinical link to healthcare facilities in the area serviced by the NEAS trust.
- To ensure NEAS’s compliance with legislative, mandatory and regulatory requirements (in terms of the group’s scope).

The document listed the meeting membership.

The minutes of the CAG for October and December 2017 and May 2018 were reviewed. The meetings were well attended and there was a clear audit trail of actions and follow up.

**Management of risk, issues and performance**

We saw evidence NEAS had a major incident plan which detailed what a major incident and a critical incident were. The plan had identified command and control structures with defined roles and responsibilities for staff. The plan was effective from 24 November 2017 and due for review 1 October 2018.

Following the last inspection NEAS were given a should do action by CQC to ensure all relevant staff had received appropriate major incident training. During this inspection we saw evidence staff had received major incident training including training in command and control roles which enabled staff to complete the actions required in the NEAS major incident plan.

Major incident training for health advisors was delivered during the 999-conversion course when staff were upskilled from 111 to 999. To date this training had been delivered to all health advisors who completed their conversion course. During inspection we saw evidence the provider delivered
initial operational response (IOR) training to all 111 staff. The number of staff trained was 110. The training covered the response to chemical, biological, radiological or nuclear incidents (CBRN).

Communication Support Operators who were new to the service and joined NEAS between January and April this year had received the following training, IOR, marauding terrorism firearms attack (MFTA) and a visit to HART with an input from the divisional educational lead. Communication Support Operators who joined NEAS after April this year had received the following training, IOR, the Joint Emergency Service Interoperability Programme (JESIP) which covered major incidents where multi-agency responses were needed eg firearms, police, fire and terrorist incidents, and a visit to HART with an input from the divisional educational lead.

Training figures provided by the trust showed between January to April four members of staff had received the training and from April to the present six members of staff had received the training.

At the last inspection there had been concerns regarding the resilience of dispatch at NEAS. Dispatch was located at Bernicia house only and in the event of system failure to dispatch or Bernicia house not being able to facilitate dispatch services, staff told us they would move the dispatch team to Russell House. This would take around 20 minutes and dispatch would use radios from the car park during that 20 minutes to manually dispatch ambulance crews.

During this inspection we spoke to the business continuity manager in relation to this. We saw evidence NEAS contingency plan was to use an NHS building next to Bernicia House to deal with C1 or C2 calls. The C3 calls would be picked up at Russell House.

NEAS also had another option of using a facility at West Denton Fire Station if both Bernicia House and the NHS building next door were inoperable.

We obtained evidence of all the live testing and planned tests that had been carried out to test the time it took to move and be set up ready to deal with calls. The tests were done at differing times and with different teams. The average time to move buildings and set up to dispatch ambulance crews was on average seven minutes which was an improvement on the previous 20 minutes found at the last inspection.

During the inspection 14 planned tests and eight live tests were reviewed each had a report for the executive board with lessons learned and improvements identified if appropriate. Additionally, we observed a live test and a walk-through test during our inspection. Within the live test, we observed that from the start of the live test to the dispatch of an ambulance, it took less than eight minutes and staff were very familiar and experienced in undertaking this procedure. However, during the walk through, some difficulties were experienced with the member of staff logging onto the system. This was due to user error rather than system error as this member of staff ordinarily would oversee the procedure rather than undertake the operational implementation of it.

Managers told us funding had been agreed to establish a permanent dispatch function at Russell House. To achieve this had meant increasing staffing establishment by 6 wte. In addition to establishing the creation of a specialist dispatch desk to enhance the utilisation of alternate resources across the region, it would provide resilience to the dispatch function at Bernicia House in case of service disruption in that building. By always having dispatch capacity in Russell House, this would negate the need to have team one move to Waterfront 4 (next door to Bernica House) and have a seven minute dispatch lag. This would be enough to keep critical dispatch going whilst staff transferred location to restore full dispatch capacity. In addition to that the trust had secured funding to move the “mirror” server away from the main server at Bernicia House’ During inspection we went to Russell House and saw an area with desks and computers were set up
ready to go live once the computer servers were installed. The managers we spoke with all knew about the installation which was progressing without delay.

We reviewed six operational orders in relation to four large public events and two covering periods of high demand over bank holiday periods. All the orders were detailed and clearly outlined roles and responsibilities of NEAS staff.

NEAS had a quality and risk framework which was supported by a number of key meetings where the EOC senior management team were represented including:

- Quality governance group
- Serious incident review group
- Patient safety group
- Experience complaints litigation incidents PAL’s
- Clinical effectiveness group
- Clinical advisory group
- Executive risk management group
- Finance committee
- Information governance
- Workforce planning and development

Risks were identified through a range of sources including staff feedback, NEAS 07’s, complaints and Family and Friends Test. Information was monitored and reviewed and appropriate actions taken at the weekly senior management meeting. Any issues that needed to be escalated were done so via the appropriate committee. EOC was represented at the executive risk management group.

The risk register risks were split down to EOC and service level.

We saw evidence that the terms of reference of the clinical advisory group (CAG) had been regularly reviewed, the last time being March 2018. The document outlined the aims of the meeting which were:

- To provide assurances to the quality committee of NEAS board that best evidence was applied in clinical protocols, guidelines and practices.
- Members would provide medical opinions and advice to NEAS, maintaining an essential clinical link to healthcare facilities in the area serviced by the NEAS trust.
- To ensure NEAS’s compliance with legislative, mandatory and regulatory requirements (in terms of the group’s scope).
- The document listed the meeting membership.

NEAS held clinical review meetings however these meetings were not minuted. Any cases brought individually to the clinical review group were updated on a clinical review template. The meeting was a forum whereby the facts of each case would be discussed and agreement reached if the case met the criteria to be recorded as a SI. The rationale for the decision was also recorded.
Any patient safety incidents which were recorded as moderate harm and above had a high-level review, including the duty of candour requirements and the relevant information was updated live on a NEAS computer system.

During inspection we reviewed eight clinical review meetings meeting records relating to EOC incidents. All had a clear auditable trail covering a description of the incident and the decision making around whether the incident was an SI or not.

**Information management**

NEAS had an information governance policy which was effective from December 2017 and due for review in December 2020. Managers we spoke with in EOC were aware of the policy and how to access it through the NEAS intranet site.

The policy outlined NEAS’s intentions and approach to fulfilling statutory and organisational responsibilities in relation to information governance. The information in the policy enabled staff to make informed decisions, comply with relevant legislation and help deliver NEAS’s aims and objectives.

The policy complied with the applicable laws and standards.

NEAS had a records management policy which had been effective since March 2018 and was due for a review in March 2021. Managers we spoke with in EOC were aware of the policy and how to access it through the NEAS intranet site. We saw evidence the policy was followed in relation to the quality assurance systems in the EOC which included security of patient records and how information was limited to key staff who had access to offender flag information. The flags did not refer to an offence but provided an overview on the risk e.g. knives, drugs, alcohol.

The policy outlined the approach to records management. The aim of the policy was to ensure that the record in whatever form it took was accurate, reliable, ordered, complete, useful, up to date and accessible whenever it was needed.

The policy covered the management of records and not the detailed requirements of what a record should contain for either corporate or clinical use. The policy covered all sites and systems operating and utilised by NEAS and applied to any individual employed, in any capacity, by NEAS and any volunteer or contractor who held a NEAS domain account.

NEAS had a records management initiative linked to “strive for excellence’ by streamlining the process and initiating a number of cost saving measures. It also improved patient experience and aided in serious incidents investigations, thereby facilitate learning. During inspection we reviewed the records management status reports for May, July and September 2018. The reports highlighted progress toward the overall aim of the project.

This policy covered the management of all documents and records, in all technical or physical formats or media, created or received by NEAS in the conduct of its business activities.
During inspection we saw evidence of weekly manager meetings with the head of EOC. The meetings had a set agenda which included inputs from:

- Monthly finance team
- Patient experience team
- IMT
- Information from the governance quarterly meeting
- Informatics which reviewed weekly information requests which required approval.

**Engagement**

Managers we spoke with told us historically it had been difficult to have the ability to alter the EOC shift system.

NEAS recognised consultation and engagement with the unions and staff played a pivotal role in the design of new rosters to enable staff to have a direct input into their future shift patterns to overcome the difficulties previously encountered. NEAS utilised the support of a rostering company who had a proven track record in implementing roster changes, particularly in ambulance services.

At the time of the inspection, managers told us the consultation process had concluded and proposed shift patterns resulting from the consultation had been shared with staff to receive feedback before seeking final agreement.

We saw evidence NEAS had developed an action plan following the 2017 staff survey. The action plan had an overall aim to improve the overall staff engagement score. The action plan was split by 11 themes with key actions, action owners, progress update and dates for completing actions as follows:

- **Leadership and Management:** To continue to make improvements in leadership and management scores throughout survey
- **Errors and incidents:** Continue to ensure that all staff were aware of the policy for raising concerns about unsafe practice and that their concern would be treated seriously, openly and transparently. Ensure that all staff involved in an adverse event were treated fairly and consistently.
- **Job Satisfaction:** Increase trust scores relating to involvement of employees in important decisions and acting on staff feedback. Work directly with staff groups to understand why some would not recommend the organisation as a place to work or receive treatment.
- **Appraisals and Support for Development:** Maintain and build on completions of appraisals. Make improvements to the quality and effectiveness of staff appraisal/performance reviews;
- **Communication between Staff and Managers:** Improve scores around communication between senior management and staff. Involve staff in important decision making processes.
• Health and Wellbeing: Continue to improve scoring in relation to staff health and well-being questions.
• Patient care and experience: Increase the percentage of staff who receive regular feedback on patient experience.
• Violence, Harassment and bullying: Reduce the percentage of staff/colleagues reporting most recent experiences of harassment, bullying or abuse
• Equality and Diversity: Increase the percentage of staff believing that the organisation provided equal opportunities for career progression or promotion. Analyse the actual numbers of staff who felt they had been discriminated against. Identify areas that had increased numbers and take action e.g. training on policies
• Working Patterns: Provide more opportunities for flexible working patterns to improve scores.
• Quality and Improvement: Implement the involvement of staff at all levels in improvement work where appropriate.

At the time of the inspection many of the actions were still live.

Staff we spoke with, some of whom had been in staff focus groups following the staff survey, expressed a view that not much had changed since last year.

We were told that staff had fed back they did not know who the executive team were. The executive team responded by increasing their visibility and spending time with operational staff.

There was evidence from the staff survey, EOC had the highest response rate. Managers told us a new suggestion box for staff had been provided for staff, there had been managers events to identify solution to the issues arising from the staff survey and use of the ‘You said, we did’ response to feedback.

Managers did identify a problem with the work life balance of the staff engaging with call handlers because they were not in teams and set shifts whereas the other groups such as dispatch were team based which gave more opportunity for feedback and sharing information. At the time of the inspection the shifts for call takers was under review to identify a method to overcome this, setting up both services with the same team structures and improving work life balance. During inspection we reviewed the August 2018 training newsletter which was circulated to all EOC staff. The letter contained information and guidance in relation to delivering and negotiating dispositions, palliative care transport on urgent calls and auditing.

Learning, continuous improvement and innovation

The quality risk and safety manager informed us that work had been done in relation to restorative justice with youth offender teams where NEAS staff had spoken to groups of young offenders about impact of frequent calling.

We were also told of a new project commencing in October 2018 with staff training on use of body worn cameras which would be activated when attending flagged calls or when there was a threat or use of violence. The footage would be used to improve and update risk assessments as well as patient flags which EOC used.
NEAS was exploring how improvements could be made using remote visual assessment by ambulance crews using Skype and cameras to seek real time clinical advice from EOC linked to the electronic patient clinical records (EPCR) on crew computer tablets.

Work was ongoing exploring the possibility of NEAS providing nursing homes with computer tablets to enable staff to provide real time footage of elderly patients to assist in the clinical assessment process and to ensure the correct resource was allocated.

NEAS had a document on their intranet called 90 improvements which outlined to staff improvements and innovations that had been made to the service. The document was a living document which could be added to. There were 20 improvements highlighted which had been made in EOC.