North West Ambulance Service NHS Trust

Quality Report

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

Ratings

Overall rating for this trust	Requires improvement
Are services at this trust safe?	**Requires improvement**
Are services at this trust effective?	**Good**
Are services at this trust caring?	**Good**
Are services at this trust responsive?	**Good**
Are services at this trust well-led?	**Requires improvement**

Summary of findings

Letter from the Chief Inspector of Hospitals

The North West Ambulance Service (NWAS) NHS Trust is one of 10 ambulance trusts in England and provides emergency medical services across the North West region, which has a population of around 7, 052,000 million people. The trust employs 5,409 whole time equivalent (WTE) staff who are based at ambulance stations and support offices across the North West.

The trust has 109 ambulance stations distributed across the region, three emergency operations centres,one support centre, three patient transport service control rooms, and two Hazardous Area Response Team (HART) buildings (one being shared with Merseyside Fire & Rescue).

The trust also provides, along with Urgent Care and out of hours partners, the NHS 111 Service for the North West Region. Operating from five sites across the North West, in Greater Manchester, Merseyside and Lancashire and Cumbria.

We last inspected this trust between 19 and 22 August 2014 for the announced element of the inspection, and the unannounced inspection visits took place on 26 and 27 September 2014. As the first ambulance trust inspected under the new model, the trust was not rated as part of this inspection. Additionally the 111 service was not inspected at the time of this previous inspection. We told the trust that they must make improvements to:

- Review the process for pre-alerting hospital accident and emergency departments to make sure that communication is sufficient for the receiving department to be made fully aware of the patient's condition.
- Make sure that emergency operations centre staff across all three emergency operation centres (EOCs) are consistently identifying and recording incidents as appropriate.
- Make sure dosimeters (that measure exposure to radiation) on vehicles are in working order.
- Improve access to clinical supervision for all clinical staff.
- Review medicines formulary guidance issued to front-line staff to make sure it is current.
- Ensure that all staff are receiving the mandatory training necessary for their role.
- Ensure that all staff across all divisions are consistently receiving appraisals.

Before carrying out this inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the Ambulance Service. These included clinical commissioning groups (CCGs); NHS Improvement and the local Healthwatch.

We carried out our announced focused inspection of NWAS between 23 and 26 May 2016, with an unannounced inspection taking place on 6 June 2016. We carried out this inspection as part of the CQC's comprehensive inspection programme.

We inspected three core services:

- Emergency Operations Centres
- Urgent and Emergency Care
- Patient Transport Services

We also inspected the NHS 111 service provision during this inspection.

Our key findings were as follows:

Leadership and Culture

- There were regional variations in the culture both across the trust as a whole and within regions. Staff in some areas felt very positive about the culture, but in other areas they felt there was a high degree of pressure and that focus was on performance targets rather than care for patients.
- The Chief Executive Officer had recently commenced in a substantive post on 10 May 2016, following a period of covering the post as an interim, from March 2016.
- The urgent and emergency care service has had a clinical leadership model in place since 2012, with more focus on clinical quality than was previously the case. The leadership model includes a Consultant Paramedic in each area and advanced paramedics in each sector. The structure has been reviewed recently and the operational and clinical team leader roles are in the process of being merged.
- Staff reported that the new clinical leadership structure with senior paramedics assuming a combined management and clinical leadership role

was a positive development. This change had been well received as it provided clearer lines of reporting and less confusion, at the stations where it had already been implemented.
- Staff felt that leadership from heads of service was strong and visible. Heads of service and sector managers had been supported to develop their leadership skills with attendance at higher education courses.
- In Liverpool many of the staff said that staff morale was affected by the building which was cramped with teams located in different rooms.

Staffing

- There were staff vacancies across all areas of the urgent and emergency care service and the overall vacancy rate was 5.7%.
- Staff vacancy rates in North Cumbria were the highest in the trust with 35 vacancies, which represented 20%. The paramedic vacancy rate in this area was 16.7%. One of the initiatives to manage this deficit was the employment of paramedics from other countries. Two paramedics from Europe had worked in Cumbria for some time. The trust had employed 35 new European paramedics in Greater Manchester at the time of the inspection. There were plans to recruit a further 36 with 24 of these being appointed to North Cumbria.
- A high proportion of vacancies related to band five paramedics. A total of 15.7% whole time equivalent (WTE) posts for this role were vacant at the time of our inspection across all areas. This reflected a national shortage of paramedics. Eight seven paramedics had been recruited between 1 April 2016 and June 2016.
- The staff turnover rate for the 2015/16 period for the service was 7.2%. The trust was looking at new ways to recruit paramedics to fill these vacancies. This included progression programmes for their EMT staff and also international recruitment. The trust's human resources department was working with managers on developments to improve the retention in Cumbria where rates were higher at 11%. This included the consideration of relocation packages.

Records

- Information relating to patients' care and treatment was recorded on patient record forms (PRFs) which were paper based forms in a duplicate book. This meant the ambulance service could maintain their own record and also supply one copy to the hospital or patient, depending on whether the patient was conveyed to hospital. They also had one copy without patient identifiable information to use for audit purposes.
- We reviewed 236 PRFs within urgent and emergency care. We saw that, in 218 of these cases, the records were completed in legible handwriting, were signed and dated and the history of the patient incident, treatment provided, medicines administered, assessments of pain and observations were completed.
- There was a limited amount of free text space available to record a full history and clinical assessment. If there was not enough space to complete all details, a second PRF would be completed. Some staff felt a continuation sheet would be beneficial but others told us there was enough space to document all necessary details.

Governance and Risk Management

- The quality committee met every two months and discussed areas, such as risk and mitigation, safeguarding, response times, complaints, incidents, medicine management, infection prevention, quality improvement and National Ambulance Clinical Quality Indicators. This meant that the executive team only got oversight on these quality areas every two months.
- Due to the length of time it took the trust to investigate and conclude serious incidents, the board did not have a full overview of the reporting and monitoring of serious incidents. This meant there was no monitoring of how quickly serious incidents were reported, timescales for investigations and how quickly actions were implemented following the outcome of the investigation. Serious incidents regularly took longer than the 60 day timeframe (set by NHS England in the serious incident framework) to investigate and conclude.
- There was a trust-wide risk register in place which recorded all operational risks with a score of 12 and above. There was evidence that the register was reviewed and updated regularly. However, there were some improvements required. In particular, some risk descriptions did not clearly describe the risk; some of the information recorded under controls and assurance were not actually controls or sources of assurance; there was no target rating for risks on the

Summary of findings

risk register, meaning it was unclear what level of risk the trust was aiming for, and there were a number of risks without actions identified to mitigate the identified risk. Additionally a significant number of risks had been on the risk register for a number of years with little evidence of progress or impact being reported. In addition local risk registers were not totally aligned to the trust wide risk register.

We saw several areas of outstanding practice including:

- The Hazardous Area Response Teams (HART) in both Manchester and Merseyside were delivering an excellent service to patients. They were proactive in their approach to gaining new skills and forging relationships with other emergency services, to ensure the smooth running of rescues in difficult areas. Their co location with the fire service training headquarters in Merseyside afforded them and all NWAS staff excellent and unique training opportunities. This ensured that they were equipped to deal with and manage a wide range of hazardous emergencies and undertaken formalised de briefs in a multidisciplinary manner.
- The service had community care pathway designed to share information across services and ensure ambulance clinicians were aware of pre-existing care plans for patients being managed by community services. This included when it was most appropriate for patients to be treated at home, involving other professionals or conveyed to an alternative care setting than an emergency department. This was also supported in some areas by the long term conditions teams based at local hospital trusts.
- The community engagement manager was in the process of implementing an electronic application initiative called 'Good SAM'. This application could be downloaded onto mobile devices and alerts users who have been vetted and checked to a nearby cardiac arrest. Through this initiative the manager had also mapped all defibrillators in the North West area and from August 2016, this information would be available to call centre staff so that they could direct members of the public attending cardiac arrests to these devices.
- All staff we observed were exceptionally caring in their approach and went above and beyond their duty to provide compassionate, supportive care.

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

Importantly, the trust must:

Trust wide

- Ensure the consent policy and guidance on mental capacity assessments issued to staff is in line with the Mental Capacity Act (2005) code of practice.
- Ensure they are compliant with the fit and proper person regulation when appointing both executive and non-executive directors.
- Ensure the complaints policy reflects timescales for investigations and ensure complainants are given information in relation to how to take action if they are not satisfied with how the trust has managed the complaint.

In Urgent and Emergency Care:

- The service must ensure staff are given adequate opportunities to report incidents and safeguarding issues.
- The service must ensure that staff are reporting all adverse incidents in line with NWAS policy.
- The service must ensure all staff receive the required level of mandatory training.
- The service must ensure that all staff receive the required level of mandatory safeguarding training and ensure that there is a mechanism to check that staff have completed this training.
- The service must ensure all community first responders have the required level of training to undertake their role including how to recognise and act on safeguarding issues.
- The service must ensure that vehicle log books are completed fully and that checks undertaken by managers reflect the true content of the log books.
- The service must ensure that all equipment used in the delivery of patient care is subject to the appropriate and required checks, including that held by the community first responders.
- The service must ensure that vehicles receive deep cleaning when required.
- The service must ensure that controlled drugs are stored, managed and checked in line with trust policy and national legislation.

Summary of findings

- The service must ensure that all staff involved in the administration of medical gases, for example Entonox, have received the required level of training to ensure they are competent to undertake this duty.
- The service must ensure there are adequate numbers of suitably qualified staff deployed in all areas.
- The service must ensure that all policies used in the delivery of patient care are reviewed and updated at the frequency required.
- The service must ensure that patients have timely access to care and treatment in line with national targets.
- The service must ensure all staff received their annual appraisal.
- The service must ensure all staff have received the required level of training to ensure they are able to exercise their duties in line with the Mental Capacity Act (2005).
- The service must ensure that the consent policy and guidance on mental capacity assessments issued to staff is in line with the Mental Capacity Act (2005) code of practice.
- The service must ensure that there is specialist equipment and training for staff to safely manage the care of bariatric patients.
- The service must ensure that staff received back up when requested in a timely way.
- The service must ensure that risks are appropriately documented, reviewed and updated.
- The service must ensure that any allegations of bullying are taken seriously and managed appropriately with support provided to the staff involved.
- Ensure that departmental risk registers are kept up to date and reviewed appropriately.
- Ensure that processes are robust and effective in relation to Safeguarding processes and procedures.
- Ensure compliance with the fit and proper person regulation.

In Emergency Operations Centres:

- The service must ensure that staff are reporting all adverse incidents in line with NWAS policy and ensure all staff have received appropriate training on the incident reporting system.
- The service must ensure there are robust processes for sharing lessons learned from incidents and complaints with staff across the three sites.
- The service must ensure that all safeguarding concerns are reported in line with the NWAS policy and must improve staff awareness of the safeguarding policy.
- The service must ensure all staff receive their annual appraisal.
- Ensure that risk registers clearly document short and long term risks local to each emergency operations centres (EOC) site as well as to the EOC service as a whole, including control measures that have been identified and implemented, and planned review dates.
- Ensure the clinical escalation plan is reviewed and updated.

In Patient Transport Services:

- The trust must ensure that investigation reports fully reflect the actions taken during an investigation and provide a summary of the root cause of the incident and the lessons learned, in line with trust policy.
- The trust must ensure patient information is kept confidential. The management of patient information provided to volunteer drivers did not promote confidentiality.
- The service must finalise its existing PTS structure and quality reporting framework to ensure that there is a clear oversight of escalation and monitoring of governance, risks and performance of the service.

In addition, the trust should:

Trust wide:

- Continue to monitor staffing levels and recruit sufficient frontline paramedic and other staff to meet patient safety and operational standards requirements.
- Review the duty of candour policy and ensure it fully reflects the regulation.

In Urgent and Emergency Care:

- The service should consider implementing systems to ensure that feedback from incidents and investigations is consistent and accessible to all staff including community first responders.
- The service should ensure that communication aids for patients with visual or mental capacity impairments are available.

Summary of findings

- The service should consider providing training to all frontline staff on the duty of candour and their responsibilities in relation to this.
- The service should consider ensuring that staff with level three safeguarding training are available for staff to access for advice and guidance.
- The service should consider providing training on key safeguarding subjects which crews may come across such as female genital mutilation, radicalisation recognition and human trafficking.
- The service should consider implementing a system to ensure the key codes to access keys in the ambulance stations are changed regularly.
- The service should ensure that all records are completed fully and legibly.
- The service should consider implementing a system by which all staff members creating a written record of patient care can sign the relevant sections patient record.
- The service should consider ways to improve staff compliance with the use of patient pathways and care bundles.
- The service should ensure that patients can be provided if necessary with information on how to feedback about the service.
- The service should ensure that complaints are dealt with consistently and in line with trust policy.
- The service should ensure that staff are aware of the trust vision and values.
- The service should consider implementing a more consistent way of monitoring of performance and quality across the regions.
- The service should improve staff engagement and address areas of low morale.

In Emergency Operations Centres:

- Improve EOC staff's skills in managing calls from children or from people who may have mental health problems, those who may be in crisis, and those living with dementia or learning disabilities.
- Improve communication across all EOC teams, including those working night shift patterns, of changes to procedures or announcements.
- Improve accessibility, and readability, of information transferred by the system to the EOC from NHS111, including the reduction of duplication of information.
- Raise awareness among all EOC staff on the trust's vision and strategy and how they can contribute to it.
- Consider how the environment at the Liverpool site can be improved, including what reasonable adaptations may be needed for staff who have reduced mobility.
- Review the policy for deploying the HART team and how it reflects the way in which the triage and dispatch system operates in practice.
- Review the use of the MPDS system in terms of the tools not being available when a second follow-up call is made.
- Review the Mental Capacity Act (2005) training for all staff.

In Patient Transport Services:

- The trust should consider facilitating ambulance crews to meet regularly to ensure new developments and lessons learned from local, trust wide and national incidents can be shared and discussed.
- The trust should explore that all recorded safeguarding incidents have been appropriately referred and that PTS staff are aware of what constitutes abuse or neglect and that they are all clear about the referral process.
- The trust should review the staff training requirements for the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) guidelines to provide a common understanding of how patients are cared for in accordance with their best interests.
- The trust should review its process for maintaining all vehicles in good visual repair and that rusty items are replaced as quickly as possible.
- The trust should review its process for reviewing and updating policies and procedures as appropriate.
- The trust should review the process for ensuring that DNACPR documentation travelling with the patient is in the appropriate format.
- The trust should review the process for responding to and investigating complaints to improve the timeliness of this procedure.
- The trust should review its process for including operational issues within a strategic overview or central risk register related to internal risks.
- The trust should review its PTS operating model to produce a formal vision and strategy for PTS linked to the overarching organisation vision and strategy.

Professor Sir Mike Richards

Summary of findings

Chief Inspector of Hospitals

Summary of findings

Background to North West Ambulance Service NHS Trust

The North West Ambulance Service NHS Trust was established on 1 July 2006 by the merger of ambulance trusts from Greater Manchester, Cheshire and Merseyside, and Cumbria and Lancashire.

The trust headquarters is in Bolton, and there are four area offices serving Cheshire and Merseyside (Liverpool), Cumbria (Salkeld Hall, Carlisle), Lancashire (Broughton near Preston) and Greater Manchester (Whitefield). The trust serves a population of seven million over 14,000 square kilometres. Services to this area are commissioned by 33 clinical commissioning groups; the lead commissioner is Blackpool Clinical Commissioning Group. The trust works with 39 NHS trusts, 46 local authorities, five police forces and five fire and rescue services.

At the time of our inspection, there were 109 ambulance stations, three emergency operations centres, one support centre, three patient transport services control centres and two Hazardous Area Response Team buildings – one shared with Merseyside fire and rescue. The trust operates around 1,000 vehicles on both emergency and non-emergency operations.

The trust receives over 1.3 million 999 calls each year, with emergency crews attending more than 952,000 incidents each year; around 800,000 of these need emergency transport. The trust undertakes over 1.2 million non-emergency patient transport journeys each year. It currently employs over 4,900 staff.

North West Ambulance Service provides an emergency department service to respond to 999 calls; an NHS 111 service for when medical help is needed but it is not a 999 emergency; a patient transport service (PTS), for nonemergency patients between community provider locations or their home address and emergency operation centres (EOC), where 999 and NHS 111 calls were received, clinical advice is provided and emergency vehicles dispatched if needed. There is also a Resilience and Hazardous Area Response Team (HART) and an air ambulance service.

Our inspection team

Our inspection team was led by:

Chair: Shelagh O'Leary

Head of Hospital Inspection: Nicola Kemp and Simon Regan (Inspection Managers)

The team included two CQC Inspection Managers, 11 CQC inspectors, an analysis, inspector planner, two assistant inspectors and a variety of specialists including: the National Patient Advisor for ambulance services, Senior Quality and Risk Manager, a non-executive director, Head of Safeguarding, Accident and Emergency Nurse, Paramedics, Interim Clinical Project Manager, Call Handler, a Pharmacist, Workforce Race Equality Specialist, a Commercial Services Director, Director of 111 NHS services, National Operations Manager, Emergency Operations Centre Manager and Clinical Educator in Ambulance Service.

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?

Summary of findings

• Is it responsive to people's needs?

• Is it well-led?

The inspection team inspected the following:

• Emergency Operations Centres

• Urgent and Emergency Care

• Patient Transport Services

Prior to the announced inspection, we reviewed a range of information that we held and asked other organisations to share what they knew about the trust. These included the clinical commissioning groups (CCGs), the Trust Development Authority, NHS England and the local Healthwatches.

We interviewed staff and talked with patients and staff from areas. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at North West Ambulance Services.

What people who use the trust's services say

- The trust participated in the 'hear and treat' survey for 2013/14. This survey looked at the experiences of over 2,900 people who called an ambulance service in December 2013 or January 2014. Responses were received from 263 patients for the North West Ambulance Service NHS Trust. Overall the trust was performing similar to other trusts that had taken part, with the exception of one question (If you had questions to ask ambulance staff did you have the opportunity to ask them?), which performed worse than other trusts.
- NHS Friends and Family test results indicated 95% of patients would recommend the service to others.

Facts and data about this trust

The trust receives over 1,170,000 emergency calls per year, with emergency crews attending more than 952,000 incidents each year, with around 800,000 of these requiring emergency transport. This represents approximately 16% of national activity. The trust undertakes over 1.2 million non-emergency patient transport journeys each year.

The trust employs 5162 whole time equivalent (WTE) staff.

The trust operates around 1,000 vehicles on both emergency and non-emergency operations. The trust has 109 Ambulance Stations, 35 being in the Cheshire and Merseyside area, 41 in the Cumbria and Lancashire area and 33 in the Greater Manchester area.

The trust undertakes over 1.2 million non-emergency patient transport journeys each year.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? We rated the trust as 'Requires Improvement' overall for safe. This is because; • Duty of candour was not fully reflected in the trust's duty of candour guidance, policies were not cross referenced and the description of incidents that required duty of candour consideration did not include those incidents where moderate or severe harm was identified within a complaint and so were not consistently applied. • The duty of candour procedure did not fully reflect the key performance indicators. • The trust as a whole performed worse than the national average for other ambulance services in the 2015 NHS staff survey for the percentage of staff reporting errors, near misses or incidents witnessed in the last month (NWAS 73%, average 79%). • Staff were aware of how to refer a safeguarding issue to protect adults and children from suspected abuse. However, staff in the Cheshire and Merseyside area told us they were given time to complete children's safeguarding referrals but not referrals for adult safeguarding concerns. They told us this subsequently discouraged them from referring adult safeguarding issues. • Within patient transport service (PTS), safeguarding concerns were often dealt with at a local level and not always reported for review through the safeguarding system; this meant additional steps could not be taken, if required. • Within emergency operation centres (EOC), the safeguarding policy was not embedded and not all staff were acting according to the policy by reporting safeguarding concerns directly to the support centre in Carlisle. • Community First Responders (CFRs) were not required to complete mandatory safeguarding training. CFRs were unclear about policies and procedures governing safeguarding referrals and were not issued with the same information as mainstream staff about how to identify potential abuse and progress a safeguarding concern or the identity of key contacts. • Within Urgent and Emergency care, we were told about incidents that had happened but were not reported. • There was limited evidence of systematic investigation or actions being put in place to ensure lessons were learned.	**Requires improvement** 

- There was a high proportion of vacancies relating to band five paramedics. A total of 16.2% whole time equivalent (WTE) posts for this role were vacant at the time of our inspection across all areas. This reflected a national shortage of paramedics. The trust reported that a total of 87 paramedics had been recruited between 1 April 2016 and June 2016.
- Log books used to record essential vehicle checks including infection control and prevention checks were not completed consistently and some vehicles were overdue for deep cleaning.

However:

- Incidents were reported via an electronic reporting system. All staff were able to demonstrate how they would report an incident and gave recent examples, including safeguarding issues and abuse by members of the public.
- There was evidence of organisational learning and improvement as a result of incident investigations.
- There was a clear trust wide safeguarding policy to follow and an action chart with guidance for staff to refer to readily available for staff to refer to in all ambulances.
- There was evidence that managers planned staffing while taking into account the skill mix and competencies of the staff on duty.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- The trust had a duty of candour procedure. However, duty of candour was not fully reflected in the trust's duty of candour guidance, policies were not cross referenced and the description of incidents that required duty of candour consideration did not include those incidents where moderate or severe harm was identified within a complaint and so were not consistently applied.
- The duty of candour procedure did not reflect the key performance indicators or define time-scales to apply the regulation.
- Staff knowledge and understanding of the duty of candour regulations was understood at department level; however there were limited examples of the regulation being robustly applied.

Safeguarding

Summary of findings

- There was a clear trust wide safeguarding policy to follow and an action chart with guidance for staff to refer to readily available for staff to refer to in all ambulances.
- Face to face safeguarding training was part of the two yearly mandatory training cycle. This training was supplemented by a workbook to be completed outside of face to face sessions. Staff within urgent and emergency care told us they were not given any additional time to complete the workbook and were not expected to submit the workbook for review or complete any form of assessment following the training. This meant that, although training rates were 87% within this core service, this figure may not reflect the true number of staff who had completed the workbook. The trust told us that staff were given 90 minutes of paid time to complete the workbook and that the workbook was an additional training resource and reference guide.
- Staff were aware of how to refer a safeguarding issue to protect adults and children from suspected abuse. Referrals were made via a call centre. Staff told us they were given time to make safeguarding referrals and were taken off the road to allow them to complete referrals. They told us the process was quick and simple. However, staff in the Cheshire and Merseyside area told us they were given time to complete children's safeguarding referrals but not referrals for adult safeguarding concerns. They told us this subsequently discouraged them from referring adult safeguarding issues.
- The intercollegiate document stated there should be access to a level three trained professional at all times. Staff had access to a senior paramedic trained to level two who could offer advice and guidance on issues of a safeguarding nature via the clinical hub; or to an advanced paramedic who was trained to level three, although at the time of the inspection we were told that this training was not up to date due to operation pressures. There were two professionals within the safeguarding team trained to level four who could also provide guidance and support during normal office hours, however the trust told us that these members of staff were not part of the clinical advice structure.
- The intercollegiate document also stated there should be access to a level three trained professional at all times. Staff had access to a senior paramedic trained to level two who could offer advice and guidance on issues of a safeguarding nature via the clinical hub; or to an advanced paramedic who was trained to level three, although at the time of the inspection we were told that this training was not up to date due to operation pressures. There were two professionals

within the safeguarding team trained to level four who could also provide guidance and support during normal office hours, however the trust told us that these members of staff were not part of the clinical advice structure. This meant that ambulance crews may miss key opportunities to safeguard children or adults from abuse.

- Community First Responders (CFRs) were not required to complete mandatory safeguarding training and this aspect of training relied on attendance at non-compulsory training days organised by volunteer trainers which was not quantified. CFRs were unclear about policies and procedures governing safeguarding referrals and were not issued with the same information as mainstream staff about how to identify potential abuse and progress a safeguarding concern or the identity of key contacts.
- Within patient transport service (PTS), safeguarding concerns were often dealt with at a local level and not always reported for review through the safeguarding system; this meant additional steps could not be taken, if required.
- Within EOC, the safeguarding policy was not embedded and not all staff were acting according to the policy by reporting safeguarding concerns directly to the support centre in Carlisle.

Incidents

- Incidents were reported via an electronic reporting system.
- The trust had seen a gradual decline in the number of incidents being reported, between August 2015 (406) and January 2016 (311). Within this reporting period April 2016 and January 2016, 3490 incidents had been reported across all services. Of these incidents, eight had met the criteria to be reportable on the Strategic Executive Information System (StEIS). However, the severity of the majority of incidents reported were categorised as no or low harm.
- The trust as a whole performed worse than the national average for other ambulance services in the 2015 NHS staff survey for the percentage of staff reporting errors, near misses or incidents witnessed in the last month (NWAS 73%, average 79%).
- All staff were able to demonstrate how they would report an incident and gave recent examples, including safeguarding issues and abuse by members of the public. However, staff within EOC, did not receive training in the electronic incident reporting system as part of the induction or mandatory training. Not all call handling staff had direct access to the reporting system.

Summary of findings

- Within Urgent and Emergency care, we were told about incidents that had happened but were not reported. The Greater Manchester Hazardous Area Response Team (HART) team gave examples of where they were not requested to respond to calls and subsequently had feedback which identified their skills would have been appropriate to use, or where they had been deployed to calls with delays
- Some staff told us they felt they were not given sufficient time to undertake their incident reporting duties. We found that, not all staff were given protected time to undertake incident reporting and were expected to do this while on the road or on their meal breaks. The service lead told us they were aware of concerns from staff regarding this and, in response, were planning to implement computer screens at acute hospitals in the Cheshire and Merseyside area so that staff could have protected time to report incidents. However, although staff in the other localities raised similar concerns, there were no similar plans in place.
- Individual station managers had information about reported incidents in their area and the progress towards investigation. In one station there were 24 open incidents, the longest of which had been under investigation since October 2015. Incidents were discussed at senior management meetings, however we found there were no references to the number of incident reports left open.
- There was evidence that individual incidents were being managed appropriately at a local level, but limited evidence of systematic investigation or actions being put in place to ensure lessons were learned. This meant that similar types of incidents were recurring. For example, there were 649 incidents for patient transport services (PTS) reported between 1 April 2015 and 20 May 2016. Of these, 237 had nothing documented in the 'actions taken (investigation)' column of the report submitted to us by the trust, despite 18 of them being categorised as either moderate or major.
- Although the trust told us there was a formal process for sharing learning from incidents between the three EOC sites and across the trust as a whole; staff we spoke with were unaware of learning being shared between the three sites.
- Regular and single issue bulletins were produced by the trust in order to keep ambulance staff informed of safety issues, changes and developments in the service. We reviewed 10 different types of bulletins covering January 2015 to May 2016 and these did not provide information about lessons learnt from incidents that had been reported by staff.

- Joint reviews of incidents took place with partner organisations such as other trusts, the police, the fire service, and the coastguard. We saw one example of a joint review with two other trusts following the death of a patient and another joint review with a prison following the death of an inmate.

Staffing

- Staffing ratios and establishments were calculated using an electronic programme that used historical information about demand for services to plan what level of staffing was required. Rotas were compiled by administrative staff four weeks in advance.
- There were staff vacancies across all areas of the urgent and emergency care service and the overall vacancy rate was 5.7%. Vacancy rates varied across geographical areas with the highest rate in Greater Manchester at 7.3% of posts vacant at the time of the inspection, 4.6% of posts were vacant in the Cumbria and Lancashire area and 5.3% of posts were vacant in the Cheshire and Merseyside area.
- Staff vacancy rates in North Cumbria were the highest in the trust with 35 vacancies, which represented 20%. The paramedic vacancy rate in this area was 16.7%. One of the initiatives to manage this deficit was the employment of paramedics from other countries. Two paramedics from Europe had worked in Cumbria for the past few months and 24 more had been employed by the trust. Managers in Cumbria had requested the majority go to work in that area.
- A high proportion of vacancies related to band five paramedics. A total of 16.2% whole time equivalent (WTE) posts for this role were vacant at the time of our inspection across all areas. This reflected a national shortage of paramedics.
- The staff turnover rate for the 2015/16 period for the service was 7.2%. The trust was looking at new ways to recruit paramedics to fill these vacancies. This included progression programmes for their EMT staff and also international recruitment. The trust's human resources department was working with managers on developments to improve the retention in Cumbria where rates were higher at 11%. This included the consideration of relocation packages.
- Within EOC, on 1 March 2016, Liverpool had 62.3 whole time equivalent (WTE), Preston had 54 WTE and Manchester had 102.4 WTE call handling staff in post, with 9.3 WTE vacancies in Liverpool, 3.4 WTE vacancies in Preston and 16.5 WTE staff over the establishment level in Manchester.

Summary of findings

- Within EOC, on 1 March 2016, Liverpool had 52.8 WTE dispatchers with 0.3 WTE vacancies, Manchester had 59.6 WTE dispatchers in post with 5.9 WTE vacancies and Preston had 45.9 WTE dispatch staff with 10.7 WTE vacancies.
- Within PTS, there was a 12% whole time equivalent (WTE) vacancy rate for front line staff, which meant that, of the baseline number of 168 ACAs established in March 2016, there were 464 in post and 56 vacancies. The staff we spoke with reported no issues regarding staff shortages. ACA staffing was supplemented by an operational bank and recruitment to permanent posts was ongoing.
- The vacancy rate within PTS for control staff was around 29% in March 2016. Control staffing was supplemented by agency staffing which did not show in these figures. This was being maintained until the impact of the new contract was seen in call demand profiles.
- The turnover rate for PTS frontline staff was around 5% between April 2015 and February 2016, and a similar rate between 1 April 2015 and 31 March 2015.
- Information provided by the trust showed, at 1 April 2016, 51% of full time staff were paramedics, senior paramedics or assistant operations managers. Data showed that 41% were technicians (EMT staff) and 6% were urgent care staff. Data also showed that, in a three month period between 1 February and 1 May 2016, attendance at calls by emergency ambulances had between 44% and 55% paramedic crews with the remainder being attended by technicians.
- On rapid response vehicles (which were only staffed by paramedic staff) between 88% and 100% of calls, between 1 February 2016 and 1 May 2016, had been attended by paramedics. This means that a high proportion of calls were attended by qualified paramedics.
- Some staff raised concerns about the length of time they waited for back up at busy times. Between 1 December 2015 and 1 May 2016, there were 2587 incidents where a rapid response vehicle waited over 60 minutes for emergency ambulance back up. The vast majority of these were in Greater Manchester where 1836 such incidents occurred. In the same time period there were 25 occasions when a CFR waited between 60 and 90 minutes for assistance at a call.
- The HART was staffed by teams of six crew members. Four staff members had to be at base at all times to allow them to respond quickly to any call. Two paramedics worked in RRV's to

support delivery of response to 999 calls. There was an agreement that crew members working in RRVs would be stood down or backed up immediately if they were required to respond to a designated HART call.

- There was evidence that managers planned staffing while taking into account the skill mix and competencies of the staff on duty. There were systems in place to ensure that skill mix on DCA's was appropriate and the EOC was aware of the skill mix on these ambulances so that vehicles could be deployed correctly. A matrix was available detailing each variation of skill mix on a DCA and which type of call combinations of staff could attend safely. For example, an ambulance staffed by two probationer EMT1's could only respond to urgent care calls, not 999 calls.
- Monthly meetings were held with human resources to discuss staffing and recruitment. There was a recruitment plan in place in Cumbria with identified short term and long term actions to be taken to address the high vacancy rate of band five paramedics in this region. There were plans to replicate this plan in Greater Manchester. In Greater Manchester, leaders attended colleges, universities and job fairs to increase interest in positions within the trust and the trust was engaging with higher education providers to develop the provision of paramedic training places in Cumbria. The success regime in West, North and East Cumbria is a multiagency collaboration established to help develop the right quality of health and social care in the region. The NWAS Chief Executive was on the board of the organisation and the senior paramedics were involved in the clinical developments.

Cleanliness and infection control

- A quarterly infection, prevention and control forum was held, attended by representation from the patient transport services, paramedic emergency service, governance team and Public Health England.
- Log books used to record essential vehicle checks including infection control and prevention checks were not completed consistently and some vehicles were overdue for deep cleaning.
- Within PTS, we observed ambulance crews with good infection prevention control practice and systems were in place to ensure ambulances were regularly deep cleaned.
- All three EOC sites were visibly clean and workstations were visibly clean and tidy at the time of the inspection. Antiseptic

hand gel was available throughout the Liverpool and Preston sites and we saw antiseptic wipes for desks, keyboards and monitors in all three sites. Wipe-down cleaning was also carried out in the training/major incident room after use.

Records

- Information relating to patients' care and treatment was recorded on patient record forms (PRFs) which were paper based forms in a duplicate book. This meant the ambulance service could maintain their own record and also supply one copy to the hospital or patient, depending on whether the patient was conveyed to hospital. They also had one copy without patient identifiable information to use for audit purposes.
- We reviewed 236 PRFs within urgent and emergency care. We saw that, in 218 of these cases, the records were completed in legible handwriting, were signed and dated and the history of the patient incident, treatment provided, medicines administered, assessments of pain and observations were completed.
- There was a limited amount of free text space available to record a full history and clinical assessment. If there was not enough space to complete all details, a second PRF would be completed. Some staff felt a continuation sheet would be beneficial but others told us there was enough space to document all necessary details.
- Paramedics on the Manchester urgent care desk completed patient review forms for each patient seen. These records were posted into a locked cabinet in the office and were collected once a month to be stored securely elsewhere in the trust. The urgent care desk team did not have access to the cabinet and, as such, we were unable to review any of these records. This meant there was a risk these records could not be accessed urgently if required.

Are services at this trust effective?

Good

We rated the trust as 'Good' overall for effective. This is because;

- National Institute for Health and Care Excellence (NICE) guidelines were available for staff and the 2013 Joint Royal Colleges Ambulance Liaison Committee (JRCALC) clinical practice guidelines had being issued to all staff. Evidence based care bundles were up to date and available in all vehicles we inspected.
- The trust routinely collected, monitored and reviewed information about the care and treatment people received from

the trust and service. Data from Clinical Quality Indicators measured the overall quality of care and outcomes for patients. The trust submitted data as a whole and this was therefore not available to us by region.
- The trust participated in local and national audits. Action plans were formulated following audits and progress on these actions were monitored.
- Patients received care and treatment from competent staff who worked well as part of a multidisciplinary team.

However:

- Although the majority of policies that we reviewed were up to date, we found the Emergency Control Procedure had a review date of November 2013 and this had not been reviewed at the time of the inspection. Additionally the management of bariatric patients' policy had not been reviewed since 2013.
- Performance against care bundles was reviewed by senior paramedics and data showed the trust did not meet any of their care bundle improvement target levels of 95% for the last year.
- While there were processes to support deployment of the Hazardous Area Response Team (HART), we found inconsistencies between the procedure and system used.
- Trust procedures relating to the assessment of a person's capacity under the Mental Capacity Act (2005) were not compliant with the Mental Capacity Act (MCA) code of practice.
- There was a unified do not attempt cardiopulmonary resuscitation (uDNACPR) North West policy issued in October 2014 which had been due for review in April 2015, but was still in use.
- We reviewed 236 patient records and found no evidence on the patient record form (PRF) that patients have consented to assessment, treatment or transportation to hospital, this means the trust cannot demonstrate a process for assessing patients under the Mental Capacity Act (MCA).

Evidence based care and treatment

- National Institute for Health and Care Excellence (NICE) guidelines were available for staff and the 2013 Joint Royal Colleges Ambulance Liaison Committee (JRCALC) clinical practice guidelines had being issued to all staff.
- The trust participated in local and national audits. Action plans were formulated following audits and progress on these actions were monitored.

- The majority of policies and procedures were up to date, however we found that the Emergency Control Procedure had a review date of November 2013 and this had not been reviewed at the time of the inspection. Additionally the management of bariatric patients' policy had not been reviewed since 2013.
- Evidence based care bundles and pathways were available in all the vehicles we inspected. These included specific pathways for patients presenting with symptoms of a stroke and children presenting with signs of serious infections.
- The trust submitted clinical performance indicator information to the National Ambulance Service Clinical Quality Group. This included cyclical information audited on measures against expected management of febrile convulsions, single limb fractures and asthma. This information was used to benchmark the service against other ambulance trusts and identify areas for improvement.
- Staff accessed advice on the care and treatment of patients from the clinical hub or the trauma cell based at the emergency operations centre (EOC). The hub was staffed by senior or advanced paramedics who provided advice over the telephone or arranged for support from senior staff, on the scene, if this was required.
- EOC staff used Medical Priority Dispatch System (MPDS) to assess and prioritise emergency calls. The International Academy for Emergency Dispatch (the academy), a standard setting research based non-profit organisation, oversaw the creation, development and updates of the emergency protocols.
- Staff on the urgent care desk used the Manchester Triage System for the telephone triage of certain calls. The Manchester Triage System is a triage system used by emergency clinicians worldwide. The trust used the latest version of the system. Relevant National Institute for Health and Care Excellence (NICE) guidelines were extracted and embedded into the prompts and advice in the triage tool.
- Clinical staff working in the EOC provided advice within their scope of practice, and in line with both NICE and, the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidance. Staff told us that, on occasions, they were asked to provide advice on situations that may not be covered by the guidance. Staff discussed these situations with the trust's Medical Director.

Patient outcomes

- The trust routinely collected, monitored and reviewed information about the care and treatment people received from

the trust and service. Data from Clinical Quality Indicators measured the overall quality of care and outcomes for patients. The trust submitted data as a whole and this was therefore not available to us by region.

- The trust collected data that included both out of hospital and in-hospital periods of care. This measured the effectiveness of the overall acute healthcare system in managing out of hospital cardiac arrest, which reflected the care delivered by both the ambulance services and acute trusts. NWAS data showed that only 9% of patients with coronary heart disease (CHD), were discharged from hospital alive (all patients) following cardiac arrest between November 2014 to October 2015. This was slightly above the England average of 8%. The Utstein comparator group showed that the percentage of patients discharged from hospital alive following a cardiac arrest was slightly lower (26%) than the England average of 27%. This meant that slightly more patients were not getting the care and treatment they required in this group.
- Performance against care bundles was reviewed by senior paramedics and data showed the trust did not meet any of their care bundle improvement target levels of 95% for the last year. The following care bundle pathways; asthma care, cardiac chest pain care bundle, pain care bundle, patient referral form completion care bundle, patient pathway care bundle, paediatric febrile convulsion care bundle and trauma- single limb bundle all showed a downward trend of performance against achieving the trust target between November 2015 to January 2016. The stroke care bundle year to-date (93.7%) performance was within 5% of the trust target of 95%.
- There were key performance indicators (KPIs) set by commissioners of the EOC service as part of the contract agreement. KPIs are a set of measurable standards used to check and compare performance in terms of meeting agreed standards or comparing to similar organisations. Control monitored performance and produced a daily 'p' (performance) report using data generated by the mobile data terminals. Where targets were missed, the control centre informed the local duty manager who sent a team leader to investigate. This enabled the control centre to stay neutral and not become directly involved with the teams.
- The KPIs included patients spending less than 40 minutes on the vehicle and a pre-appointment wait target of less than 30 minutes for enhanced priority service (EPS) patients, and a wait

less than 45 minutes for routine outpatient appointments. EPS work was primarily renal and oncology patients attending regular treatment clinics so these patients were always prioritised.

- The KPI target provided an allowance to be no more than 15 minutes late for appointments.
- The control threshold for compliance with EPS patients spending less than 40 minutes on the vehicle was 85% and this had not been achieved in any area for the 11 months between April 2015 and February 2016.
- In August 2014, the percentage of patients treated over the telephone was 3.6%. Between April 2015 and January 2016, the number of calls resolved by 'hear and treat' were consistently higher than the national average of 10%. Between 1 January and 22 March 2016, 9.7% of patients were treated over the telephone. This meant there were more calls resolved by the EOC, therefore avoiding an emergency response and possible transfer to hospital.
- While there were processes to support deployment of the Hazardous Area Response Team (HART) we found inconsistencies between the procedure and system used. An EOC procedure set out the process for deploying HART resources to an incident. The procedure said that the computer aided dispatch system would display an automatic pop-up for incidents in which HART could be used; however, there was no evidence that this function was available. Staff we spoke with said they identified potential HART incidents from the details recorded in the call and from the system generated dispatch code. Staff would then speak to their manager about dispatching HART resources for incidents which they could be used for. The manager would contact the HART team to confirm it was appropriate for them to be used.

Multidisciplinary working

- Patients received care and treatment from competent staff who worked well as part of a multidisciplinary team.
- Feedback from staff working in emergency departments about the care and service provided by the trust was positive. We observed a good working relationship between ambulance and hospital emergency staff.
- Hospital Ambulance Liaison Officers (HALO) were located in certain ED's across the region, not all hospitals we visited had this service. The HALO helped to manage the transfer and management of patients during periods of high demand.

- There was evidence of good initiatives and partnership working in the community to reduce the pressure on the ambulance service and admissions to emergency departments.
- There had been close collaboration between the trust and local acute hospitals to develop joint protocols and pathways for patients with an STEMI and the organisations worked together to complete the national Myocardial Ischaemia National Audit Project (MINAP) audit.
- The computer aided dispatch system used by the EOC enabled all staff to have access to information about all emergency calls and activity across the trust.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- There was a unified do not attempt cardiopulmonary resuscitation (uDNACPR) North West policy issued in October 2014 which had been due for review in April 2015, but was still in use.
- The North West regional joint protocol for MCA was due for review in April 2013 but this had not been completed at the time of the inspection and would now be three years past the review date. The protocol also did not reflect updates to the Deprivation of Liberty Safeguards.
- There was no documentation to provide evidence that a decision had been made in a patient's best interest or the reasons for this decision when a patient lacks capacity.
- Trust procedures relating to the assessment of a person's capacity under the Mental Capacity Act (2005) were not compliant with the Mental Capacity Act (MCA) code of practice.
- The North West regional protocol states that "ambulance staff are trained to assess and record mental capacity in line with the requirements of the MCA." However, we directly asked five EMT1 staff who told us they are not able to assess capacity. If they doubted capacity they would seek advice from the clinical hub and request back up from a paramedic. This was confirmed by two paramedics.
- Target training figures for Mental Capacity Act (MCA) training varied across regions for urgent and emergency care staff ranging from 60% to 92% without a rationale. In Cheshire and Cumbria training on the MCA had been completed by 62% of urgent and emergency care staff and in Greater Manchester by 64%. The MCA (2005) was not well understood by front line staff. Staff we spoke with confused mental capacity with mental health issues.

Summary of findings

- We reviewed 236 patient records and found no evidence on the patient record form (PRF) that patients have consented to assessment, treatment or transportation to hospital, this means the trust cannot demonstrate a process for assessing patients under the MCA.
- The MCA (2005) was not well understood by front line staff. We spoke with staff delivering emergency and urgent care who confused mental capacity with mental health. For example, when we asked about the process of assessing mental capacity, front line ambulance crew answered in reference to the Mental Health Act and patients who may self-harm.
- Trust procedure detailed that assessment of capacity was mandatory for patients who refuse care and treatment or are discharged using a self-care pathway. This is not in line with the MCA (2005) two-stage test and may cause staff to carry out capacity assessments for people who do not require it.
- We saw 10 examples of PRFs where the patient's mental capacity should have been assessed and was not or was incomplete. This included instances where patients were confused, had a diagnosis of dementia and one case of a 17 year old with symptoms of psychosis who refused conveyance to hospital and was subsequently left at home.

Are services at this trust caring?

Good

We rated the trust as 'Good' overall for caring. This was because:

- Patients were treated with compassion, empathy and kindness. Staff respected their privacy and dignity in all situations.
- We received many positive comments from patients and relatives about the care and dedication of trust staff and this was confirmed by patients using the service at the time of our inspection. Patients gave positive feedback about the care they received. Patients and carers consistently told us that staff explained information to them clearly during their journeys, and supported them fully.
- We witnessed effective communication with callers. Staff gave reassurances and for urgent cases they stayed on the line until paramedics arrived on the scene.
- Staff were dedicated and committed to caring for patients and often went above and beyond the expectations of their employment to provide care. There were many examples of staff receiving letters of thanks from patients or their families citing the care they had received in a time of great distress.
- Care and treatment was explained to patients and their loved ones. Patients were involved and given choices when this was possible.

- Emotional support was offered to patients and their relatives in both life threatening and emergency situations and also during less urgent situations. Staff continued to provide emotional support with friendly, personal interactions with patients whilst waiting to handover their care at emergency departments.
- The trust had a Frequent Callers Team who supported frequent callers to manage their own health and reduce the number of instances they contacted the emergency operations centres. The team had been successful in reducing the number of calls made by the frequent callers who were referred to them and had assisted people to receive the right support and treatment elsewhere using increasing levels of support.
- Hospital staff we spoke with were positive about the attitude displayed by the ambulance service staff. They told us the staff were friendly and had a good rapport with the patients.
- NHS Friends and Family test results indicated 95% of patients would recommend the service to others.
- Staff showed kindness, respect and empathy for those experiencing mental health crises.

However, within Emergency Operations Centres:

- Staff told us they felt the strict system prompts and scripts restricted what they said to callers and prevented them from being as caring with callers as they would like to be on occasions.

Compassionate care

- Across all regions, patients told us the care and treatment they received was good. They felt they had been treated with dignity and respect and were extremely positive about the care and kindness shown by both ambulance and patient transport service (PTS) staff.
- We received many positive comments via our 'share your experience' web form about the care and dedication ambulance crews had provided.
- The trust participated in the 'hear and treat' survey for 2013/14. This survey looked at the experiences of over 2,900 people who called an ambulance service in December 2013 or January 2014. Responses were received from 263 patients for the North West Ambulance Service NHS Trust. Overall the trust was performing similar to other trusts that had taken part, with the exception of one question (If you had questions to ask ambulance staff did you have the opportunity to ask them?), which performed worse than other trusts.

- In emergency departments, we overheard staff interacting with patients on a personal level while waiting to handover their care. They checked they were comfortable, if they needed anything and spoke with them in a comforting and informal manner.
- Staff were dedicated and committed to caring well for patients. Staff often went above and beyond to provide care and treatment to patients, in Greater Manchester for example, attending uncovered red calls despite having finished their shifts. Some staff also worked as 'staff responders' in their own time. This was a system where staff informed the Emergency Operations Centres (EOC) if they were available to respond to red 1 or 2 calls even though they were not on duty.
- Formal debriefing sessions were available to staff, if requested, following abusive or distressing calls. Staff were also able to request counselling if necessary.
- We saw letters of thanks from patients and their families and these demonstrated that staff had been caring and compassionate when dealing with their call.
- Call handling staff gave 'ring-back' calls to those patients who were waiting for non-urgent transport to provide reassurance and check on their welfare.
- The trust had a policy for handling abusive calls from the public. The policy set out how a member of staff would escalate an abusive call to their supervisor and manager. A caller would be given three warnings about their behaviour before a call would be terminated. Staff told us they felt supported by their managers in dealing with abusive callers.
- Call handlers used an electronic triage system which gave them prompts and scripts to follow, depending on the answers given to the questions by the caller. This meant they were restricted in what they said to callers. Some staff told us they were frustrated by having to follow the script and were worried about receiving negative feedback in audits. Staff told us they felt this prevented them from being as caring as they would like to be on occasions.
- NHS Friends and Family test results indicated 95% of patients would recommend the service to others.

Understanding and involvement of patients and those close to them

- Staff were professional and ensured they informed patients, callers and those close to them about what was happening, along with information on any treatment or other interventions being provided. They checked with patients to ensure they understood and agreed to the treatment offered.

- We listened to staff repeating information back to callers to ensure they had correctly understood what callers had told them. This ensured the correct response would be sent to the right address.
- We observed staff adjusting the way they communicated with different patients in order to explain treatment and gain their consent. One example of this in Cheshire and Merseyside was the use of a writing pad to convey messages to a patient who was profoundly deaf. In Cumbria and Lancashire we saw that staff understood the needs of patients with dementia and included their relatives in discussions about their care and treatment.
- Staff respected patient's decisions to refuse treatment or to be conveyed to hospital and this was documented, as required.

Emotional support

- Ambulance crews reassured patients at all times while they were in their care. They remained with patients on arrival at hospital emergency departments to provide continued support and comfort until responsibility for their care was handed to hospital staff, despite long delays in some instances.
- Patients told us they were given reassurance about their health condition. This happened even in emergency and life threatening situations. Relatives or friends were able to travel on vehicles to provide additional support and comfort.
- Both ambulance and PTS staff were observed providing emotional support to patients and their relatives. With Urgent and Emergency care, once a patients' condition was stabilised, staff talked to relatives, understanding their need for emotional support in emergency situations.
- We observed ambulance crews acting in a calm and supportive manner to reassure distressed patients and their relatives.
- We listened to staff providing support to callers and patients who were very distressed. Without exception staff, remained calm and clearly gave the advice prompted by the system. While staff told us they were unable to tell callers exactly when an ambulance would arrive (for example because it may develop a fault or be re-routed to a higher priority call) they gave reassurance that help was on its way.
- For the most unwell patients the system prompted staff to stay on the telephone until an ambulance arrived. We listened to calls where staff stayed on the line with callers who were very distressed, keeping them calm while an ambulance arrived. During this time, staff continued to ask questions about the welfare of the patient.

- Staff showed kindness, respect and empathy for those experiencing mental health crises. We listened to a call in which a clinician on the urgent care desk provided compassionate support to a patient in crisis. The clinician spent time listening to the caller and their concerns.

Are services at this trust responsive?

Good

We rated the trust as 'Good' overall for Responsive. This is because;

- The trust was meeting the demands of the patients by providing a patient transport service to all patients who were eligible in keeping with the commissioning contracts.
- The emergencyand urgent care serviceco-ordinated a 'see and treat' service. This included a number of rapid response vehicles staffed by clinicians across the region, including clinicians based in the urgent care desks.
- The trust had a complaints policy which was up to date and available on the intranet.
- As the three EOC sites took calls from across the region, differing levels of demand in various localities across the region did not have an impact on the service.

However:

- Pictorial books to assist with communication were available; however, there was no consistency in their use across the trust.
- There was no lead for mental health within the trust. This meant there was no overall trust wide leadership for training, support and guidance on caring for this group of patients. The trust recognised mental health care as an area for improvement in the information they provided to us.
- The responsiveness of the service was adversely affected by frequent, long handover delays at hospital emergency departments which resulted in a shortage of staff and response vehicles to attend to emergency and urgent calls. Turnaround times for attendance at the emergency departments were monitored and had remained over 25 minutes, on average, since 2013.
- There was a reliance on volunteer services to provide first response to emergency calls when mainstream staff were not available.
- The complaints policy did not identify key performance indicators or time scales in regards to the handling of complaints. It also did not include competencies required in terms of individuals responsible for leading the investigation of a complaint.

- There was no reference made in any of the complaints we reviewed as to what actions the trust would or had taken to prevent recurrence.
- There was no reference in the complaints policy of the duty of candour process where severe or moderate harm had been identified within a complaint. Additionally, there was no reference to dissemination of learning from complaints.

Service planning and delivery to meet the needs of local people

- The emergency and urgent ambulance service was commissioned collaboratively through a formal consortium agreement by the 33 Clinical Commissioning Groups (CCG's) across the North West region. There was a single contract, derived from the National Standard Contract for Ambulance Services.
- The lead Commissioner for NWAS was NHS Blackpool CCG, which worked on behalf of the CCGs across the North West, with an overarching Strategic Partnership Board (SPB) that was responsible for setting the strategic direction of ambulance service provision. This was further supported by local area based commissioning groups in Manchester, Cumbria, Lancashire, Cheshire and Merseyside.
- Services were planned, through these groups, to meet the needs of local people and to ensure that patients received the right care in the right place. There had been a number of initiatives using the skills of paramedics differently to enable this to happen. Examples included multidisciplinary working in admission avoidance schemes and education to other care services, such as care homes.
- Patient transport could be booked by patients, relatives, and health care professionals. Patient transport service (PTS) control centre staff used standardised assessment tools to ensure patients were provided with transport, as appropriate. Staff responsible for arranging transport had received training in how to complete the assessments.
- The trust was meeting the demands of the patients by providing a patient transport service to all patients who were eligible in keeping with the commissioning contracts.
- Private ambulances, taxis and volunteers were used to deal with an increase in demand, as necessary.
- Many of the ambulance journeys were scheduled in advance by the planners who sent out job lists to the vehicle mobile data terminals ready for the crews to receive each morning. There was also the facility to send these via email to be printed out, if for any reason there was a problem with the mobile devices.

- The emergency operation centres (EOC) had a number of different specialist clinical services designed to meet the needs of the local population. These included the 'hear and treat' service, where the urgent care desk triaged and assessed patients who required medical help but did not need an emergency ambulance.
- The HEMS desk worked closely with the mountain rescue teams and coastguard to respond to emergency incidents in remote and rural locations. This included the ability to use a helicopter based near Penrith for incidents in the North Cumbria area.
- The EOC developed and reviewed the triage system to reflect the needs of the local population. This meant the service was able to change the response code for certain types of calls based on the answers given. For example, the trust increased the types and number of calls which were passed to the urgent care desk to be telephone triaged. The impact of the changes was evaluated and reviewed by the trust.

Meeting people's individual needs

- There were good systems in place to meet a patient's individual needs.
- Interpreter services, via a language line, were available for patients and relatives if their first language was not English. There were multi-lingual phrase books to assist with communication for patients who required assistance with the English language.
- Pictorial books to assist with communication were available; however, there was no consistency in their use across the trust. Whilst they were used in Cumbria, Lancashire and Greater Manchester, staff across Cheshire and Merseyside did not carry them. In these areas, staff gave an example of how pain assessments were recorded by observing expressions and sounds made by the patient.
- The trust developed and reviewed the triage system to reflect the needs of the local population. This meant the service was able to change the response code for certain types of calls based on the answers given. For example, the trust increased the types and number of calls which were passed to the urgent care desk to be telephone triaged. The impact of the changes was evaluated and reviewed by the trust.
- The trust was involved in planning for major events in the North West region. We reviewed event contingency plans for events taking place at local stadia and a register of mass gatherings for the region. The plans were comprehensive and took into account a range of information including the type of event, the

expected crowd numbers, and demographics of event attendees. This enabled the trust to determine the numbers of trust resources, voluntary sector resources, on-site medical team resources and the type of equipment required at the event. The plans also identified primary, secondary and specialist receiving hospitals in the event of patients requiring transportation to hospital.

- As the three EOC sites took calls from across the region, differing levels of demand in various localities across the region did not have an impact on the service. Each site was responsible for dispatching vehicles in their areas. As staff in all sites had access to the same information on the computer aided dispatch system they could see ambulances and other resources outside their area. If there was an increase in demand in a locality, dispatchers could use out of area resources. However, dispatchers had to speak directly to the neighbouring site in order to allocate an ambulance that was outside their area but closest to the patient.
- The service had a low number of specialist vehicles to convey bariatric patients. This meant the first response crew would provide immediate support to the bariatric patient and the call centre would be contacted for further support and approval of a bariatric vehicle. This caused delays in conveying patients to hospital, but senior managers felt that risks were mitigated with this backup vehicle system. We also noted that most crew members had not been trained in assessing this patient group because their vehicle did not house such equipment.
- A North West Regional Mental Capacity Act (MCA) joint protocol had been developed following consultation with the North West region police forces and NWAS. This formed a memorandum of understanding that all stakeholders had agreed to support and follow; however, this protocol was three years past its review date.
- There was no lead for mental health within the trust. This meant there was no overall trust wide leadership for training, support and guidance on caring for this group of patients. The trust recognised mental health care as an area for improvement in the information they provided to us.
- Staff knew where the nearest place of safety was for patients requiring, or subject to, a section under the MHA and were aware of how to contact the police, if required, to assist these patients.

- There were no pathways in place to allow direct referral to mental health services which meant that patients had to be conveyed to emergency departments for referrals to mental health liaison teams.
- Staff were aware of particularly vulnerable patients and understood the need to communicate in a way that was supportive. Staff told us they had received awareness training for dementia. Wherever possible vulnerable patients, such as those living with dementia or a disability could have a relative or carer with them if booked in advance.
- Within patient transport services, the eligibility process determined whether or not a patient could or should travel with an escort and they could choose who that was.

Access and flow

- Senior managers monitored the response times of emergency vehicles and used performance indicators to review each teams' productivity. This was fed back to the teams on a monthly basis and provided to the individual stations. We saw these displayed and the reasons for any targets that had not been met were discussed at team meetings.
- Data supplied by the trust showed that between 1 December 2015 and 30 May 2016 the Cheshire and Mersey team spent 276,480 hours servicing its home area, and the time spent servicing other areas was 5,430 hours. When compared to the Greater Manchester and Cumbria and Lancashire team, Cheshire and Merseyside spent more time providing care in neighbouring areas than the other teams.
- The responsiveness of the service was adversely affected by frequent, long handover delays at hospital emergency departments which resulted in a shortage of staff and response vehicles to attend to emergency and urgent calls. Turnaround times for attendance at the emergency departments were monitored and had remained over 25 minutes, on average, since 2013.
- In April 2016, 7% of patient calls had been managed through the "Hear and Treat" system. The Hear and Treat system was an advanced triage system which used senior paramedics to assess patients over the telephone. Crew members agreed this helped to improve the flow of care to patients in more rural areas and patients were placed on the correct pathways as a result. They may receive advice on how to care for themselves or where they might go to receive assistance. The implementation of this service was highest in Greater Manchester at 8% of calls and lowest in Cumbria and Lancashire at 5.8%.

- There was a reliance on volunteer services to provide first response to emergency calls when mainstream staff were not available. In the six months between 1 November 2015 to 30 April 2016 there were 9253 incidents where a community first responder or rapid response vehicle first attended and waited over 30 minutes for the emergency ambulance assistance they requested. Community first responders we spoke with did not always report these delays as incidents as they had seen no change in practice when they had done so in the past.
- North West Ambulance Service (NWAS) had liaised with acute trusts and the CCGs to develop the North West divert and deflection policy. This document provided a clearly defined approach to aid consistency throughout trusts and ensure the timely handover of patients arriving at hospital by preventing or reducing delays.
- The neonatal transfer policy provided guidance for emergency staff on how to facilitate a transfer of an infant, what equipment was required and deployment of the appropriate crew with the relevant skill mix. Transfer response times differed depending upon their priority and the clinical need of the patient and were not routinely measured.
- Electronic screens, in each of the EOC sites, displayed the number of calls answered, the number waiting to be answered, and performance against the target of answering 95% of calls within five seconds. Screens in the dispatch rooms displayed the day's performance for dispatching ambulances by the assigned code, and also the number of ambulances waiting in hospitals to handover patients, including the times taken to handover patients.
- All managers within EOC had access to the live performance and daily performance information on the trust's intranet site. The data could be filtered by area or time period. This meant managers could respond if performance dropped; for example, by implementing the clinical escalation policy if appropriate.
- HEMS team performance was monitored by a bespoke system. The Air Desk Information Sheet was planned and developed internally by one of the trust's HEMS desk dispatchers. The system provided quick and easy access to resources needed by the HEMS dispatchers, including relevant telephone numbers for other emergency and local services, and enabled each incident to be logged and notes added. This meant that managers were able to monitor HEMS performance.

Learning from complaints and concerns

- The trust had a complaints policy which was up to date and available on the intranet. The policy did not identify key

Summary of findings

performance indicators or time scales in regards to the handling of complaints. It also did not include competencies required in terms of individuals responsible for leading the investigation of a complaint.

- As part of the inspection, we reviewed five complaints files, where we found the final written responses did not include advice on how the complainant could take their complaint to the Parliamentary Health Service Ombudsman (PHSO) if they were not satisfied with the investigation into their concerns. Action logs had not been completed in any of the files.
- There was no reference made in any of the complaints we reviewed as to what actions the trust would or had taken to prevent recurrence.
- There was no reference in the complaints policy of the duty of candour process where severe or moderate harm had been identified within a complaint. Additionally, there was no reference to dissemination of learning from complaints.

Are services at this trust well-led?

Requires improvement

We rated the trust as 'Requires Improvement' overall for Well-led. This is because;

- The trust's values and vision were available on the intranet page for all staff to access and were displayed around stations we inspected. However, we found there was little awareness of the trust's vision, values or five year strategy and operational staff were not clear about the ambitions of the trust.
- In Liverpool many of the staff said that staff morale was affected by the building which was cramped with teams located in different rooms.
- The quality committee met every two months and discussed areas, such as risk and mitigation, safeguarding, response times, complaints, incidents, medicine management, infection prevention, quality improvement and National Ambulance Clinical Quality Indicators. This meant that the executive team only got oversight on these quality areas every two months.
- Due to the length of time taken for the trust to investigate and conclude serious incidents, the board did not have a full overview of the reporting and monitoring of serious incidents. This meant there was no monitoring of how quickly serious incidents were reported, timescales for investigations and how quickly actions were implemented following the outcome of the investigation.
- Within the risk registers, some risk descriptions did not clearly describe the risk; some of the information recorded under controls and assurance were not actually controls or sources of

assurance; there was no target rating for risks on the risk register, meaning it was unclear what level of risk the trust was aiming for, and there were a number of risks without actions identified to mitigate the identified risk.
- Risks for the EOC were recorded in different documents but did not give a complete picture of the risks to each individual site or to the EOC service as a whole. We could not be assured that all appropriate risks for the sites had been identified or mitigated.
- Regional risk registers did not always reflect risks identified at individual ambulance stations, specifically in Cheshire and Merseyside and Cumbria and Lancashire.
- Vehicle infection prevention and control audits were not always completed. We checked 14 log books and found that 12 were not fully completed. The system for ensuring that front line ambulances were cleaned in line with trust policy was not robust and did not ensure that vehicles were clean to reduce the risk of the spread of infection.
- We reviewed four executive level personal files for directors appointed after November 2014 and identified the absence of identified checks within one file, including absence of a full employment history, copy of a Disclosure and Barring Service (DBS) check and disqualified directors and insolvency check. DBS checks were not being completed at the time of our inspection for non-executive directors. The trust felt that non-executive directors did not meet the criteria for needing a DBS check.

However:

- Staff within patient transport services (PTS) were positive about their roles and said they were encouraged to develop professionally. There were annual 'going the extra mile (GEM) awards' where colleagues were nominated in various different categories, such as frontline member of staff of the year.
- Within the 111 service, there was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- Staff felt that leadership from heads of service was strong and visible. Heads of service and sector managers had been supported to develop their leadership skills with attendance at higher education courses.

Vision and strategy

- The trust's vision was to deliver the right care, at the right time, in the right place and there were a set of values based on the NHS constitution (2015). The trust had a five year business plan

in place labelled "good to great". There were three strategic values attached to this plan: to deliver safe care closer to home, being a great place to work and causing no harm. The trust was aiming for foundation status and there was a shadow board of governors in place.

- In addition to the trust wide business plan, there was also a resilience business plan which outlined the work the resilience team was undertaking in relation to the NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR) and NHS England Emergency Planning Framework (2015).
- The trust's values and vision were available on the intranet page for all staff to access and were displayed around stations we inspected. However, we found there was little awareness of the trust's vision, values or five year strategy and operational staff were not clear about the ambitions of the trust. In Cheshire and Merseyside for example, only two of the 44 staff we spoke with could articulate the current strategy and vision for the service.

Governance, risk management and quality measurement

- The quality committee met every two months and discussed areas, such as risk and mitigation, safeguarding, response times, complaints, incidents, medicine management, infection prevention, quality improvement and National Ambulance Clinical Quality Indicators. This meant that the executive team only got oversight on these quality areas every two months.
- Due to the length of time taken for the trust to investigate and conclude serious incidents, the board did not have a full overview of the reporting and monitoring of serious incidents. This meant there was no monitoring of how quickly serious incidents were reported, timescales for investigations and how quickly actions were implemented following the outcome of the investigation. Serious incidents regularly took longer than the 60 day timeframe (set by NHS England in the serious incident framework) to investigate and conclude.
- There was a trust-wide risk register in place which recorded all operational risks with a score of 12 and above. There was evidence that the register was reviewed and updated regularly. However, there were some improvements required. In particular, some risk descriptions did not clearly describe the risk; some of the information recorded under controls and assurance were not actually controls or sources of assurance; there was no target rating for risks on the risk register, meaning it was unclear what level of risk the trust was aiming for, and there were a number of risks without actions identified to

mitigate the identified risk. Additionally a significant number of risks had been on the risk register for a number of years with little evidence of progress or impact being reported. In addition local risk registers were not totally aligned to the trust wide risk register.

- Risks for the EOC were recorded in different documents but did not give a complete picture of the risks to each individual site or to the EOC service as a whole. We could not be assured that all appropriate risks for the sites had been identified or mitigated.
- There was an ongoing EOC action plan that also evidently held risks as well as planned improvements and developments. The plan did not appear to differentiate between elements that were general improvements and those that were related to risks, and there did not appear to be any indication of pre and post risk scoring following agreed actions. However, the plan was clear about actions, responsibilities, review and completion dates and was updated on a regular basis and discussed at EOC level three sector meetings.
- Risks related to the HEMS desk were fed into the main risk register; these included delays to the dispatch of helicopters which was being mitigated through the desk's ability to monitor the radio channels for other emergency services.
- Within urgent and emergency care, each region held a regional risk register, with a separate register for HART. Registers identified risks and reflected area wide risks, for example delays at emergency departments. These risks were documented with appropriate action plans to mitigate and manage risks. However, it was unclear how long risks had been held on the register as a new register was prepared each financial year. Dates of the last review were detailed on the register but there were no details of when the next review was due, there were insufficient details of actions required to mitigate gaps in controls and there were no target dates for completion of required actions.
- Regional risk registers did not always reflect risks identified at individual ambulance stations, specifically in Cheshire and Merseyside and Cumbria and Lancashire.
- Sector managers and operations managers were aware of the main risks on the regional risk register. These risks were reviewed at the level three (sector managers and head of service) meetings and sector managers were able to escalate any new risks to the register at this meeting.
- There was a trust wide process in place to review area risk registers. This was a monthly meeting of the risk moderation group chaired by the Director of Quality.

Summary of findings

- We found local systems were in place to review the quality, governance and risk management of the service. However we reviewed minutes of meetings where risk and quality was discussed and found there was a lack of senior PTS management attendance at these meetings. We were not assured that the PTS service had robust operation of its systems in place to provide assurance for governance and risk management of the service. The risk register we reviewed had seven risks documented, of which the two which focused on quality were related to a third party provider performance, as well as the core PTS service.
- Information provided by the trust showed that, within PTS, risks were discussed at three different meetings, the risk moderation management group, the performance committee and the quality committee. We could not discern the objectives of the different meetings. Senior managers we talked with could not describe the purpose of the different meetings.
- Vehicle infection prevention and control audits were not always completed. For example, we saw that vehicle infection prevention and control audits were not completed in some areas. We checked 14 log books and found that 12 were not fully completed. The system for ensuring that front line ambulances were cleaned in line with trust policy was not robust and did not ensure that vehicles were clean to reduce the risk of the spread of infection. Audits completed by managers to check that cleaning had taken place did not identify when vehicles had not been cleaned correctly in each of the 12 logs we checked and subsequently no actions were taken to address any potentially unclean vehicles.
- Within the 111 service, there was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- The information used in reporting, performance management and delivering quality care and treatment was accurate, valid, reliable, timely and relevant.

Leadership of the trust

- The Chief Executive Officer had recently commenced in a substantive post on 10 May 2016, following a period of covering the post as an interim, from March 2016.
- The urgent and emergency care service had had a clinical leadership model in place since 2012, with more focus on clinical quality than was previously the case. The leadership

model included a Consultant Paramedic in each area and advanced paramedics in each sector. The structure had been reviewed recently and the operational and clinical team leader roles were in the process of being merged.

- Staff reported that the new clinical leadership structure with senior paramedics assuming a combined management and clinical leadership role was a positive development. This change had been well received as it provided clearer lines of reporting and less confusion, at the stations where it had already been implemented.
- Staff felt that leadership from heads of service was strong and visible. Heads of service and sector managers had been supported to develop their leadership skills with attendance at higher education courses.
- Senior staff described that the size of the organisation could sometimes mean that making changes or improvements to services was a challenge. Leaders also felt that, in some circumstances, NWAS was being held back by acute trusts from making changes to services that would better meet the needs of local people.
- Within PTS, the head of service was in an interim role and the two new manager posts for quality, systems and processes and contract delivery (control, planning and booking) were being advertised. Senior managers told us until these posts were recruited to it was not possible to formalise any senior management meetings.
- Within EOC, staff in Liverpool and Preston told us the executive team usually visited the sites over the Christmas period, which was a particularly busy time for the service. However, staff felt they were not visible and those that we asked had difficulty in recalling who the executive team were.
- Staff in Manchester told us the trust board were visible. Letters of thanks were sent to staff for coping with winter pressures. One staff member told us that, when they had been off long-term, the Chief Executive had sent their good wishes.

Culture within the trust

- There were regional variations in the culture both across the trust as a whole and within regions. Staff in some areas felt very positive about the culture, but in other areas they felt that there was a high degree of pressure and that focus was on performance targets rather than care for patients.
- Staff in HART and the air ambulance service spoke very positively about the culture, cohesiveness and commitment of all team members. However, there were some feelings that HART RRV staff were treated differently to RRVs deployed in the

general operation of the service. For example, at night time, HART single crew RRVs were expected to be 'on the road' whereas those in general operation were able to work out of a station, for safety reasons.

- All staff told us they felt secure raising a concern or issue with their immediate line managers. However, four staff in Cheshire and Merseyside told us that they felt they would be viewed negatively for raising a concern but that this would not deter them from doing so.
- In Liverpool many of the staff said that staff morale was affected by the EOC building which was cramped with teams located in different rooms. This was compared to the other two sites which had been recently built or refurbished.
- The combined average sickness rates across all three EOC centres varied between 5.7% and 8.2% between April 2015 and January 2016. The individual sickness rates at all three centres were consistently higher than the trust average. Liverpool consistently reported the highest sickness rate of the three sites, with between 8% and 11.5% days lost to sickness each month for the same period.
- Staff within PTS were positive about their roles and said they were encouraged to develop professionally. There were annual 'going the extra mile (GEM) awards' where colleagues were nominated in various different categories, such as frontline member of staff of the year. Staff spoke positively about these.

Fit and Proper Persons

- The trust did not have a policy in place to meet 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 NHS providers are fit and proper to carry out this important role. However there was a trust process in place.
- A paper was presented to the trust board in January 2015 that set out steps the trust would take to ensure compliance with the regulation. Differentiation was made in this document between actions taken in regards to existing and new director and deputy director appointments. However, it was unclear in terms of checks that would be taken for new appointments where the successful candidate was an internal candidate and had previously held a director's position within the organisation.
- We reviewed four executive level personal files for directors appointed after November 2014 and identified the absence of identified checks within one file, including absence of a full employment history, copy of a Disclosure and Barring Service

(DBS) check and disqualified directors and insolvency check. DBS checks were not being completed at the time of our inspection for non-executive directors. The trust felt that non-executive directors did not meet the criteria for needing a DBS check. However, we raised this with the trust at the time of the inspection and they took action to ensure DBS checks were completed for all relevant staff.

Public and staff engagement

- Within the Urgent and Emergency Care service, with the exception of HART and the air ambulance service, there were no routine meetings within areas or at individual stations and there was no evidence of information cascade from managerial meetings to frontline staff. This was due to the difficulties gathering staff to a meeting who were also required operationally to respond to emergency calls. HART held team meetings on a two monthly basis. We reviewed minutes of meetings and saw they were well attended and followed a set agenda including business continuity, training, appraisals and risks.
- Staff arranged forums that were attended by the heads of service and run by staff. Forums took the form of a question and answer session and information sharing opportunity. These were regionally organised and usually outside of working hours so attendance tended to be variable. For example, at a meeting held on 23 May 2016 in Cumbria and Lancashire, 22 staff attended which we were told was an unusually high number. This meeting had been for staff to discuss how to better manage the shortage of clinical staff.
- All staff we spoke with told us they would have liked more forums and meetings to express their views and learn about what was going on in the wider trust.
- The trust was using a number of different methods to increase the uptake of the NHS Friends and Family test (FFT) to gain feedback from the public. This included freepost postcards, text messaging services, online surveys and telephone surveys.
- The trust engaged in a number of public events, including Mela events; community first responder events; lesbian, gay, bisexual and transgender pride events; and visiting local schools. There was a community engagement manager in post who had worked closely with local businesses, communities and schools. This work included recruiting and training community first responders, offering basic life support training in schools and increasing the numbers of automated external defibrillators (AEDs) within the community.

- The service launched an information campaign called 'Make the Right Call' to educate people about the services available to them if they or their family members or friends were unwell. The campaign included a website and online videos.
- Patient representatives were sought when there was a planned change to a service. These representatives would sit in on meetings and give the patient perspective on any planned service changes.
- Leaders used social media to engage with the public to publicise the work they were undertaking and to improve public awareness of alternatives to 999 outside of life threatening situations.
- Volunteer groups visited the centre to see and build an understanding of the work undertaken by the EOC. Carers had also been encouraged to visit the centre.
- The trust used a variety of mechanisms to engage with the public including surveys, social and other media, and community focus groups and events. We found the patient experience form was not readily available in all PTS vehicles and the return rate was under 50% of those sent out. Therefore whilst this process did elicit patient's views it was limited in its scope.
- The trust used a number of mechanisms to engage with the public, set out in a communication and engagement plan. This included roadshows, media (television and radio), social media, meetings with communities and hard to reach groups and an annual general meeting with events organised for the public.

Innovation, improvement and sustainability

- Community paramedic initiatives were improving the care patients received closer to home. This was part of the NHS five year forward view to deliver more healthcare out of acute hospitals and in the community. In Greater Manchester, there was close working with the system resilience group and Clinical Commissioning Groups to improve community referral pathways, for example there was a pilot scheme in progress with district nurses to test out a pathway for patients with skin tears.
- There were a number of admission avoidance initiatives across the trust that aimed to keep patients at home rather than admit them to hospital. The Healthier Radcliffe scheme was a pilot system in one part of Greater Manchester that aimed to avoid admission to hospital. There was partnership working between NWAS, local GPs, the local social services department, housing and the community response team. Paramedics working in this scheme were able to arrange short term care (up to 72 hours) or

six weeks of reablement services to allow patients to remain at home. Around 60% of patients were able to stay at home and avoided conveyance to emergency departments, compared with the overall emergency department avoidance for the trust of 27%.

- The scheme had also demonstrated success with a reduction in calls from frequent callers within the area of 72.5%. There was a similar scheme being run by a community paramedic in South Cumbria.
- In 2015/16 the EOC service was involved in a pilot where clinicians from the urgent care desk were seconded to police force control rooms to triage police incidents that would ordinary be passed to the service and would generally require an ambulance to respond. The clinicians had access to the service's systems and triage tools.
- In January 2016, the EOC service started a 'Telehealth' scheme. Patients identified as being suitable for the scheme were given equipment to record their own vital signs such as blood pressure, oxygen saturation, pulse and weight. These measurements were uploaded to a secure internet server each day by mobile telephone and monitored by urgent care desk staff. When there was an alert, urgent care desk staff would arrange a response.
- Emergency call handlers were awarded certificates for outstanding performance in call audits. We saw certificates displayed on a noticeboard with the names of staff who had performed well.
- The trust had introduced new technologies and we saw examples of staff using mobile devices for the management of information.
- Within PTS, the trust had piloted the use of text reminders for appointments and was looking to develop the use of mobile phone technology for seeking patients' views and improving service delivery. The trust had been able to retain the contract for patient transport services in April 2016 for Cumbria, Lancashire and Mersey. However, there was no change in the contract which would encourage improvement or innovation. The key aim was to reduce costs through better planning and usage, such as the more effective use of resources and application of the eligibility criteria. We found the pace of change and improvement since our last inspection had been slow.
- There was concern amongst staff about the sustainability of the PTS service with the increased amount of work for the private ambulance service and the heavy reliance on the volunteer car service.

Overview of ratings

Our ratings for North West Ambulance Service

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Patient transport services (PTS)	Good	Good	Good	Good	Requires improvement	Good
Emergency operations centre (EOC)	Requires improvement	Good	Good	Good	Good	Good
NHS 111 service	Good	Good	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement

Our ratings for North West Ambulance Service NHS Trust

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

Outstanding practice and areas for improvement

Outstanding practice

- The HART teams in both Manchester and Merseyside were delivering an excellent service to patients. They were proactive in their approach to gaining new skills and forging relationships with other emergency services, to ensure the smooth running of rescues in difficult areas. Their co location with the fire service training headquarters in Merseyside afforded them and all NWAS staff excellent and unique training opportunities. This ensured that they were equipped to deal with and manage a wide range of hazardous emergencies and undertaken formalised de briefs in a multidisciplinary manner.
- The service had community care pathway designed to share information across services and ensure ambulance clinicians were aware of pre-existing care plans for patients being managed by community services. This included when it was most appropriate for patients to be treated at home, involving other professionals or conveyed to an alternative care setting than an emergency department. This was also supported in some areas by the long term conditions teams based at local hospital trusts.
- The community engagement manager was in the process of implementing an electronic application initiative called 'Good SAM'. This application could be downloaded onto mobile devices and alerts users who have been vetted and checked to a nearby cardiac arrest. Through this initiate the manager had also mapped all defibrillators in the North West area and from August 2016, this information would be available to call centre staff so that they could direct members of the public attending cardiac arrests to these devices.
- All staff we observed were exceptionally caring in their approach and went above and beyond their duty to provide compassionate, supportive care.

Areas for improvement

Action the trust MUST take to improve

- Ensure that the consent policy and guidance on mental capacity assessments issued to staff is in line with the Mental Capacity Act 92005) code of practice. The service must ensure that there is specialist equipment and training for staff to safely manage the care of bariatric patients.
- Ensure they are compliant with the fit and proper person regulation when appointing both executive and non-executive directors.
- Ensure the complaints policy reflects time scales for investigations and ensure complainants are given information in relation to how to take action if they are not satisfied with how the trust has managed the complaint.
- Ensure risk registers are robust and are fully aligned to the local risk registers.

Action the trust SHOULD take to improve;

- Continue to monitor staffing levels and recruit sufficient frontline paramedic and other staff to meet patient safety and operational standards requirements.
- Review the duty of candour policy and ensure it fully reflects the regulation.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed How the regulation was not being met: DBS checks were not completed for non-executive directors. Not all director files included a full employment history, copy of a DBS check and disqualified directors and insolvency check. Regulation 19 (1) (2) (3) (4) (HSCA 2008 (Regulated Activities) Regulations 2010 Fit and proper person employed.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints How the regulation was not being met: We reviewed five complaints files, where we found the final written responses did not include advice on how the complainant could escalate their complaint to other appropriate bodies. There was no reference in the complaints policy of the duty of candour process where severe or moderate harm had been identified within a complaint. Additionally, there was no reference to dissemination of learning from complaints. Regulation 16 (1)(2)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury

Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse

Consent was not always sought from the patient themselves and due consideration to mental capacity was not given when making these assessments.

Regulation 11 (1)(2)(3)