South Western Ambulance Service NHS Foundation Trust

Quality Report

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Date of inspection visit: 7- 10 June, 17, 20 and 22 June
Date of publication: 06/10/2016

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?	Requires improvement
Are services at this trust caring?	Outstanding
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

South Western Ambulance Service NHS Foundation Trust is one of 10 ambulance trusts in England. On March 1, 2011 the trust became the first ambulance service in the country to become a Foundation Trust, and acquired Great Western Ambulance Service in February 2013. It provides services in the following geographical area:

• Cornwall

• Isles of Scilly (IOS)

• Devon

• Dorset

• Somerset

• Wiltshire

• Gloucestershire

• The former Avon area (Bristol, Bath, North and North East Somerset and South

• Gloucestershire)

The area is made up of approximately 5.3 million people with an additional 17.5 million visitors per year and covers 10,000 square miles (around 20% of mainland England). It spans 13 Clinical Commissioning Groups and serves 18 acute trusts.

The trust employs over 4,000 mainly clinical and operational staff, including Paramedics (1,788), Emergency Care Practitioners, Advanced Technicians, Ambulance Care Assistants and Nurse Practitioners) plus GPs and around 2,785 volunteers (including community first responders, BASICS doctors, fire co-responders and volunteer PTS drivers).

The trusts primary role is to respond to emergency 999 calls, 24 hours a day, 365 days a year. 999 calls are received in one of three emergency operation centres (EOC), where clinical advice is provided and emergency vehicles are dispatched if required. In addition, the trust also provides patient transport services, hazardous area response teams, NHS 111 services for the people of Cornwall, Devon and Dorset, urgent and emergency care at one minor injuries unit in Devon and out of hours GP services in Gloucestershire and Dorset. The service also provides clinical teams for six air ambulances.

In 2014/15 the trust responded to 867,505 emergency and urgent incidents, received 918,227 NHS 111 calls, helped 155,965 patients calling their out of hours service and completed 99,907 patient transport journeys.

We carried out this inspection as part of the CQC's comprehensive inspection programme. We undertook our announced inspection between 6-10 June 2016 and conducted unannounced inspections on 17, 20 and 22 June 2016 and inspected the following core services:

Emergency Operations Centres

Urgent and Emergency Care

Patient Transport Services

Resilience

Emergency and Urgent Care

Out of Hours

We undertook a comprehensive inspection of the trusts 111 service in March 2016. Details of that inspection have been published separately.

Overall, the trust was rated as requires improvement. We rated caring as outstanding and rated responsiveness as good.

Our key findings were as follows:

Safe

- Not all staff were reporting incidents, particularly when they were verbally abused by callers and in some areas staff did not routinely report incidents related to patient safety. Some staff felt that due to the demands on the service they did not have time to report all incidents. However, the trust had taken steps to make the reporting process more straightforward by providing a link within the electronic patient record. This allowed staff to complete incident forms without having to return to the ambulance station.
- Feedback to staff following incident reporting did not always take place. Whilst not in all areas, some groups of staff were unable to identify learning from incidents that had occurred during the twelve months preceding our inspection.

Summary of findings

- Some incidents were logged and resolved but not reported on the trust wide incident reporting system. This meant that managerial oversight of the themes occurring from all incidents was not comprehensive.
- Some areas of the service was significantly below the trust's target for updating mandatory training. Within these services, the levels of staffing were not sufficient to provide relief at all times when staff were training, on holiday, off sick, or taking special leave.
- Medicines systems used by staff were not always safe and trusts policies, procedures and protocols were not always followed. Within the minor injuries unit, prescription pads were not monitored in order to prevent misuse.
- Ambulances and rapid response cars were not always secured when staff were escorting patients into emergency departments at hospitals or tending to patients at other locations. This meant that unauthorised people could access the ambulances.
- Cleanliness and control of infection was not being managed effectively. Clinical waste was not always disposed of as required. The trust was not meeting its targets for cleaning of vehicles or stations. Infection control training for staff was not meeting the trusts targets for the number of staff who had completed this.
- Within patient transport services, there were several vehicles with ripped seat covers and one with a hole in the internal wall. These defects meant that the vehicle could not be cleaned adequately to prevent the spread of infection.
- In patient transport services, not all staff were completing vehicle daily inspection checklists. Checklists were not reviewed effectively to enable the safety of vehicles to be assured. Only 21.3%of vehicles had been consistently deep cleaned every eight weeks or less during the twelve months preceding our inspection.
- There was insufficient space in the minor injuries unit waiting area for the number of people attending the centre.
- Safeguarding arrangements for vulnerable adults were not sufficiently robust within the minor injuries unit.
- Patient confidential information was not always stored securely.
- Some staff within patient transport services provided treatment for patients but no records of these interventions were completed. These treatments included administering Entenox (nitrous oxide and oxygen gas mixture) and adjusting oxygen.
- At the time of our inspection, emergency preparedness drills had not been completed on the patient transport boat on the Isles of Scilly.However, the emergency preparedness drills are part of the Domestic Safety Management Plan for the Star of Life that went live in June 2016. The first drill is scheduled for September 2016.
- Within the minor injuries unit, the environment and use of facilities was not designed to ensure the safety of children. Initial clinical assessment of patients was undertaken by experienced healthcare assistants. However, they did not use an assessment framework to do this and there was no competency assessment to ensure their practice was safe. Computer errors in patient records could not be corrected. This sometimes led to an incorrect diagnosis or medicines dose remaining on patient records.
- Within the out of hours service procedures for the management of the safety and secure management of controlled drugs were not always followed

However:

- There was a good system in place for reporting incidents, carrying out investigations, providing feedback to staff, learning and making improvements. In places the culture for incident reporting was very positive.
- Within the majority of services there were reliable practices for safeguarding people from abuse.
- Patients' records were held securely on electronic systems and special notes were available to help support and protect patients and staff.
- When calling, the risks to patients were assessed with approved triage systems. Decisions were monitored and revised by clinicians when appropriate, or risks changed.
- There had been a good implementation of the pilot for the ambulance response programme. This triage system was being trialled by the service to assess the safety, effectiveness, and responsiveness of the service should it move away from time-target based responses to sending the right response, first time.

Summary of findings

- The service was able to respond to major incidents and change priorities in times of extreme pressure. There were protocols for staff to follow in high-risk situations to keep staff and the public safe.
- The service had recognised the growth in call volumes and was responding by increasing staffing levels above establishment levels in the emergency operation centres.
- There was a good skill-mix among the staff within emergency operations centres, and there were plans to broaden the experience in future.
- Staff training met the national requirements set out by the National Ambulance Resilience Unit (NARU).
- Within emergency and urgent care we saw that staff regularly cleaned their hands and we observed staff cleaning their vehicles at the end of shifts. The vehicles we checked were visibly clean and equipment and vehicles were serviced in line with manufacturer's instructions to make sure they were fit for purpose.

Effective

- Within the emergency operation centres, staff were not being assessed for their competency and performance and the service was significantly below the trust's target for completing these appraisals each year. Some senior staff had not had appraisals for a number of years, but the organisation was not aware of this, and not addressing it. This issue had been on the trust's risk register for over nine years.
- The rate of annual performance appraisals within emergency and urgent care was variable ranging from 38.4% for specialist paramedics to 87.7% for paramedics. This was below the trust target of 90%. The quality of the appraisals was also variable.
- Staff in patient transport services did not participate in the learning development review process and compliance with appraisals was low
- Due to other training priorities, there had been a reduction in the number of calls audited for their quality and safety. The emergency operation centres had not been able, therefore, to determine if the handling of incoming calls was effective at all times. However, we recognised this was being addressed, and improving.
- The service was struggling with rising call volumes and this had resulted in more calls being abandoned.
- Response times for most categories were consistently below the England average. The proportion of Red 2 calls responded to within 8 minutes was worse than the England average from April 2015 to January 2016. The trust had not met the national target of 75% since October 2014. From May 2015 the data provided showed a steady decline in performance.
- From February 2015 to January 2016 the proportion of A19 calls responded to within 19 minutes was mainly worse than the England average. The national standard of 95% was not met for 10 of these 12 months.
- From April to October 2015 the average proportion of patients who received angioplasty (unblocking of a coronary artery) following ST segment elevation myocardial infarction within 150 minutes was worse than the national average.
- The average proportion of patients assessed face to face who received an appropriate stroke or transient ischaemic attack care bundle in April to October 2015 was worse than the national average.
- Not all staff were competent in providing treatment and care to patients with mental health issues.
- Within patient transport services, competencies of intermediate care assistants to administer Entenox (nitrous oxide and oxygen gas mixture) and perform cardiac monitoring had not been refreshed. Standard operating procedures were not accessible to staff when they were out and about transporting patients. Staff were not informed when patients were diabetic and this meant that staff did not have access to important information that may be needed by emergency crews attending to assist. The process of gaining consent was not recorded.
- It was not always clear for people on how to raise a complaint.

However:

- There were evidence-based systems to provide assessment and advice for patients. The emergency operations centre teams were using national guidelines and following best practice protocols to assess people's needs and provide the right service.
- Staff had the skills and knowledge to deliver effective advice and guidance. There were internal and external development opportunities and training available for staff.
- There was multidisciplinary work between teams and other local stakeholders. Hazardous area response teams, critical care and the air operations teams

Summary of findings

worked more closely together as 'special operations' to enhance the care patients received. The EPRR teams worked well and had good co-ordination with a range of other agencies including NHS Providers, other emergency services, local authorities, commercial operators, voluntary organisations and the different departments internally.

- There was good access to information with special notes being used to provide effective outcomes for people where there were known risks or other issues.
- The service was performing within its target for 'hear and treat' calls, although this was above (not as good as) the England average.
- The proportion of Red 1 calls responded to within 8 minutes was better than the England average for 16 out of 19 months between July 2014 and January 2016.
- From April to October 2015 the average proportion of patients with ST elevation myocardial infarction who received an appropriate care bundle was better than the national average.
- The service provided evidence based care and treatment in line with national guidelines such as the Joint Royal Colleges Ambulance Liaison Committee and the National Institute for Health and Care Excellence.
- The trust had developed an initiative to reduce the number of patient transfers to hospitals. There were pathways to prevent hospital transfers and staff had received additional training to enable them to treat patients at home. This had reduced the number of hospital transfers.
- The patient transport service was achieving the targets identified in key performance indicators for commissioner satisfaction and patient satisfaction and the service was working well with local acute hospitals to provide useful information that enabled wards to plan better for patient arrivals and departures
- Business continuity plans were developed in line with International Standardisation Organisation (ISO) standards.
- The special operations team were supported by six air ambulances provided by five charities providing cover for the whole of the geographical area covered by SWAST.
- Within the minor injuries unit (urgent and emergency care), pain relief was administered quickly and effectively. X-ray results were reviewed by a specialist radiology doctor within 24 hours and there was a low rate of unplanned re-attendances.
- Clinical audits took place within the minor injuries unit and the information gained was used to improve care and treatment. The learning needs of staff were identified at six-weekly clinical supervision sessions and at annual appraisals.

Caring

- Staff in all areas consistently demonstrated a high level of compassion, kindness and respect towards people, whether callers, patients or relatives/ carers. At all times, patients, relatives, and callers were treated as individuals and given support and empathy in often the most difficult circumstances.
- Feedback from patients and those close to them was consistently very positive. We accompanied crews on emergency and urgent calls and spoke with patients and relatives in emergency departments. Without exception, patients, relatives and other healthcare professionals told us that ambulance staff acted with care and compassion.
- Staff were passionate about their patients' care and wellbeing. We saw numerous examples where staff 'went the extra mile' to ensure their patients' comfort and wellbeing.
- Staff recognised when patients required further information and support and this was provided at all times.
- Staff made sure people had understood the information given back to them by telephone advisors. Staff asked questions in a calm approach but with empathy and clarity. Staff recognised it was hard for people calling the service to interact over a telephone line, but staff got the best information and gave the best responses they could when they were otherwise not able to see the patient. Distressed and overwhelmed callers were very well supported by staff. Staff used their initiative and skills to keep the caller calm, and provide emotional support in often highly stressful situations.
- There were systems to support patients to manage their own health and to signpost them to other services where there was access to more appropriate care and treatment. Staff involved patients in

decisions about their care and treatment. When appropriate, patients were supported to manage their own health by using non-emergency services such as their GP
- Staff took time to interact with patients and were supportive to them and to their relatives/carers and treated patients with dignity and respected their privacy at all times.
- Staff showed understanding of the challenges faced by patients and their carers.
- Communication with children and young people was age appropriate and effective.

Responsive

- The emergency operations service was operating a responsive 'hear and treat' service to ensure the best use of limited resources. Resources were used where they were most needed.
- The trust had been commended for its service to reduce and respond to frequent callers and to reduce unnecessary admissions to emergency departments.
- There was service planning to meet the immediate urgent and emergency care needs of local people. There was flexibility, choice and continuity of care which was reflected in the types of services we saw. Most patients had timely access to initial assessment, diagnosis or urgent treatment.
- The ambulance response project or ARP started 19 April 2016. The expected outcome of ARP was to ensure that the most appropriate response vehicle was sent to each patient's correct location rather than just meeting a time target by sending the nearest vehicle. Call centre staff would provide additional time to triage patients on the phone when it was clinically safe and appropriate to do so, and this helped them to decide on the best vehicle to send. The full impact of the ARP project was not known during the inspection period, as it was still in pilot phase.
- The trust used a network of volunteer community first responders, responders such as fire co responders, doctors and others including trust staff that could supplement core ambulance resources
- Reasonable adjustments were in place for some patients. Action was taken to remove barriers to patients with physical disability, those with reduced mobility or those who had bariatric needs who found it physically hard to use or access services. The trust also ran blue light days where people with a learning disability could familiarise themselves with ambulance vehicles, equipment and staff to understand the service better. This also enabled staff to better understand the needs of people with learning disabilities.
- Two new Patient Transport Service bases had been opened at Weston Super Mare and Soundwell ambulance stations to meet local need. There was a '24/7'service which consisted of one vehicle and a crew available between 6p.m.and 6a.m. Escorts were encouraged to accompany patients living with dementia or learning disability or for patients whose first language was not English. This enabled staff to meet the patient's individual needs
- The resilience facilities were purpose built and located to cover the majority of the trusts operational area.
- The trust was supported by five air ambulance charities with six aircraft providing good air ambulance coverage.
- There was a dedicated events team who took the lead for assessing, planning and resourcing public events to minimise the effect on the trust's normal business.
- 99.8% of patients attending the minor injuries unit were treated, discharged or transferred within four hours in the year ending March 2016. The average time to treatment was 49 minutes. Waiting times were constantly monitored in real-time by clinical staff.
- Complaints were handled with sensitivity and time was taken to provide a considered response within most core services. There was learning and improvements made when people complained about the service they received, though not all complaints were being responded to in the time required.

However:

- It wasn't easy for patients or people close to them to know how to complain or raise a concern. Staff gave a variety of responses of how patients could make a complaint describing that patients could telephone or submit their concerns online on the trust website. Not all vehicles had complaints forms or information for patients to read or take away with them.
- There were no communication aids or hearing loops within patient transport vehicles. Staff did not use interpretation facilities when patients did not speak

English as their first language. Instead they relied upon patients bringing an escort for the journey. However, staff could access the language line for translation services whilst at the ambulance base

- The triage systems used within the emergency operations centres did not prompt staff to ask whether a person was vulnerable, such as living with dementia or a learning disability.
- The HART teams were able to respond quickly to emergencies within their area, except within Cornwall due to the distance from Exeter.
- Within the minor injuries unit, X-ray services were not always available when patients needed them. The x-ray department closed at 5pm during the week and was only open for four hours a day at weekends. Although patients told us they did not mind returning the next day, there was a possibility of delayed treatment.
- Within the out of hours service, people reported finding it easy to make appointments.

Well led

- Quality, in terms of patient outcomes and experience, did not feature highly at operations meetings, although a quarterly quality report had recently been introduced.
- Within most areas, risks to quality and safety were well understood at a local level but were not locally recorded and accountability for managing these risks was not defined. Risk registers maintained at directorate and corporate levels did not align with the risks and worries described to us by staff and managers. We saw little evidence that the risk register was regularly discussed at service line or division or actions to mitigate risks reviewed. There were some risks on the risk register that had remained there too long without resolution. This included the poor performance in staff appraisals which had been added in 2007 and staff turnover added in 2013.
- We were concerned about a lack of local oversight in respect of infection control. This highlighted a disconnection between different reporting lines.
- Whilst the trust had made significant efforts to support staff wellbeing, their efforts were somewhat overshadowed by the intensity of work, due to relentless and increasing demand on the service and the pressures this placed on staff. Staff morale and motivation was mixed. Some worrying messages had emerged from the 2015 staff survey in relation to frontline ambulance staff. Staff dissatisfaction was reflected by results which showed that a significant proportion of staff felt unwell due to work related stress, felt pressurised to work despite not feeling well enough to perform duties, and had experienced musculoskeletal problems as a result of work activities. The survey also highlighted that a significant proportion of staff suffered physical violence and/or harassment, bullying or abuse from patients, their relatives or other members of the public. Local action plans had recently been developed but this was work in progress. The leadership was not aware of when the levels of professional support given to staff were failing.
- There was a culture in which there was an unspoken expectation that staff would work longer hours than they were contracted to work. Staff told us they regularly finished their shifts late, missed their meal breaks, arrived early for work to undertake vehicle checks and undertook activities such as reading email updates and bulletins and undertaking training in their own time.
- The intensity of work undoubtedly contributed to staff absenteeism and high levels of staff turnover. There was a variable degree of and formality in one-to-one support for staff.
- There was a limited approach to obtaining the views of patients and staff were not engaged in this process.
- The 2013/2014 integrated business plan included was some evidence of forward planning for service improvement in the patient transport services. However at a local level, leaders appeared demotivated to effect improvement. Staff did not feel valued by their employers or by the managers of their service where the culture was described as insensitive to the needs of staff.
- Some aspects of governance related to safety issues were not adequately monitored within patient transport services, for example, infection control. Risk registers did not capture all known risks, including clinical risks and the governance processes did not identify a lack of incident report. Identified training needs were not acted upon.

Summary of findings

- There was very limited oversight of quality in the Patient Transport Service other than performance against key performance indicators. Some aspects of governance related to safety issues were unclear and were not monitored effectively.

However:

- There was a clear vision and credible strategy for the emergency operations service. The leadership reflected the values of the service and were open, approachable and supportive. The service was innovative and looking for ways to improve and sustain.
- There was a clear vision in place for the EPRR teams, especially special operations and where they wanted to take the service over the coming five years.
- The governance framework had clear responsibilities.
- The trust had introduced the 'Staying Well' service in December 2015 in response to a year-long staff consultation and staff requests for a coordinated support system, with an emphasis on mental health. There was a peer support network introduced in April 2016 and the trust had 38 trained peer supporters. Staff could also access 'fast track' physiotherapy treatment, which was funded by the trust.
- There was a well-publicised mission statement and a set of core values within emergency and urgent care. Whilst not all staff could articulate these, they consistently demonstrated their commitment to delivering high quality care to patients.
- Leaders of the patient transport service had ensured that all staff were fully informed about the outcome of the tendering process. Performance of the service against the key performance indicators was monitored effectively.
- Staff within the EPRR teams attended/chaired a wide variety of national groups and committees to lead and share best practice.
- The trust conducted traumatic risk monitoring and the 'staying well service' were available to staff should they need it.
- A dedicated events team had taken responsibility for planning, resourcing and managing SWAST attendance at public events.
- A computer application 'SWAST Commander' had been developed for iPad and Android platforms to be used by operational commanders during major incidents

We saw several areas of outstanding practice including:

- The trust was influencing service improvements at a national level, for example the ambulance response programme.
- The Aspire programme, developed by the trust, was providing excellent opportunities for personal and career development to all staff.
- There was, at times, outstanding professionalism and grace under pressure among the emergency medical advisors in the Bristol and Exeter emergency operation centre (clinical hub) teams. We heard staff being criticised, shouted at, called abusive names and threatened. All of this was disruptive to staff and unsettling. The staff remained calm, and handled the callers with courtesy and patience.
- Staff in the emergency operations centres showed outstanding compassion and understanding to people in difficult and stressful situations. Staff made a genuine connection with patients and others who were scared or anxious and developed an, albeit temporary bond, with the person trying to help them. Staff would, appropriately, say "take care" and "all the best" to people, and this was often repeated back to staff by people who had appreciated their friendliness and warmth.
- Although the emergency operation centres' call-quality audit programme was not completed as often as required because of other priorities, and staff shortages, it had been previously commended and recognised for its quality. There was, nevertheless, an outstanding quality to the audits when they were being undertaken. This included the feedback, which was delivered with thoughtfulness, professionalism and the intention for staff to do well. There had been changes based on staff being asked how they found the process to make it more empathetic for those being examined.
- There was an outstanding and commended programme to manage frequent callers to the service. This was helping to release the organisation's limited resources to more appropriate situations. There was strong multidisciplinary working to support frequent callers with the service promoting the issue among the wider community and partner organisations.
- At the time of our inspection the service had just embarked on a trial, known as the Ambulance Response Programme. This 12-week pilot aimed to

improve response times to critically ill patients, making sure the best response was sent to each incident first time and with the appropriate degree of urgency. The trust was one of two ambulance services nationally participating in this trial.
- The introduction of Right Care had resulted in 56.8% of patients, who called for an ambulance, being treated at the scene or referred to other services, rather than being conveyed to hospital emergency department.
- Operational staff took time to interact with patients and were supportive to them and to their relatives/ carers. Staff treated patients with compassion and dignity and respected their privacy at all times.
- The range of staff support schemes provided showed a commitment to improving staff wellbeing and we received positive feedback from staff who had used these services. The introduction of a fast track physiotherapy service had resulted in a reduction in sickness absence due to musculoskeletal injury.
- The trust had a dedicated events team to manage the assessment, planning and resourcing for public events.
- The trust produced a newsletter called "twentyfourseven" published for members of the public with news, long-service awards for staff, notable events taken place or coming up in the trust's area, and success stories. These newsletters were available on the trust's website. The high-quality publication provided the public with good information about the service and its achievements.

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

Importantly, the trust must:

- Ensure mandatory training for all staff, including safeguarding for vulnerable people, is updated and maintained in accordance with the trust's target.
- Ensure staff appraisals are completed each year to meet the trust's target. The organisation must also ensure it is aware of those staff who have not had an appraisal for many years, and offer support and recognition where warranted.
- Ensure risk registers are aligned with operational risks and that risk registered are reviewed regularly to monitor and mitigate risks
- Ensure work intensity and fatigue is monitored and actions put in place to mitigate risks to staff
- Ensure governance meetings at local levels contain a strong focus upon quality and safety. This will include performance reports on training, appraisals, patient outcomes, complaints and incidents relevant to the local level. Actions from addressing any shortcomings or changes must be recognised and completed. Leaders of the Patient Transport Services must ensure that staff are encouraged to report incidents and that feedback and learning from incidents is shared with the team. Incidents should be an integral part of the governance process and viewed as a positive opportunity for learning.
- Ensure patient transport service engage in a regular programme of audit including infection control, safety of vehicles. These audits should be recorded and an agreed action plan documented and progress monitored through the governance processes.
- Ensure accurate, contemporaneous and complete record of all treatment undertaken by Patient Transport Services staff and that across all services records are stored securely at all times to prevent unauthorised access.
- Ensure adequate guidelines and protocols are in place to guide patient transport staff in their clinical decisions regarding adjustment of oxygen therapy.
- Ensure a system is put into place which informs patient transport service crews of any important clinical information relating to the patients they convey, such as when a patient has diabetes.
- Ensure that healthcare assistants who undertake initial clinical assessment of patients are assessed as competent before working independently
- Ensure that all staff are familiar with their responsibilities in regard to the safeguarding of vulnerable adults and that robust reporting arrangements are in place.
- Ensure partly administered controlled medicines no longer required are disposed of in accordance with the service standard operating procedures and that medicines are stored securely in the back of ambulances and cars when the crew is not present.
- Review the management of clinical waste in ambulance stations to avoid risks to staff.
- Ensure infection control issues identified in this report are addressed.
- Ensure complaints are handled effectively. Information and guidance about how to complain must be

available and accessible to everyone who uses the service in a language and format to meet the needs of the people using the service, for example those who were hearing or sight impaired.
- Take action to meet locally agreed thresholds in respect of Ambulance Clinical Quality Outcomes.

In addition the trust should:

- Ensure all staff have the time and resources to directly report incidents, and all staff recognise and respond to their duty to report them in a timely way following trust policy.
- Make improvements to the delays in investigating and reporting on serious incidents within the period granted.
- Be clear as to how the feedback from serious incidents is disseminated to staff in future.
- Extend the infection control policy in the emergency operations centres so the procedures for staff around the use of hand gels were clear and consistent for all members of the teams.
- Consider implementing occasional test or practice runs for IT system failures in the emergency operations centres when most convenient and safe to do so.
- Continue with the work to provide commonality among the systems used within the emergency operations centres.
- Ensure all emergency operations centres staff are aware of the need to have clinical input into the decision to stand down an ambulance from a scene.
- Consider possible solutions for emergency operations centres staff from having outdated special notes linked to an address where the notes were no longer relevant.
- Undertaken a staff review within the emergency operations centres to review the percentage of relief cover modelled against the increasing call volumes. Ensure staff can be released for training, holidays, special leave, and sickness, for example, without this affecting the quality of the service and pressure on remaining staff.
- Remodel the staffing rotas to take account of the known or predictable changes in seasonal demand.
- Ensure the major incident room in Exeter is not being used for other things preventing it being established for its purpose at immediate notice.
- Re-focus upon the emergency operations centres call-quality audit programme to provide staff with good feedback, encourage improvement, and reward excellence.
- Provide some relevant and useful mental-health training to all emergency operations centres staff.
- Improve the response to stroke patients so at least 57% of patients reach a hyper acute stroke centre within 60 minutes of their call to the service.
- Look for methods for emergency operations centres staff to spread out their continuing despatch education throughout the year and not just prior to their recertification being due.
- Consider training or guidance for emergency operations centres staff for communicating with young children.
- Ensure there is a formal handover period factored into the working pattern of the emergency medical dispatchers in the emergency operations centres.
- Establish one-to-one sessions for staff and line managers to take place within the emergency operations centres on a regular basis. Ensure these are taking place and add value to the staff concerned and the organisation.
- Ensure all staff who do not have direct access to emails or the trust's intranet are kept up-to-date and well informed of new or updated information at all times.
- Review how a patient's mental health status is determined. Triage protocols do not proactively determine if the person is living with dementia or might have a learning disability.
- Develop and nurture valuable connections between staff in the emergency operations centres in Bristol and Exeter.
- Review security for all staff working in the emergency operations centres, when the surrounding area was largely unoccupied by other people, were able to leave the offices safely.
- Work to develop a more positive culture within patient transport services. This includes taking action to listen to all groups of staff in a forum that is perceived to be safe and confidential, and addressing the development needs of staff in leadership positions.
- Ensure exit interviews are conducted and take action to address concerns identified by staff within these exit interviews.

Summary of findings

- Ensure regular staff meetings occur within patient transport services and these are recorded for the benefit of those staff unable to attend.
- Ensure the environment in the urgent care centre is safe for children.
- Ensure that there is sufficient space in the waiting area and that waiting patients can be viewed by staff at all times.
- Ensure the handheld electronic patient care record devices are fit for purpose in all areas.
- Review the lighting for vehicles reversing onto the quay in St Agnes to ensure safety of staff and patients when reversing onto the quay to meet the boat.
- Review the audit of the services provided on the Isles of Scilly undertaken in June 2015, to ensure actions identified have been implemented.
- Review the provision, availability and contact ability of community first responders on the Isles of Scilly.
- Ensure that patient transport services monitor compliance with The National Institute for Health and Care Excellence (NICE) Quality Standard QS72 Renal Replacement Therapy services for Adults.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to South Western Ambulance Service NHS Foundation Trust

On March 1, 2011 the trust became the first ambulance service in the country to become a Foundation Trust, and acquired Great Western Ambulance Service in February 2013. It covers the following geographical area

- Cornwall
- Isles of Scilly (IOS)
- Devon
- Dorset
- Somerset
- Wiltshire
- Gloucestershire
- The former Avon area (Bristol, Bath, North and North East Somerset and South Gloucestershire)

The area is made up of approximately 5.3 million people with an additional 17.5 million visitors per year and covers 10,000 square miles (around 20% of mainland England). It spans 13 Clinical Commissioning Groups and serves 18 acute trusts.

The trust provides the clinical teams for six air ambulances (two in Devon, one in Cornwall and the Isles of Scilly, one shared across Dorset and Somerset, one in Wiltshire and one based near Bristol). There are three control rooms (clinical hubs); in St Leonards, Exeter and Bristol.

The trust provides the following services:

- 999 ambulance services
- HART (hazardous area response teams)
- Patient transport services
- GP out of hours services
- Minor injuries unit (Tiverton, Devon)
- NHS 111 (Devon, Cornwall, IOS and Dorset) – This was inspected in March 2016 and is reported separately.

The trust employs over 4,000 mainly clinical and operational staff, including Paramedics (1,788), Emergency Care Practitioners, Advanced Technicians, Ambulance Care Assistants and Nurse Practitioners) plus GPs and around 2,785 volunteers (including community first responders, BASICS doctors, fire co-responders and volunteer PTS drivers).

Calls from the public and urgent calls from healthcare professionals are received and triaged in one of three emergency operations centres (Bristol, Exeter and St Leonards, Dorset) where callers are provided with advice and ambulances are dispatched as appropriate. The emergency operations centres also provide assessment and treatment advice to callers and manage requests from health care professionals to convey people either between hospitals or from community services into hospital.

In 2014/15 the trust responded to 867,505 emergency and urgent incidents, helped 155,965 patients calling their out of hours service and completed 99,907 patient transport journeys.

Resources and teams include:

• 306 ambulances

• 234 rapid response vehicles

• 57 patient transport service vehicles

• 7 motorcycles

• 6 helicopters

• 5 bicycles

• 1 boat

• 96 stations and two Hazardous Area Response Teams (HART), based in Bristol and Exeter.

Patient transport services (PTS) provided non-emergency transport for adults and children in Bristol, North Somerset and South Gloucestershire, who were unable to use public or other transport due to their medical condition. Vehicles were based at six sites: Bristol, Almondsbury, Yate, Nailsea, Soundwell and Weston Super Mare. The trust also utilised a boat to facilitate patient transport services in the Isles of Scilly. Eligibility criteria were applied by the healthcare professionals who made the referral to the PTS control center. There were 120 members of staff working in PTS. During April 2015 to March 2016, the service provided 105,317 patient journeys, accounted for 2% of the budget held by the operations team, and were responsible for 5.0% of the patient contacts by the trust.

Summary of findings

The Out of Hours services are run from the clinical hub based at East Division, (St Leonards), where calls are received, triaged and assessed by clinicians. There is also a second hub office with a small call centre located in Gloucester.

The trust provides out of hours services seven days a week out of hours GP service when patients' own GP practices are closed. This includes medical advice and assessment for patients who have an urgent problem that can not wait until a visit to their own GP can be arranged. The Dorset hub covers 550,000 to 600,000 patients with six treatment centres and 12 mobile units (cars). Treatment centres are based at; Bournemouth, Dorchester, Poole, Shaftesbury, St Leonards and Weymouth. The service also provides an out of hours contact for HMP Prisons located in Dorset. The Gloucester hub covers six treatment centres in Cheltenham, Cirencester, Dike, Gloucester, Moreton and Stroud.

Access to the out of hour's service is via the NHS 111 telephone system in both Dorset and Gloucestershire. However patients in Gloucestershire have the additional provision of walk-in services that they can attend without an appointment. The out of hour's service is available from 6.30pm until 8am, every night of the week and 24 hours a day at weekends and bank holidays.

We inspected this location as part of our planned comprehensive inspection programme. Our announced inspection took place on 6-10 June 2016. During the inspection, we visited PTS premises, ambulance stations, HART bases and hospital locations as well as five out of hours treatment centre in order to speak to patients and staff about the ambulance service.

Our inspection team

Our inspection team was led by:

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

Head of Hospital Inspections: Mary Cridge, Care Quality Commission

The team of over 45 included 19 CQC inspectors and inspection managers, a pharmacy inspector, an analyst, an inspection planner and variety of specialists including past and present directors and associate directors of NHS Direct, NHS 111 and urgent care, an assistant director for performance improvement, director of nursing and governance, a director of special operations, HART Trainer, a consultant in adult & paediatric emergency medicine, contact centre team leader and manager, paramedics, a senior emergency care practitioner, emergency care technician, clinical supervisor and a community responder volunteer.

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The inspection took place from 6-10 June 2016, with unannounced visits taking place 17,20 and 22 June 2016.

The inspection team inspected the following services:

- Emergency operations centre (EOC)
- Emergency and urgent care
- Patient transport services (PTS)
- Resilience
- Urgent and emergency care
- Out of hours

The 111 service was inspected in March 2016 and is reported separately.

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about the trust. These included local clinical

Summary of findings

commissioning groups (CCGs); NHS England; NHS Improvement, Health Education England (HEE); College of Emergency Medicine; General Dental Council; General Medical Council; Health & Safety Executive; Health and Care Professions Council; Nursing and Midwifery Council; National Peer Review Programme; NHS Litigation Authority; Parliamentary and Health Service Ombudsman; Public Health England; the medical royal colleges; local authorities, local NHS Complaints Advocacy Service; local Healthwatch groups; and local health overview and scrutiny committees. The inspection team also spoke to staff trust-wide at focus groups the week before the inspection.

We visited two emergency operations centres (Bristol and Exeter) and 20 ambulance stations, two hazardous area response teams and the patient transport service base. We spoke to staff during our visits including call handlers, dispatchers, clinicians, managers, paramedics, emergency care technicians and emergency care assistants, patient transport managers and crew, community first responders, infection prevention and control, and safeguarding leads. We also spoke with managers within the services inspected as well as directors of the trust.

We spoke with the relatives, carers and patients. We also examined information sent to us by the public.

We inspected ambulances and reviewed patient records. We also attended hospitals, where we observed the interaction between ambulance crews and hospital staff. Whilst there, we spoke with emergency department staff to get feedback on the service provided by the ambulance trust and observed patient handovers at emergency departments. We rode in ambulances in order to observe interactions between staff and patients and listened in to emergency calls in the operations centres.

We spoke with staff in various roles including paramedics, emergency medical technicians, team leaders, station officers, senior managers and community first responders and PTS staff. We looked at vehicle maintenance, cleanliness, the planning of vehicle servicing and MOT testing.

What people who use the trust's services say

The trust provided an effective 'hear and treat' service for patients. The service was recognised as one of the highest performing in England for this service enabling clinicians to assess and triage patients over the telephone and close the call without sending an ambulance. The trust performed within expectations in the 'hear and treat' survey.

We received feedback from local Healthwatch organisations in all areas. The majority of feedback was favourable about patient experience.

We reviewed responses to 'friends and family' surveys and obtained patient views during inspection. Patients and their relatives/carers also contact us by telephone, email and wrote to us before, during and after our inspection. All comments received were mostly positive across all services. We also spoke with staff receiving patients at acute hospitals across the area.

Facts and data about this trust

Demographics:

The area is made up of:

- approximately 5.3 million people
- 10,000 square miles (around 20% of mainland England)
- 13 CCGs
- 18 acute trusts and has 17.5 million visitors per year

In 2014/15 the trust:

- Responded to 867,505 emergency and urgent incidents
- Received 918,227 NHS 111 calls (at the time, the Trust also provided this service to Somerset)

Summary of findings

- Helped 155,965 patients calling their out of hours service
- Completed 99,907 patient transport journeys

Resources and teams include:

- 306 ambulances
- 234 rapid response vehicles
- 57 patient transport service vehicles
- 7 motorcycles
- 6 helicopters
- 5 bicycles
- 1 boat
- 96 stations and two Hazardous Area Response Teams (HART), based in Bristol and Exeter.

The trust provides the clinical teams for six air ambulances (two in Devon, one in Cornwall and the Isles of Scilly, one shared across Dorset and Somerset, one in Wiltshire and one based near Bristol). The trust's three 999 control rooms (clinical hubs) are in St Leonards, Exeter and Bristol.

The trust employs over 4,000 mainly clinical and operational staff, including Paramedics (1,788), Emergency Care Practitioners, Advanced Technicians, Ambulance Care Assistants and Nurse Practitioners) plus GPs and around 2,785 volunteers (including community first responders, BASICS doctors, fire co-responders and volunteer PTS drivers).

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? Overall we rated the safe as requires improvement. We rated safe as good in emergency operations centres and outstanding in resilience. However we rated it as requires improvement in emergency and urgent care, patient transport services, urgent and emergency care and out of hours services. • Although there was a strong safety culture within the trust not all staff reported incidents, particularly within patient transport services and the emergency operations centres. • Medicines were not always securely stored or safely administered and disposed of. There were occasions when medicines were left unattended on ambulances and doors were unsecure in stations. Administration of medicines and disposal was not always safely carried out. • Cleanliness and control of infection was not being managed effectively However: • The trust complied with the duty of candour regulations and had a proactive approach to issuing apologies. • There was a strong emphasis on learning lessons from incidents and complaints. • There was an appropriate mix of skills within the staff groups to provide a safe service. Where staffing levels were below the establishment (planned) levels, the trust was responding by attempting to recruit new staff. **Duty of Candour** • The trust had a clear and comprehensive duty of candour policy in place as part of the serious and moderate harm incident policy. This set out the statutory framework and gave clear guidelines on the processes to be followed. • The trust arrangements for the reporting and management of incidents included arrangements for support to staff. A review of serious incident investigation reports showed that the duty of candour had been appropriately triggered, that learning had been captured and that staff had been supported. There was evidence of appropriate communication with patients and their relarives. • The Trust displayed a clear commitment to openness beyond the statutory requirements of duty of candour. For example	**Requires improvement** 

there was a policy of giving proactive apologies. These were sent to patients who have suffered harm but who have not submitted a complaint and where the duty of candour had not been triggered. These were identified from incident reports by the incident team. The team saw a number of examples of these apologies being given.

- Details of the duty of candour were available on the trust intranet and had been included in communications to staff bulletin. Both executive and non executive directors displayed a clear understanding of the duty.

Safeguarding

- The trust had a safeguarding lead with overall responsibility for providing support, training and advice to staff. The lead was responsible for the relationships with the 30 safeguarding adults and safeguarding childrens boards that exist within the trust's area. There were named professional leads for safeguarding in each of the trust's divisions and these were the people who attended their local safeguarding boards. The trust always attended child death review panels and participated as required in serious case reviews.
- Safeguarding referrals were triaged ahead of referral. A recent audit of 20 adult and 20 childrens referrals had been undertaken which confirmed that 80% of the referrals were appropriate. Referrals for children made up 29% of the trust's total referrals and of these 30% were related to safeguarding and 70% to welfare. A safeguarding report was provided to the quality committee and covered both numbers and the quality of referrals. Where staff have acted and triggered a referral, the safeguarding lead called to give feedback.
- All safegauarding training was delivered face to face within the trust. Volunteers also received training and were subject to enhanced checks. However, not all staff were up to date with training. For example only 49% of emergency operations centres staff had updated their mandatory skill set, which included safeguarding children and vulnerable adults.

Incidents

- There were well established and effective systems in place for incident reporting and management. There was an incident reporting policy and a serious and moderate harm incident policy incorporating both Duty of Candour and Never Events. The policies and arrangements took account of and complied with the latest relevant guidance.
- Incidents were reported via an electronic form on the intranet to the trust's risk management system. All reported incidents

were reviewed by an incident team who sifted for potential moderate and serious incidents. The team made decisions against clear criteria that reflected national best practice. All serious incidents were reported to commissioners through the national reporting system.

- However, not all staff were reporting some of the things classed as an incident by the trust. For example, the incident report supplied for the emergency operations service contained 1,108 incidents reported between 1 October 2015 and 31 March 2016. In this six-month period there were only nine reported incidents under the category "abuse from persons external to the trust" and "verbal abuse or disruption". Most described this as part of the job, and they did not see this as an incident, unless it stood out as exceptionally bad. Trust policy required staff to report security incidents, including verbal abuse, described as the use of "inappropriate words or behaviour causing distress and/or constituting harassment." Some staff members within emergency and urgent care described at times feeling too busy dealing with urgent and emergency work to report all incidents. When incidents occurred, staff informed the dispatch team who logged these onto the electronic management system which was particular to the patient transport services. Managers of the service then decided which of these incidents to report on to the trust electronic reporting system. This process meant that not all incidents were visible to the trust wide governance system, and trends involving incidents within the patient transport service might not be identified or monitored effectively
- Line managers acted as the investigating officer or appointed one from the list of relevant managers on the system. Serious incidents were investigated by one of a group of staff, known as quality leads, who had been extensively trained in root cause analysis. The template report had recently been amended to make it more patient focussed. Commissioners conducted their own panel hearings before closure. All completed reports were referred to a Serious Incident Review Group, which was chaired by a director and included all relevant parties, including staff, non executive directors and commissioners. Commissioners conducted their own panel hearings before closure.
- There was a strong emphasis on learning lessons from incidents and complaints. Lessons learned were gathered and themes identified from each source areas. These were reviewed at quarterly Quality Development Forums and a staff bulletin, Reflect, reported on lessons learned. The trust had gone to great lengths to reassure staff that the emphasis was on learning and that they would be supported.

- The team reviewed six serious incident investigation reports and found them to be robost and thorough. All six included details of the support given to the patient and their relatives and to the staff involved and identified the arrangements for shared learning.
- There was a weekly decision making group, chaired by the head of governance, to oversee the categorisation and handling of incidents, third party enquiries, complaints and reports from the coroner. A quarterly report on incidents was submitted to the Quality Committee chaired by a non executive director. The Board received a quarterly report on the content and progress of serious incident investigations and there was an annual report on Patient Safety and Experience, the most recent of which was submitted to the Board in May 2016.
- In the 2015 NHS staff survey 30% of respondents reported witnessing potentially harmful errors, near misses or incidents in last month. However, this was slightly better than the national average for ambulance trusts.
- In the 2015 staff survey the trust's score in relation to the fairness and effectiveness for reporting errors, near misses and incidents was 3.4 out of five which was better than the national average for ambulance trusts.
- At the time of the inspection there was a large backlog, around 2000, of low level incidents that had not been closed. Whilst the robust arrangements for the categorisation of incidents provide assurance that serious issues have not been missed this backlog was a concern to the team.

Staffing

- There was an appropriate mix of skills within the staff groups to provide a safe service. Where staffing levels were below the establishment (planned) levels, the trust was responding by attempting to recruit new staff.
- There was some local competition from other call centres, which had advantages for some potential recruits, with which the ambulance service could not compete. This included generally shorter shifts, and working daytime-hours only. The rates of pay were generally not dissimilar, but, due to different packages, some of the call centres looked better at first glance. To compensate for the dropout rate among new recruits, the emergency operations service had increased the length of their training for emergency medical advisors from 8 weeks to up to 12 weeks. There was pre-interview job experience for potential candidates to try to deter candidates who might otherwise

drop out during or shortly after training. The emergency operations service was considering loyalty bonuses for staff within a trust-wide retention strategy to support the frontline workforce.

- Within the emergency and urgent care service, actual verses planned staffing levels for April and May 2016 showed the trust was meeting their planned staffing levels 98% of the time with a 1% use of agency staff. The trust did not use a staffing tool as staffing levels were based on the needs of each division.
- We were told that staffing levels in the patient transport service was reviewed every twelve months. However, this process was not recorded and no adjustments to staffing levels had been made as a result of these reviews.
- The trust was supported by doctors working on honorary contracts across the whole area. These doctors were trained to provide medical support at the scene of an accident, major incident or public event. They worked closely with paramedic crews and in particular the critical care and hazardous area response teams. Some of the doctors were also attached to the air ambulance operations of which there were six across the area covered by the trust. These aircraft were provided by five charities who either owned the aircraft and employed their own pilots, or the aircraft and pilot were provided on leased arrangements by a separate company. These aircraft were staffed by 44 paramedics who had been specially trained to work in air operations.
- Flexibility of staffing meant that the minor injuries unit had not had to close on any occasions in the last year.

Infection control

- Cleanliness and control of infection was not being managed effectively across the trust. There were rotas for environmental cleaning of ambulance stations. However, practices and levels of cleanliness varied between stations. Some stations had cleaning staff and for other stations, it was the responsibility of the clinicians. Staff reported not always having time for cleaning to take place due to the volume of calls to clinical incidents. Staff were unable to provide cleaning schedules or logs of the cleaning had been carried out at some stations.
- In most of the stations we inspected, boxes of equipment were kept on the floor of storage areas making effective cleaning difficult. We saw debris and dirt on the floor around the boxes. Sluice rooms varied in their cleanliness and tidiness. In places

cleaning chemicals, clean equipment and soiled storage boxes were stored together. In Plymouth, there was the potential for cross infection from guano from nesting birds which were also reported as a concern on St Marys.

- Staff were responsible for cleaning their vehicles during their shift and there was equipment available on ambulance stations for this purpose. Staff were required to clean their vehicles during the last 20 minutes of their shift; however, many staff told us they rarely had time to do this. If this was the case they would inform the incoming crew. Deep cleaning facilities were available if the vehicle was seriously contaminated.
- Make ready operatives were employed in the larger stations. They were responsible for routine and emergency deep cleaning of vehicles. However some members of staff told us they had not received updates in infection control training since induction. For one member of staff, this had been six years.
- There were medical device storage rooms at most of the stations we visited. However, the processes, storage and standards for cleaning of equipment varied. In some stations, equipment, which was visibly contaminated, was stored with clean equipment, items were stored on visibly dirty floors and there was not a system to indicate which items were clean or dirty.
- The trust standard required vehicle 'deep cleans' to be completed every 8 weeks. Only 21.3% of PTS vehicles had consistently achieved this standard during April 2015 to March 2016.
- Systems were in place for the management and disposal of clinical waste. However, processes and practices for clinical waste varied and at some of the ambulance stations and the management and disposal of clinical waste was not always safe. Sharps were appropriately disposed of on ambulances in rigid containers. We noted however, that these were not consistently dated and some were left open, putting staff and patients at risk.
- However, hand washing facilities were available and staff were observed washing their hands and using the hand decontamination gel.
- Staff were made aware of known infection and hygiene risks associated with individual patients. Information regarding patients was sent to them via the electronic patient care record and details about infection and hygiene were included.

Medicines

- The patient triage system used by the emergency operations centre staff provided them with advice to give to patients or

carers about medicines that could be taken by the patient awaiting an ambulance. The system was regularly updated as part of the licence by the provider of the software, so advice provided was based upon current guidance.

- Patients were given information about the medicines they had been given and why and staff routinely recorded medicines given to patients.
- Ambulances carried “green pharmacy bags” used to transfer patient’s own medicines from home to hospital which ensured they were safely handled and secure during the transfer.
- However, not all medicine procedures were safe and followed trust protocol. Medicines were not always stored securely. Examples we saw included, at Torquay station, the door to the storeroom containing medicines was propped open and at Plymouth station, the door was tied open with a bandage. We observed vehicles unattended and unlocked and in two cases with the doors or boot wide open when the crew were attending to a patient out of sight of the vehicle. When some ambulances were outside emergency departments these were also left open and the cupboards where the medicines bags were stored were not locked. This meant that the public could access medicines and did not ensure the security of the medicines and intravenous fluids within the vehicles.
- Staff were also not consistently following the trust's procedures for the administration and disposal of part used syringes of controlled medicines. We observed morphine being drawn up into a syringe by one member of staff and administered by another who did not check it. During the inspection we were also told that excess medicines were incorrectly disposed of by either squirting on to the floor or down a sink.
- The patient transport service administered Entenox (medical nitrous oxide and oxygen mixture) to patients on journeys. We were not given assurance that the administration of this gas was governed safely or effectively. Although this gas does not require a prescription to be administered, there are risks to patients if used more frequently than every four days without monitoring the patient’s haematology. Use of Entenox (medical nitrous oxide and oxygen mixture) is designated as ‘minimal sedation’ however if used in combination with other sedatives or potent analgesia there is an increased risk of sedation. There were no clear protocols to guide staff in the safe use of this gas. Staff did not complete a patient care record when this gas been administered.
- In the out of hours service in Gloucester we noted the controlled drugs book was not fully completed and blank prescription paper was not always securely stored.

Summary of findings

Are services at this trust effective?

Requires improvement

We rated the effective domain as requires improvement. We rated effectiveness as good in resilience, out of hours and urgent and emergency care but rated it as requires improvement for emergency operations centres, emergency and urgent care and patient transport services.

We rated the effective domain as requires improvement because:

- Large numbers of staff had not had appraisals for some time, despite this being raised as an issue and put onto the risk register in the emergency operations centre in 2007
- The auditing of calls had fallen well below trust target at the time of inspection.
- Response times for most categories were consistently below the England average. The proportion of Red 2 calls responded to within 8 minutes was worse than the England average from April 2015 to January 2016. The trust had not met the national target of 75% since October 2014. From May 2015 the data provided showed a steady decline in performance against the target from 73.2% to 63.3%. Red 2 performance has been impacted by the introduction of the ARP. The Trust had national agreement that recognised this impact for performance management purposes and the target has been reduced to 70%. However, from August 2015 to January 2016, the trust had not met the new reduced target of 70%.
- From February 2015 to January 2016 the proportion of A19 calls responded to within 19 minutes was mainly worse than the England average. The national standard of 95% was not met for 10 of these 12 months.

However:

- Patient care was assessed and delivered using evidence based guidelines. There was an effective 'hear and treat' service.
- There was effective multidisciplinary working and coordination between other providers.
- The proportion of Red 1 calls responded to within 8 minutes was better than the England average for 16 out of 19 months between July 2014 and January 2016

Evidence based care and treatment

- Patient care was assessed and delivered using evidence based guidance, for example, accredited triage and clinical management systems in the form of the advanced medical priority dispatch system and NHS Pathways. Clinical assessment and the delivery of care followed National Institute

for Health and Care Excellence Guidelines and Joint Royal Colleges Ambulance Liaison Service Committee guidelines, with patients also being supported at home when it was safe to do so.

- Policies and guidelines were accessible. Revised guidance and policies were distributed throughout the trust by email on a Wednesday unless urgent. This was part of the 'Change Wednesday' initiative which aimed to reduce the number of emails throughout the week. Patients were supported at home in accordance with both JRCALC and NICE guidelines when it was safe to do so.
- However, there were 16 standard operating procedures used in the patient transport service including topics such as rest break management, assisting wheelchair users and wheelchair stability. There were no copies accessible to staff in their vehicles or means for staff to access the standard operating procedures when out of the office.
- Business continuity plans were developed in line with International Standardisation Organisation (ISO) guidance. The trust's emergency preparedness, resilience and response strategy complied with the Civil Contingencies Act 2004, and the core framework and standards from NHS England.

Patient outcomes

- Emergency operations centre clinical teams provided an effective 'hear and treat' service for patients. The service was recognised as one of the highest performing in England for this service enabling clinicians to assess and triage patients over the telephone and close the call without sending an ambulance. The service also had relatively good results against their own targets to provide patients with the right care pathway.
- The quality of care and patient outcomes were measured using Ambulance Clinical Quality Indicators. Results were variable with some results better than the England average, and others worse.

Response times

- The trust was one of only two trusts nationally piloting a new system of response called the Ambulance Response Programme (ARP). This aimed to improve response times to critically ill patients by allocating resources appropriately when patients initially contacted the service. The data provided by the trust would be used to help inform further national

developments. Since the introduction of the ARP the trust was reviewing all areas of resource dispatch and response times to ensure the most appropriate responses were made based on the clinical need of the patient.

- Calls to the service which were immediately life threatening such as cardiac arrest were termed Red 1. From July 2014 to January 2016, the proportion of Red 1 calls responded to by the trust within eight minutes was better than the England average for 16 out of 19 months. However, since October 2015, the trust data showed there has been a steady decline in performance against the national target from 73.3% to 69.9%.
- Calls which were serious but not the most life threatening such as chest pain were termed Red 2. From April 2015 to January 2016, the proportion of Red 2 calls responded to by the trust within eight minutes was worse than the England average. The trust had not met the national target of 75% since October 2014 and from May 2015, the trust data showed a steady decline in performance against this target from 73.2% to 63.3%. Red 2 performance has been impacted by the introduction of the ARP. The Trust had national agreement that recognised this impact for performance management purposes and the target has been reduced to 70%. However, from August 2015 to January 2016, the trust had not met the new reduced target of 70%.
- Handover delays at hospitals were managed locally on a daily basis and there were agreed escalation procedures. In the west division, a standard operating procedure had been agreed with one of the local hospitals and as ambulance staff had been experiencing delays, this was in effect at the time of our inspection. Staff we spoke with said the operating procedure worked well and reduced delays during the periods it was applied. The trust was also working closely with NHS commissioners to target other hospitals where long delays were experienced.

Competent staff

- Not all staff had annual appraisals and there was not always evidence of action plans to deliver improvements. The issue of poor performance in appraisal within emergency operations centre staff had been on the trust's risk register without a solution being reached since 2007. In some areas, compliance was very low. For example, in May 2016, appraisals completed in the previous 12 months were:
  - 29% of clinical supervisors at Bristol EOC and 52% at Exeter EOC.
  - 20% of control officers at both Bristol and Exeter.

  - 17% of dispatchers and supervisors at Bristol and 25% at Exeter.
  - 11% of emergency medical advisors at Bristol and 50% at Exeter.
  - 24% of administration staff and managers at Bristol and 41% at Exeter.
- Data provided by the trust showed from April 2015 to March 2016 compliance with appraisals within emergency and urgent care ranged from 38.4% for specialist paramedics to 87.4% for paramedics. Administration and managerial staff compliance was 41.6%.
- There were audit processes to monitor and assess how staff were handling calls into the service, but at the time of our inspection these had fallen well below target.
- Staff from all stations had access to a fully equipped training room in one of the larger ambulance stations in their area. Session with a learning development officer were provided in the training room to update staff skills. Themed workshops were also available to all staff at the training centre for example, life support for children and airway management.
- Additional role specific training was also available. There was a range of educational and developmental opportunities provided for staff as part of the 'GROW' element of the trust's 'Aspire' initiative. Part of the Aspire initiative was an intranet website designed to help staff develop their career by providing them with information and tools.

Multidisciplinary working

- We observed good multidisciplinary working. The triage systems used by the emergency operations centres enabled all staff to provide a multidisciplinary approach to working. The system enabled information to flow from the emergency medical advisor through to the dispatch team to provide the appropriate response
- There were effective handovers between ambulance and hospital staff. The trust policy was for clinical staff to handover care to emergency departments using a specified model called ATMIST. The initials stood for age, time, mechanisms, injuries, signs, treatment and ensured information relevant to the patient was passed on. We observed a number of handovers at emergency departments. We saw these provided emergency departments staff with detailed information regarding the patient when the trust policy was followed.

Summary of findings

- The patient transport service worked closely with two of the local acute hospitals to provide information that assisted the ward staff to prepare for patients imminent arrival or departure. This included a list the night before of expected patients and their anticipated time of arrival at the hospital.
- There was good coordination of services between other providers

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- Consent was obtained for any procedures undertaken by the staff. This included both written and verbal consent.
- Staff received training to support a patient with mental health problems including legal powers relating to transporting these patients.
- For unaccompanied patients or those who were unconscious staff we spoke with said they acted in the patients' best interest and were able to explain the process. Staff completed mental capacity assessments on occasion when a patient was unable to give consent due to confusion. Most staff were very knowledgeable about the assessment process and had a good understanding of the Mental Capacity Act and the Deprivation of Liberty Safeguards.

Are services at this trust caring?

Outstanding ☆

We rated caring at the trust as outstanding overall. We rated caring within emergency operations centres and emergency and urgent care as outstanding. All other services were rated as good.

We rated caring at the trust as outstanding because:

- Care was delivered that was truly compassionate and demonstrated kindness and respect.
- Staff were seen and heard 'going the extra mile'
- Feedback from patients carers and relatives was largely very positive.
- Distressed and overwhelmed callers were well supported by staff.

Compassionate care

- Staff in all areas were seen to deliver care with kindness and compassion. Even where the triage system provided a scripted text, it was delivered with real compassion and empathy.

Understanding and involvement of patients and those close to them

Summary of findings

- Staff recognised when patients and their relatives needed additional support to help them be involved in their care and treatment. Staff took time to support patients, relatives and other parties during distressing events.

Emotional support

- Distressed and overwhelmed callers were well supported by staff. Staff used their initiative and skills to keep the caller calm, and provide emotional support in often highly stressful situations.
- Emergency medical advisors provided continuous emotional support in certain circumstances to callers when an emergency ambulance response was on its way. Where necessary, and unless other priorities took over, advisors remained on the line until the ambulance crew arrived at the scene, providing reassurance to callers that they were not alone during a possibly distressing time.
- Staff gave appropriate and timely support and information to help patients and their relatives cope emotionally. They supported patients, relatives and other parties during distressing events.
- Some staff used appropriate humour to reduce people's anxiety levels and we witnessed friendly banter between patients and ambulance staff.

Are services at this trust responsive?

Good

We rated the responsive domain as good in all services.

We rated the responsive domain as good because:

- Services were planned and delivered to meet the needs of local people with a good organisation and distribution of staff and services and a wide variety of vehicles.
- Services delivered took account of the needs of patients and callers
- There were systems in place to ensure the timely responsiveness of ambulances
- There were processes in place to ensure complaints were reviewed, investigated and for learning to be shared. However there was concern that improvements were needed in informing and supporting patients, carers and others to raise complaints and concerns, specifically within the emergency and urgent care service and the visibility and availability of information about this on ambulances.

Summary of findings

Service planning and delivery to meet the needs of local people

- The trust was commissioned to provide services by 13 clinical commissioning groups across the region, one of whom took a coordinating role for contract monitoring and negotiations.
- There was good organisation and distribution of staff and services to manage specific areas of the region. The trust had 96 ambulance stations, rapid response vehicles located in busy areas awaiting dispatch, access to six air and other vehicles such as motorbikes to mobilise. Emergency medical dispatch teams in both emergency operations centres were organised within a geographical area so staff had a clear picture of how the emergency response teams were managing. Emergency medical dispatchers also gained more specialist knowledge of a specific area, including temporary or longer-term problems. They were therefore able to update crews with essential information on route to an incident.
- The trust planned staff and vehicle levels using computer software to identify demand for urgent and emergency care staff, vehicles and their locations. Variations to core staff and vehicle needs were discussed at a divisional and local level via weekly resource management group meetings held and chaired by heads of operations. Demand and resource availability planning to meet the needs of local people was also seen in documents such as South Western Ambulance Service NHS Foundation Trust winter plan document 2015/16, integrated business plan 2014/15 to 2018/19, operational plan 2016/17 and resource escalation action plan November 2015.

Meeting people's individual needs

- Emergency medical advisors and clinicians had been trained to speak in a certain way to be able to communicate effectively. Staff did not shout or raise their voice with callers who could not hear well or were not listening. Staff spoke more slowly and firmly, and deepened their voice as if they were projecting to the back of a room. If a person said they had a hearing aid they were not wearing, staff would ask them to use it if possible if they were struggling to hear.
- The trust had a nationally recognised service for people identified as frequent callers.
- The triage system did not direct the advisors to ask whether a patient had a learning disability or was living with dementia.

However, this was typical of triage systems used nationally by ambulance trusts. There was a freeform text area to add this information if it was offered, but it would otherwise not be asked by the advisor.
- Services delivered took account of the needs of patients and callers living with dementia or learning disability or those who didn't speak English as a first language. The trust had developed a range of resources to help staff to support patients with different and sometimes complex needs.

Access and flow

- The organisation was part of the national resource escalation action plan or REAP. This plan operated at all times, but certain changes were designed to be made within operations when described circumstances occurred locally or nationally and tested resources. There were four REAP levels – of which level one was 'business as usual', through to level four which could be, for example, declaration of a major incident, much heightened activity in A&E, or a public event causing, or with the potential for, major disruption. Each level had various actions for ambulance trusts to take to endeavour to improve their responsiveness or support other services in their vicinity or beyond.
- There was a standard operating procedure to divert calls to the out-of-hours service in times of extreme demand. The procedure, for those patients triaged as needing a face-to-face assessment within one hour, was for a clinical supervisor to make a decision to seek support from the out-of-hours service.
- Actions were taken to minimise the time people had to wait for treatment. Most patients had timely access to initial assessment, diagnosis or urgent treatment.
- Control room staff prioritised the patient transport service for patients with the most urgent needs. In periods of high demand, patient transport staff asked the hospital teams to prioritise their patients

Learning from complaints and concerns

- The team raised a concern with the trust at the time of the inspection that improvements were needed in informing and supporting patients, carers and others to raise complaints and concerns. This was specific to the emergency and urgent care service (ambulances) and the visibility and availability of information about this on ambulances.
- There was evidence that people were confident to speak up as there were 1,519 comments, concerns and complaints during

raised during 2015/16 and 1,128 enquiries to the patient liaison service. The number of complaints and enquiries are consistently increasing year on year. It was not possible to confirm the reasons for this. Potential reasons included the impact of the acquisition of services, decreased user satisfaction, increased awareness and expectation and better recording. Benchmarking data was hard to find given the size of the trust and the composition of the services.

- There was no evidence that people were either actively encouraged or discouraged to complain or raise concerns. There were leaflets produced in 2014 (Getting in touch: Patient Information Leaflet) but it was not clear that these were intended as guide on how to complain. Information about making a complaint is not on the front page of the trust's website and it is not immediately apparent where to find the information. The information was found behind the "getting in touch" tab and then another click to the method of contacting the trust. This might deter some complainants. There did not appear to be any routes to raise concerns through social media.
- The trust had a complaints policy that was in the process of being updated at the time of the inspection. The current policy did not include a reference to the duty of candour. There was evidence of differences between policy and practice. Currently neither the director of nursing or medical director were involved in the complaints handling process. The chief executive signs off complaint responses where this has been specifically requested by the complainant or where the initial response to the complaint has not been accepted.
- There is no evidence to demonstrate that the complaints were not handled confidentially. However the Patient Safety Team [the complaints team] operate in a large open plan office which is noisy and they do not wear headsets. This presents a risk to confidentiality and a challenge for the staff.
- There was evidence that complaints were handled effectively. Complaints were reviewed, catregorsied and investigating officers assigned. Investigating officers contacted the complainant to clarify the concerns and then gave regular verbal feedback. The team noted this as good practice. However the trust was consistently failing to meeting their own performance target of 35 days for a response with only 35% of complaints being closed within that time in 2015/16.
- The team reviewed a number of complaints and found that apologies were sincere and correspondence was sensitively written in plain English. Letters to the complainant do not clearly state whether the complaint is upheld or not but this is recorded on the trust system. Practice varies on this across

Summary of findings

trusts and it is a decision for local leadership. Three files examined had stated recommendations and actions. Further help and support, a trust contact and parliamentary health service ombudsman details were included in all the trust correspondence examined.
- Learning from complaints was reported through the trusts governance structure and examples were seen of changes and improvements being made as a result of complaints.

Are services at this trust well-led?

Requires improvement 

The evidence from the inspection is that the well led domain at provider level was good with elements of outstanding. The trust is at the forefront of national improvements in the ambulance service and is playing a leading role in key areas. The trust has a strong and stable leadership team, is in financial balance and is investing in cultural change and development for staff. They have the highest scoring staff survey of all ambulance trusts and the well being score has improved by 20% over 24 months.

However, we have rated the well led domain as requires improvement overall. We judged well led within the emergency and urgent care service to require improvement and rated it as good in emergency operations centres, and urgent and emergency care and out of hours.

We have rated the well led domain as requires improvement overall because:

- Throughout most services there was a clear vision and strategy, the exception being the patient transport service where it was felt focus had been on the contract issues rather than future planning.
- Despite an effective governance structure at trust level, there was evidence of some disconnect at a more operational level.
- Trust leadership was strong with a stable executive team with a mix of NHS and commercial experience. The trust had a strong clinical focus and this was evidence across the services and at all levels.
- The trust had a clear strategy for changing culture and the evidence from the inspection was that this was having an impact. The culture was focused on people and there was a positive encouragement of openness and reporting.
- The trust had completed and published its WRES baseline audit for 2015. The results have been used to inform the equality

objectives and areas for improvement. There was a board member (director of human resources and organisational development) identified as responsible for WRES and EDS2 implementation.
- The trust were meeting the requirements of the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014).
- Innovation was witnessed throughout the trust.
- The trust had achieved and maintained a strong financial position. There had been significant investment to support front line service delivery and an increase in investment in staff development and well being.
- The trust was well engaged with work locally and nationally to address sustainability issues in the medium and longer term.

Vision and strategy

- The trust had a clear vision and set of values that quality and safety as key priorties. There was a robust and realistic strategy in place that had been developed in partnership with staff and commissioners. The evidence from the inspection was that staff were very clear on the key purpose and top priorities of their organisation. The depth of that understanding varied across the range of the services provided and also across the geography of the trust. The mission and values were very prominent throughout the trust premises and communications. There was evidence that progress against the strategy was actively monitored and reported to the Board and publicly. At the time of the inspection the trust were rewriting their quality strategy which they considered was safe but not ambitious enough.
- The trust's mission was "To respond to patients' emergency and urgent care needs quickly and safely to save lives, reduce anxiety, pain and suffering."
- The trust's vision was "To be an organisation that is committed to delivering high quality services to patients and continue to delveop ways of working to ensure patients receive the right care, in the right place at the right time".
- The trust had summarised their mssions and vision into the strap line "responsive, committed, effective" and this was prominent on trust information and communications.
- The trust had identified six values as follows

- Respect and dignity
- Commitment to quality of care
- Compassion
- Improving lives
- Working together for patients

- Everyone counts
- The trust had identified four strategic goals as follows.

1. Safe, clinically appropriate responses. Delivering high quality and compassionate care to patients in the most clinically appropriate, safe and effective way.
2. Right people, right skills, right values. Supporting and enabling greater local responsibility and accountability for decision making, building a workfioce of competent, capable staff who are flexible and responsive to change and innovation.
3. 24/7 Emergency and urgent care. Influencing local health and social care systems in managing demand pressures and developing new care models. Leading emergency and urgent care systems, providing high quality services 24 hours a day, seven days a week.
4. Creating organisational strength. Continue to ensure the trust us sustainable, maintaining and enhancing financial stability. In this way the trust will be capable of continuous development and transformational change by strengthening resilience, capacity and capability.

Governance, risk management and quality measurement

- There was an effective governance strategy and framework in place. At the time of the inspection the trust were updating the arrangements to combine the goverance and risk strategies. The current arrangements were sound with a comprehensive strategy grounded appropriately in the trust's statutory, regulatory, public and corporate duties and responsibilities. Governance management, decision making arrangements and responsibilities and accountabilities were all clearly defined. The arrangements had been kept under review and adjustments made ahead of the major change, examples included tightening the terms of reference for one of the board committees.
- There were four permanent board subcommittees in place covering quality, audit and assurance, finance and investment and charitable funds. All were chaired by a non executive director. Each had clear terms of reference. The Board received an integrated corporate performance report that covered the full range of information on performance including activity, quality, finance and people. The Board received information on incidents and complaints on a regular basis.
- The assurance processes worked through every level of the organisation however they were vulnerable to variation in the strength of local leadership and management in terms of

achieving consistency across the 97 ambulance stations and between the different regional bases and hubs. Corporate services, including human resources and finance, were organised using the business partner model and there was evidence that this was effective in providing support to managers.

- The Board received a joint assurance and risk report. The report included the corporate and executive risk register and the board assurance framework. The format of the assurance framework looked significantly different to that which the team had seen in other trusts, including other ambulance trusts. This was a local innovation that the board had supported and which board members, collectively and individually, were able to explain to the team although a number said it had taken some time to adjust to. The feedback was that the new arrangements had focused attention on key strategic risks and made the discussions more meaningful. The new arrangements had been subject to an internal audit report which had given assurance.
- The trust's audit plan was informed by risks and incidents. Sub committees could and did call for additional work to be undertaken around particular themes. A recent example of this was a thematic review of safety incidents. Financial management and governance was strong.
- Decisions on actions to improve local, trust and national delivery, in terms of performance, quality and safety had been taken on the strength of the information provided through the reporting, monitoring and assurance processes. These included the trust's involvement in NHS England's Ambulance Response Programme which aims to improve response times to critically ill patients by ensuring the best, high quality, most appropriate response is provided for each patient first time.
- Whilst the arrangements worked well for the majority of the trust's business the evidence from an earlier inspection of the 111 service, (representing 3% of trust turnover) suggested that the arrangements had not always identified and addressed issues in a timely way. At the time of the inspection there had already been significant changes.
- Despite an effective governance structure at trust level, there was evidence of some disconnect at a more operational level. For example, not all risks were on the risk register and some had been on there for several years. Complaince with audit of calls was below target and some infection control issues were unmonitored.

Leadership of the trust

Summary of findings

- There was a strong and stable executive team with a mix of NHS and commercial experience. The chief executive and chairman had a good working relationship. The non executives were well informed and engaged. The board functioned effectively and there was evidence of supportive challenge amongst the leadership team.
- The chief executive was highly visible and staff at all levels spoke very positively about him. There was respect for his experience and knowledge, including his clinical experience as a paramedic. He was enthusiastic and positive and had a leadership style that staff and commissioners seemed to welcome.
- The leadership team displayed insight into their strengths and challenges, both as a team and across the organisation. They were able to articulate the key challenges and what action was being taken to improve.
- The leadership team were all involved directly or indirectly with national improvement work. The trust was leading and influencing national work in a number of areas including hear and treat, see and treat, electronic patient records, clinical outcomes and ambulance response times.
- There was a leadership and development programme in place for staff at 8a and above and a development resource, known as Aspire, that had been developed by the trust and was open to all staff. There were a number of innovative schemes to support staff and organisational development. The team considered that the overall approach and the resources available were amongst the best that they had seen anywhere.
- There was a new appraisal system in the trust called “My career conversation”. It had been introduced with the aim of making appraisal conversations more meaningful and relevant to individuals. There was evidence of some improvement with appraisals being at 66% at the time of the inspection. However there was significant variation in staff completing their appraisals and undertaking mandatory training.
- The leadership team recognised that operational pressures were proving to be a barrier to staff accessing the training and development opportunities on offer. These pressures were also impacting upon the completion of appraisals although the quality of appraisals was one of the strong areas in the staff survey.
- There was a good relationship with commissioners and stakeholders and this was supported by the feedback given to the team. There had been frustrations over levels of funding for some services but the relationship overall was one of positive engagement and with a focus on best outcomes for patients.

Summary of findings

Culture within the trust

- The trust had a strong clinical focus and this was evidence across the services and at all levels.
- The trust had a clear strategy for changing culture and the evidence from the inspection was that this was having an impact. The culture was focused on people and there was a positive encouragement of openness and reporting. The evidence from the inspection was that the majority of staff felt valued and were committed to the organisation, especially in terms of their commitment to colleagues and their pride in the service being delivered. There was a strong emphasis on promoting staff safety and well being and there were a number of developments within human resources and organisational development that were supporting this.
- The trust had the most positive staff survey results for ambulance trusts nationally with 24 of the 34 indicators in the top range. Six of the indicators were neutral (neither better or worse than) against the other trusts and four were amongst the lowest scores. The areas of concern highlighted in the survey included the percentage of staff satisfied with the opportunities for flexible working patterns, the percentage of staff working extra hours, and the percentages of staff reporting most recent experience of violence and harassment, bullying or abuse. The 24 areas where the trust scored well included the fairness and effectiveness of procedures for reporting errors and incidents, staff confidence in reporting unsafe practice, staff satisfation with resourcing and support and organisation and management interest in and action on health and well being.
- In general terms staff survey results for ambulance trusts are less positive that those of acute and community trusts. The trust emphasised to the team that whilst they were pleased with the results relative to other ambulance trusts they had ambition to improve them further through improving the experience of staff working at the the trust. That said the improvements in the survey year on year are remarkable with a 20% increase on the wellbeing score over 24 months.
- The trust's sickness absence rates, generally considered to be an indicator of engagement and culture, did not go above 6% during the 12 months to November 2015. This is at or below the average for ambulance trusts.
- The trust had launched a Stay well service in December 2015 following consultation. It had been well received with over 400 referrals in four months. Staff can refer themselves to the service. The service provides some direct support and also

signposts staff to other sources of help. A peer support network was part of this service. This offered support for difficulties at work or in the personal lives of staff including support to make decisions on action to address and resolve the issue.
- The Human Resources team had run a series of successful roadshows in 2015 and these were being repeated.

Equality and diversity

- In July 2014 the Equality and Diversity Council agreed new work to ensure employees from black, minority and ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workforce. There are two measures in place, equality and diversity system 2 (EDS2) and the workforce race equality standard (WRES) to help local NHS organisations, in discussion with local partners, review and improve their performance for people with characteristics protected by the Equality Act 2010.
- The trust had completed and published its WRES baseline audit for 2015. The results have been used to inform the equality objectives and areas for improvement. At the time of the inspection the trust's draft equality and diversity strategy was out for consultation. There was a board member (director of human resources and organisational development) identified as responsible for WRES and EDS2 implementation.
- The trust had reported that 160 of the 5168 staff employed had identified themselves as BME. The proportion of staff who had self reported their ethnicity was 98.3%. The information showed that the relative likelihood of BME staff being appointed from shortlisting compared to that of White staff being appointed across all posts was marginally higher for BME staff with a key issue being the low proportion of BME applicants (8.59%). The percentage of staff experiencing harassment, bullying or abuse from patients, relatives and the public was significantly higher for BME staff than for White staff. This was also the case where the harassment, bullying or abuse was from trust staff.
- The trust was facing the challenge of effective engagement across their large geographical area (20% of England). The trust lead for this work had links with some groups across the area including a group for transgender people in Dorset, a BME group in Gloucester and a multi-faith group in Bristol. The trust planned to launch an "all equality" group across the trust. Once the strategy has been adopted the work in relation to it will be reported through the governance committee. Practical action already underway included the trust's successful bid to participate in Health Education England's Paeaemedic Pre-

Degree pilot. The project is being run jointly with the University of the West of England and will recruit a cohort of BME applicants to Emergency Care Assistant posts for a period of 12 months. Successful completion of the course will be a gateway to a further programme of training and a bank contract with the trust.

Fit and Proper Persons

- The trust were meeting the requirements of the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation, which came into force in November 2014, ensures that directors of NHS providers are fit and proper to carry out this important role.
- There was a procedure in place setting out the process to be followed. The checks covered identification, character, qualifications, competence, skills, experience, health, misconduct, mismanagement, financial and disclosure and barring.
- Once a director has been appointed the FPPR was assessed through an annual process combining self declaration and repeat checks. The self declaration took account of the FPPR regulation, the requirements of the foundation trust regulator NHS Improvement and the trust's own constitution.
- We reviewed the files of two non executive directors. This demonstrated that FPPR procedures had been followed.

Public engagement

- The nature of the trust's business, involving short and often single episodes of contact with people by telephone or in person, makes many of the traditional avenues for engagement with the public challenging. The trust had a programme of public roadshows and running stands at county shows across the patch. These were generally very popular, drawing large crowds and enabling trust staff to engage with the public and to promote awareness of the appropriate sources of help with urgent care needs. Public health messages are also promoted by these means.
- There was a programme of targeted engagement with individual groups, for example there had been work with a group of people with learning difficulties in the Plymouth area. These were people who frequently used the trust's transport and emergency service and the aim was build a positive relationship to help reduce the stress and anxiety some individuals felt in using the service.

- The trust had recognised that they needed to improve the flow of feedback from people and were looking at ways of addressing that. Surveys of people who had used the accident and emergency and 111 services had been undertaken but response rates were poor. A six monthly survey of people who used the patient transport services indicated that the 89% of people would recommend the service.
- The governors had a representational role and were engaging directly with trust members at various events. The governors were well engaged with the trust but recognised the limitations of their role in terms of direct engagement given the geography of the trust.

Staff engagement

- There was a general "we'll come to you" approach from the leadership team in recognition both of the geography of the trust and the nature of the services. The trust ran a programme of listening events known as Have Your Say. These involved the chief executive and other directors visiting different locations and parts of the service. These were well publicised in advance and locations were chosen, including the accident and emergency departments of acute hospitals, to maximise the opportunity for staff to attend.
- The roadshow approach was successfully used in many areas. These included a series of HR roadshows and a series of events around the Right Care2 programme.
- The chief executive welcomed direct contact from staff and there were a number of avenues for this including direct email. There was a weekly bulletin from the Chief Executive.

Innovation, improvement and sustainability

- Innovation was witnessed throughout the trust. Examples ranged from the "Simbulance" teaching ambulance, to innovative IT developments for patient care, the development of the Aspire leadership programme and specific clinical guidelines to supplement national guidelines.
- The trust had achieved and maintained a strong financial position. There had been significant investment to support front line service delivery and an increase in investment in staff development and well being.
- The trust was well engaged with work locally and nationally to address sustainability issues in the medium and longer term. This included the Ambulance Response Programme, a national programme significantly influenced by work within the trust. The trust was one of two trusts engaged in a 12 week trial at the

time of the inspection. The aim of the programme was to provide the best, as opposed to the fastest, response for each patient. It involved a new pre-triage set of questions for 999 incidents. If successful it would lead to an increase in resources, with less multiple allocations, to respond to life threatening immediate calls.

- Locally the trust had commissioned research from the National Institute for Health Research Collaborations for Leadership in Allied Health Research and Care South West to investigate the growth in 999 calls, a rise of 24% over the last four years. The trust was using the results to work with commissioners and stakeholders to develop services. The work included the development of a falls strategy and the establishment of a frailty group to coordinate the work across the 10 counties served by the trust.

Overview of ratings

Our ratings for South Western Ambulance NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	Requires improvement	Requires improvement	Outstanding	Good	Requires improvement	Requires improvement
Patient transport services (PTS)	Requires improvement	Requires improvement	Good	Good	Inadequate	Requires improvement
Out of Hours	Requires improvement	Good	Good	Good	Good	Good
Emergency operations centre (EOC)	Good	Requires improvement	Outstanding	Good	Good	Good
Resilience	Outstanding	Good	Good	Good	Outstanding	Outstanding
Urgent and Emergency Care	Requires improvement	Good	Good	Good	Good	Good
Overall	Requires improvement	Requires improvement	Outstanding	Good	Requires improvement	Requires improvement

Our ratings for South Western Ambulance Service NHS Foundation Trust

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

Notes

1. The 111 services provided by the trust were inspected in March 2016 and the report has been published.

Outstanding practice and areas for improvement

Outstanding practice

- The trust was influencing service improvements at a national level, for example the ambulance response programme.
- The Aspire programme, developed by the trust, was providing excellent opportunities for personal and career development to all staff.
- There was, at times, outstanding professionalism and grace under pressure among the emergency medical advisors in the Bristol and Exeter emergency operation centre (clinical hub) teams. We heard staff being criticised, shouted at, called abusive names and threatened. All of this was disruptive to staff and unsettling. The staff remained calm, and handled the callers with courtesy and patience.
- Staff in the emergency operations centres showed outstanding compassion and understanding to people in difficult and stressful situations. Staff made a genuine connection with patients and others who were scared or anxious and developed an, albeit temporary bond, with the person trying to help them. Staff would, appropriately, say "take care" and "all the best" to people, and this was often repeated back to staff by people who had appreciated their friendliness and warmth.
- Although the emergency operation centres' call-quality audit programme was not completed as often as required because of other priorities, and staff shortages, it had been previously commended and recognised for its quality. There was, nevertheless, an outstanding quality to the audits when they were being undertaken. This included the feedback, which was delivered with thoughtfulness, professionalism and the intention for staff to do well. There had been changes based on staff being asked how they found the process to make it more empathetic for those being examined.
- There was an outstanding and commended programme to manage frequent callers to the service. This was helping to release the organisation's limited resources to more appropriate situations. There was strong multidisciplinary working to support frequent callers with the service promoting the issue among the wider community and partner organisations.
- At the time of our inspection the service had just embarked on a trial, known as the Ambulance Response Programme. This 12-week pilot aimed to improve response times to critically ill patients, making sure the best response was sent to each incident first time and with the appropriate degree of urgency. The trust was one of two ambulance services nationally participating in this trial.
- The introduction of Right Care had resulted in 56.8% of patients, who called for an ambulance, being treated at the scene or referred to other services, rather than being conveyed to hospital emergency department.
- Operational staff took time to interact with patients and were supportive to them and to their relatives/carers. Staff treated patients with compassion and dignity and respected their privacy at all times.
- The range of staff support schemes provided showed a commitment to improving staff wellbeing and we received positive feedback from staff who had used these services. The introduction of a fast track physiotherapy service had resulted in a reduction in sickness absence due to musculoskeletal injury.
- The trust had a dedicated events team to manage the assessment, planning and resourcing for public events.
- The trust produced a newsletter called "twentyfourseven" published for members of the public with news, long-service awards for staff, notable events taken place or coming up in the trust's area, and success stories. These newsletters were available on the trust's website. The high-quality publication provided the public with good information about the service and its achievements.

Outstanding practice and areas for improvement

Areas for improvement

Action the trust MUST take to improve

- Ensure mandatory training for all staff, including safeguarding for vulnerable people, is updated and maintained in accordance with the trust's target.
- Ensure staff appraisals are completed each year to meet the trust's target. The organisation must also ensure it is aware of those staff who have not had an appraisal for many years, and offer support and recognition where warranted.
- Ensure risk registers are aligned with operational risks and that risk registered are reviewed regularly to monitor and mitigate risks
- Ensure work intensity and fatigue is monitored and actions put in place to mitigate risks to staff
- Ensure governance meetings at local levels contain a strong focus upon quality and safety. This will include performance reports on training, appraisals, patient outcomes, complaints and incidents relevant to the local level. Actions from addressing any shortcomings or changes must be recognised and completed. Leaders of the Patient Transport Services must ensure that staff are encouraged to report incidents and that feedback and learning from incidents is shared with the team. Incidents should be an integral part of the governance process and viewed as a positive opportunity for learning.
- Ensure patient transport service engage in a regular programme of audit including infection control, safety of vehicles. These audits should be recorded and an agreed action plan documented and progress monitored through the governance processes.
- Ensure accurate, contemporaneous and complete record of all treatment undertaken by Patient Transport Services staff and that across all services records are stored securely at all times to prevent unauthorised access.
- Ensure adequate guidelines and protocols are in place to guide patient transport staff in their clinical decisions regarding adjustment of oxygen therapy.
- Ensure a system is put into place which informs patient transport service crews of any important clinical information relating to the patients they convey, such as when a patient has diabetes.
- Ensure that healthcare assistants who undertake initial clinical assessment of patients are assessed as competent before working independently
- Ensure that all staff are familiar with their responsibilities in regard to the safeguarding of vulnerable adults and that robust reporting arrangements are in place.
- Ensure partly administered controlled medicines no longer required are disposed of in accordance with the service standard operating procedures and that medicines are stored securely in the back of ambulances and cars when the crew is not present.
- Review the management of clinical waste in ambulance stations to avoid risks to staff.
- Ensure infection control issues identified in this report are addressed.
- Ensure complaints are handled effectively. Information and guidance about how to complain must be available and accessible to everyone who uses the service in a language and format to meet the needs of the people using the service, for example those who were hearing or sight impaired.
- Take action to meet locally agreed thresholds in respect of Ambulance Clinical Quality Outcomes.

Please refer to the location reports for details of areas where the trust SHOULD make improvements.

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
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12(1) Care and treatment must be provided in a safe way for service users. (c) ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely; Most patients within the minor injuries unit were triaged by an experienced healthcare assistant, not a qualified clinician. There was no assessment framework to guide them. The nurse manager told us that healthcare assistants underwent four weeks supervised practice before being able to triage on their own. However, there was no structured competency framework for this training and no formal competency assessment. (e) Ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way; The statutory responsibility to ensure daily vehicle inspections take place could not be evidenced to give assurance of vehicle safety. (g) the proper and safe management of medicines; Patient Transport Services staff did not maintain a record of adjustment of oxygen therapy during transit and the administering of Entenox (medical nitrous oxide and oxygen mixture). Medicines were not stored securely. Examples included, at Torquay station, the door to the storeroom containing medicines was propped open and at Plymouth station, the door was tied open with a bandage. Vehicles were

left unattended and unlocked. When some ambulances were outside emergency departments these were also left open and the cupboards where the medicines bags were stored were not locked.

We observed controlled medicines being administered by a staff member who had not checked it.

Excess medicines were incorrectly disposed of by either squirting on to the floor or down a sink.

The controlled drugs register at Staverton Ambulance Station was not fully completed. There were in total 16 entries and of these, 8 were missing PIN numbers, 6 lacked quantities and 8 lacked batch numbers. FP10s (green prescriptions) were found to be left in printers in unlocked unattended rooms at the beginning of a shift prior to the doctors arrival.

(h) assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated;

Environmental cleaning did not always occur. Completion and recording of rotas for environmental cleaning of ambulance stations varied. At Barnstaple station, there were no signatures entered onto the rota to show areas had been cleaned. Here staff could not demonstrate completed cleaning schedules by the contract cleaner. At Exeter station, there was a cleaner for the station but the sluice, the supplies store for sterile consumables and the medical devices store rooms were not part of the cleaning schedule. As a result, these rooms were not routinely cleaned. In most of the stations we inspected, boxes of equipment were kept on the floor of storage areas making effective cleaning difficult. We saw debris and dirt on the floor around the boxes.

In Launceston station, cleaning chemicals, clean equipment and soiled storage boxes were stored together. The work surface area in this sluice was damaged and could not be effectively cleaned.

In Plymouth, the area around the medical devices store was contaminated with guano from nesting birds. Clean linen and stores had been delivered and placed in the

This section is primarily information for the provider

Requirement notices

area outside the medical devices room. Two linen bags had been opened, leaving clean linen exposed to the risk of guano dropping on them. Two bags had spilled from the crate and were on the floor of the garage.

In Dorchester station, consumable items, including masks, disposable bedpans and neck braces were stored in the sluice

Some clinical waste bins in the stations did not have lids meaning their contents could easily spill out if the bin was overturned. Some of the large clinical waste storage bins were not locked and were visibly dirty with used items in the bottom.

At Exeter station patient equipment was stored on trolleys which were visibly dirty with dust on the underside and around the base. These trolleys were stored alongside discarded equipment awaiting disposal such as office chairs.

The trust standard required vehicle 'deep cleans' to be completed every 8 weeks. Only 21.3% of patient transport service vehicles had consistently achieved this standard during April 2015 to March 2016. Spot checks undertaken were not routinely recorded.

Some internal patient transport service vehicle defects caused a risk to infection control. We observed several vehicles with ripped fabric on seats with exposed foam padding.

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 17(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. (2) Without limiting paragraph (1), such systems of processes must enable the registered person, in particular, to-

This section is primarily information for the provider

Requirement notices

(a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity

(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from carrying on of the regulated activity;

There was insufficient attention and understanding of the quality of the emergency operations service being provided by staff at local frontline level. This included there not being an in-depth regular review of incidents, reporting, near-misses, quality of performance, complaints, training delivered and appraisals provided in local performance meetings.

Across emergency and urgent care and patient transport services risk registers were not aligned with operational risks, nor were they always reviewed regularly to monitor and mitigate risks.

Within the Patient Transport Services there was no system of audit to inform their understanding of the safety of the service.

There were inadequate systems in place to assure the safety of patients when medical gases such as oxygen and medical nitrous oxide and oxygen mixture were administered

The Patient Transport Services staff did not reliably and consistently complete vehicle daily inspections. Leaders of the service had no system in place to monitor or audit completion of these checklists. These checklists were not reviewed effectively to provide assurance of the safety of the vehicles used to transport patients and staff.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing 18(2) Persons employed by the service provider in the provision of a regulated activity must – (a) receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Insufficient numbers of staff in the emergency operation centres were up-to-date with their mandatory training. Only around 50% of staff, from a trust target of 95% of staff, had updated their three-yearly training. (c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided; Within the emergency operations centres incoming staff members used the previous staff login to enable them to use the computer system. As a result, the records at the time did not accurately record who had made them during this period. Records of care were not maintained by patient transport staff, for example when oxygen flow was adjusted. A hand held device on an unmanned ambulance at Bournemouth Station could be accessed by unauthorised personnel to view confidential patient information. At Torquay station we saw log books for recording the use of morphine placed on a desk in the main garage. This was accessible to all staff and visitors to the garage.

This section is primarily information for the provider

Requirement notices

Insufficient numbers of staff in the emergency operation centres had been provided with an annual review of their performance and competence to perform their duties. Some results were as low as 11% of frontline staff from a trust target of 85%.

Within patient transport services, not all leaders had the necessary leadership skills to lead effectively and promote supportive relationships.

The rate of annual performance appraisals within emergency and urgent care was variable ranging from 38.4% for specialist paramedics to 87.7% for paramedics. This was below the trust target of 90%. The quality of the appraisals was also variable.

Make ready operatives had not received any update or infection control training since induction.