Review of compliance

South East Coast Ambulance Service NHS Foundation Trust
South East Coast Ambulance Service NHS Trust Headquarters

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<th>Region:</th>
<th>South East</th>
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<tr>
<td>Location address:</td>
<td>The Horseshoe Bolters Lane Banstead Surrey SM7 2AS</td>
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<td>Type of service:</td>
<td>Ambulance service</td>
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<td>Date of Publication:</td>
<td>March 2012</td>
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<td>Overview of the service:</td>
<td>South East Coast Ambulance Service NHS Foundation Trust (SECAmb) is part of the National Health Service (NHS). The services cover a geographical area of 3,600 square miles (Brighton &amp; Hove, East Sussex, West Sussex, Kent,</td>
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Surrey, and North East Hampshire).

They respond to 999 calls from the public, urgent calls from healthcare professionals and in Kent and Sussex they provide non-emergency patient transport services.
Our current overall judgement

South East Coast Ambulance Service NHS Trust Headquarters was meeting all the essential standards of quality and safety but, to maintain this, we have suggested that some improvements are made.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review as part of our routine schedule of planned reviews.

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 12 January 2012, observed how people were being cared for, looked at records of people who use services, talked to staff, reviewed information from stakeholders and talked to people who use services.

What people told us

We visited three ambulance stations across the Kent Area. These were 'make ready' ambulance stations. This means that the ambulances were cleaned, restocked and maintained by specialist team of staff, which leaves more time for ambulance clinicians to spend treating patients on ambulances.

There are other ambulance stations across the three counties which do not yet have this specialist facility and ambulances are cleaned and re-stocked by the ambulance crews.

We visited two Accident and Emergency departments (A&E) so that we could observe ambulances arriving at A&E and speak to people, relatives, front line ambulance staff and staff employed at the hospitals.

People who had used the service told us that the ambulance crews were polite and treated them with respect. People commented: "they spoke to me the same as they spoke to each other".

"Yes they were respectful, they were calm and reassuring."

People told us that ambulance crew asked for their consent before giving any treatment.

The Patient Transport Service (PTS) is operated by the trust and provides non urgent patient transport. PTS services transport people between their home or place of residence to where they need to go to for treatment. For example to a hospital or day care centre and
home again after treatment. We spoke to people who use this service. They told us:

“They don’t discuss anything about me in front of anyone else”.
“I know roughly what time they’re coming. Sometimes I have to wait a little, but it is not a problem”. “They always put me at ease”. Someone else said “They are very lovely staff, they all chat to me”.

We carried out telephone and face to face interviews with managers of care and nursing homes and people across the area who had reasons to use the ambulance service. They told us,

“The PTS is much better now. It used to be dreadful. I would have to phone two or three times and patients would be late and miss their treatment. Over the past six months to a year it is much better. They are on time so it is much better for the patient now as they do get anxious. It works much better now”.

“When we call the emergency services they are always here promptly. They are very nice as well. They always ask questions and yes they are respectful”.

“I had to call an ambulance for a person when I had taken them for walk on the beach. We were not easy to reach but the ambulance crew got to us very quickly. The crew were very polite to the person using the service (who has communication difficulties) and efficient. They carried out a variety of medical checks but could not find any evidence of anything indicating ill health. I was confident that they had been thorough in their observations and investigations and I was given a written report to refer to”.

As part of the review we visited the Emergency Dispatch Centre (EDC) to see how 999 calls are dealt with. We spoke to a range of staff who worked there.

What we found about the standards we reviewed and how well South East Coast Ambulance Service NHS Trust Headquarters was meeting them

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

South East Coast Ambulance NHS Foundation Trust values people's views and where possible gives people the opportunity to make choices. The service had ensured that people who use the service were safe and that the quality of care provision is risk managed and there is a culture of improvement.

Overall, we found that the South East Coast Ambulance NHS Foundation Trust was meeting this essential standard.

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

People received safe, effective and appropriate treatment and care that meets their needs.
Overall, we found that the South East Coast Ambulance NHS Foundation Trust was meeting this essential standard.

**Outcome 06: People should get safe and coordinated care when they move between different services**

The Trust co-operates with other providers so that people receive safe care and treatment.

Overall, we found that the South East Coast Ambulance NHS Foundation Trust was meeting this essential standard.

**Outcome 07: People should be protected from abuse and staff should respect their human rights**

Arrangements were in place ensure people were safeguarded from abuse and the risk of abuse but not all staff had received the necessary up to date training.

Overall, we found that South East Coast Ambulance NHS Foundation Trust was meeting this essential standard but, to maintain this, we have suggested that some improvements are made.

**Outcome 10: People should be cared for in safe and accessible surroundings that support their health and welfare**

At the ambulance stations visited people were transported and treated in safe, accessible surroundings that promoted their well being.

Overall, we found that the South East Coast Ambulance NHS Foundation Trust was meeting this essential standard.

**Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills**

People received safe care and treatment from staff that were competent to do their job. There were some gaps in the monitoring of training at trust level and training records did not show that all staff had received the required up to date training to enable the trust to be assured that they had a thorough knowledge of current best practise and understanding of current legislation.

Overall, we found that South East Coast Ambulance NHS Foundation Trust was meeting this essential standard but, to maintain this, we have suggested that some improvements are made.

**Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care**

The provider has ensured that people who use the service are safe and that the quality of care provision is risk managed and there is a culture of improvement.
Overall, we found that the South East Coast Ambulance NHS Foundation Trust was meeting this essential standard.

**Actions we have asked the service to take**

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

**Other information**

Please see previous reports for more information about previous reviews.
What we found for each essential standard of quality and safety we reviewed
The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

**Compliant** means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*
Outcome 01: 
Respecting and involving people who use services

What the outcome says
This is what people who use services should expect.

People who use services:
* Understand the care, treatment and support choices available to them.
* Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
* Have their privacy, dignity and independence respected.
* Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement
The provider is compliant with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
We observed ambulance crews arriving with patients at the A & E departments at the William Harvey Hospital and the Queen Elizabeth Queen Mother Hospital (QEQM). We observed them handing over information to staff in the A&E department. The crews made sure that people were comfortable and that their privacy and dignity was maintained. For example, an ambulance crew member covered a person up with a blanket and another crew member pulled a privacy curtain around a cubicle to gain some privacy for another person.

We heard the ambulance crew asking people if they were comfortable and reassuring them.

We spoke to a number of people who had been brought to the department by ambulance. Everyone we spoke to said that their privacy had been maintained and that ambulance staff had been respectful and kind.

One person said, "They were really nice, and helpful. They told me where I was going and helped me when we got here. I was well looked after. There was no rushing off and leaving me".
Another person said "I could not have asked for better treatment".

One paramedic told us they maintained the privacy and dignity of people through excluding people at accidents who are not directly involved, and moving injured people to an area of privacy if this was appropriate and safe. They told us about encouraging informed choices with people, and gave a recent example of a call involving an elderly person who had fallen in their home. They had discussed the options with the person, who preferred not to go into hospital. The paramedic suspected the cause of the fall to be caused by an infection, and requested the paramedic practitioner (a paramedic with additional skill) to review and prescribe antibiotics.

An ambulance crew member working in the patient transport service described how they checked with people that they had their hospital letters or any medication they needed for the day before they left their home. They also told us that an ambulance car service was often used for people travelling for mental health care as it was more 'low-key' and less visible in their local community.

Other evidence
Ambulance crews told us that they used blankets to ensure people being transported were sufficiently covered up and that they constantly talked to and reassured them and asked them if they were OK with the way they were being treated. One crew member told us that after a basic initial assessment at the scene, they would encourage people to get into the ambulance for a more prolonged assessment and/or treatment as it was more private with the back doors shut.

One crew member told us that there were pictorial signs available for basic communication with non-English speakers, as well as access to an interpreting service, 'Language Line'. They said that they had never had to use this service, as there were usually relatives or advocates with the person requiring care who could translate if necessary. They said that involving relatives had the benefit of familiarity, as they knew the person and could also reassure them if they were worried.

If a person requiring care refused to get into the ambulance or to go elsewhere for treatment, such as a hospital, the ambulance crew would firstly try to persuade the person of the most appropriate plan of treatment. If the person still refused, then ambulance members told us that they would inform the person's GP if possible, or ask a more qualified crew member to come out to the call to treat the person on site, if that was appropriate.

An ambulance crew member told us that he had done this with an elderly patient who was afraid of hospitals, so they had requested a more senior paramedic come out and administer appropriate medication which meant that the person could be treated at home. The person's GP was also informed and was able to implement a follow up plan of care for the person.

At the William Harvey Hospital we found that the handover from the ambulance crew to the staff in the A&E department was carried out in an open central area in the A&E department, and two of the crew members we spoke to told us that they had issues with maintaining the privacy of patients during handover. One crew member told us that they had requested a more private area for handovers in the past and this request had been met by hospital staff.
At the QEQM hospital ambulance crews handed the person over to A & E staff at the reception area and documentation was completed privately in an office. We found that staff spoke in low voices and were discreet.

We saw people being treated with privacy dignity and respect. We heard ambulance crew speak to people in a reassuring way.

Staff were knowledgeable about the Mental Capacity Act so they knew about consent issues and what to do if a person appeared to lack the capacity to make a decision or if they refused treatment.

We found when people were taken into the hospital A&E screens were pulled around their bed or chair for privacy.

We observed staff and patients in the waiting area for the Patient Transport Service. Ambulance Crew engaged with patients when they came into the room and informed them of how long they would have to wait before being taken home. Staff were friendly and approachable and had a good rapport with the patients.

In the Emergency Dispatch Centre (EDC) we heard staff speaking on the telephone to emergency callers They spoke politely and respectfully and were reassuring to the caller.

**Our judgement**
South East Coast Ambulance NHS Foundation Trust values people’s views and where possible gives people the opportunity to make choices. The service had ensured that people who use the service were safe and that the quality of care provision is risk managed and there is a culture of improvement.

Overall, we found that the South East Coast Ambulance NHS Foundation Trust was meeting this essential standard.
Outcome 04:
Care and welfare of people who use services

What the outcome says
This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement
The provider is compliant with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
We spoke with people directly and also contacted people by telephone that had used the service. Everyone we spoke to said that their call for assistance had been answered quickly and that an ambulance had arrived promptly.

One person said,"Yes, the ambulance came really quick. They made me comfortable and told me what was happening".

Everyone we spoke to said that they had received a good service. One person said "They were very good, I could not have asked for more". Another person said "They were very good indeed".

Some care home managers said "Some of the ambulance staff don't listen to what we have to say about the people. They can be dismissive. But we know the people best".

People who used the Patient Transport Service (PTS) told us that they found it easy to arrange to be picked up by the PTS. They said "You can either ring them up directly or come up with your appointment card and get it all booked in". Some people told us that sometimes they had to wait a while to be picked up but they said "They always get you to your appointments on time". Someone else said "I know roughly what time they're coming".

Other evidence
We looked at information that the trust sent us. This told us that in June 2011 the trust had changed the process it used for assessing 999 calls. It was now using NHS Pathways. NHS Pathways sets out to deliver a single clinical assessment tool that provided effective triage over the telephone in any setting taking calls from the public. This was to ensure every patient accessing urgent and emergency care services was effectively triaged, reducing the need for them to repeat information and helping to make sure that they were directed to the right care, first time.

The trust expects the new system to improve people’s experience and ensure they receive the most appropriate response from the ambulance service.

All 999 calls in the Kent area were managed through the Coxheath Emergency Dispatch Centre (EDC) and these were then fed through to the mobile ambulance vehicle. The staff at the call centre in Coxheath made the decision about the level of urgency and there was a system in place that they followed to make sure people received the appropriate service.

We observed ambulance crews arriving with patients at the A & E department at the William Harvey Hospital and QEQM, and handing over information to department staff. They did this by telling the nurse or doctor in charge why they had brought the person in. They also passed on their written information and assessment or patient report form..

The crew members told us about the patient clinical records, which was used to note any information received about the call, the assessment and treatment administered to the person, and any other relevant information. The form was also used as the basis for staff handover at the hospital. It detailed observations and examinations carried out on the person, as well as information about previous medical history, next of kin and doctor’s details, and any medications given at the scene. We saw that the forms had detailed information about the person’s condition and were dated, timed and signed. There were carbon copies for the hospital staff and ambulance crews. The original copy was taken back to the ambulance station and team leaders audited them regularly as part of the competency assessment for crew members. This meant that all the staff involved had the information they needed about patients. If the person did not go on to hospital for more treatment, a copy was left with them for their record.

The ambulances were prepared at the make ready station and then taken by operational staff to 'stand by points' so that they were ready to respond to incidents quickly. The 'stand by points' were locations known to have high demand for ambulances at different times of the day and night.

The 'make ready operatives' at the make ready station ensured that the ambulance were fully stocked with medication and equipment that people may need. There were detailed checklists including photographs to make sure that each ambulance had everything it should. Medication and potentially dangerous items including oxygen cylinders were stored safely and securely. There were good audit systems in place to check this continued.

A paramedic told us about the role of paramedic practitioner. With people for whom hospital admission was not necessarily the best option, crews could request the attendance of a paramedic practitioner who would assess and prescribe medication, and liaise with the GP. This meant that that fewer people are inappropriately admitted
into hospital. We were told that at least two paramedic practitioners were available at all times in each of the three counties covered by the trust.

Where people refuse treatment, we were told that the GP would be informed, and they could refer the person to the vulnerable adult team.

At the Paddock Wood ‘make ready centre’ a paramedic told us that handover at one local hospital was a constant problem. An A&E nurse may have signed the paperwork to admit a person, but if the person was still on the stretcher due to no available bed, then the ambulance was unable to leave. This caused a delay in the person being treated at the hospital and prevented the ambulance from answering more calls.

We visited Coxheath Emergency Dispatch Centre (EDC) to see how the 999 calls are dealt with. We observed call takers responding to 999 calls. We saw examples of call takers dealing with a range of calls. They remained calm and efficient and were reassuring to the caller.

We spoke with a patient transport service (PTS) manager who confirmed that patient transport had recently moved into the commercial services directorate, rather than linked to operations. She felt that led to a greater focus on PTS services and they were more valued now. PTS managers recently enjoyed their first PTS away day. The manager described a new PTS role to provide support to A&E services through training a number of staff to new competencies that allowed them to respond to certain types of calls. She spoke of the improved morale of PTS staff.

The PTS also told us that staff chatted to people to allay fears about going into hospital, and on discharge, checked with wards that there was support at home or a care package in place. We observed this when we visited a hospital out patients department and spoke to people who used this service.

Our judgement
People received safe, effective and appropriate treatment and care that meets their needs.

Overall, we found that the South East Coast Ambulance NHS Foundation Trust was meeting this essential standard.
Outcome 06: Cooperating with other providers

What the outcome says
This is what people who use services should expect.

People who use services:
* Receive safe and coordinated care, treatment and support where more than one provider is involved, or they are moved between services.

What we found

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<td>The provider is compliant with Outcome 06: Cooperating with other providers</td>
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<td><strong>What people who use the service experienced and told us</strong></td>
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<td>Everyone we spoke to said that they had been kept informed about what was happening and about what hospital they were being taken to.</td>
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An A&E senior member of staff at the William Harvey Hospital said "We have a fantastic relationship with the ambulance service. We all work as a team. They always give us a handover about patients. We have a good relationship with the crews and communication is very good. They will phone ahead to let us know they are coming in with a particular emergency". |

A & E staff at both hospitals said that the ambulance staff were good. They said they were polite and efficient.

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<td>The service had good links with various local and national groups including disability groups and minority groups. For example the service had been working with the National Autistic Society to gain insight into communicating and supporting people with learning disabilities and communication needs.</td>
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At the time of our site visit to the William Harvey Hospital A & E department, there was a ‘divert from other hospitals’ in place for suspected stroke patients. We observed one crew who had brought in a person with a suspected stroke. There was some discussion between the ambulance crew and the hospital staff about this decision, but it was agreed by the hospital stroke consultant and the A & E matron that it had been the best
action to take for the person. The crew had been following national guidelines about management of a suspected stroke, and the hospital's internal communication about the divert status had not been precise enough. This meant that the person received the treatment they needed.

Ambulance staff told us that they worked closely with the A&E staff at the William Harvey Hospital. One ambulance staff member said "This is the best A&E. The staff are fantastic. We always have thorough handovers and are rarely delayed here".

Concerns had been highlighted about the length of time ambulance staff were having to wait at some of the hospital A&E departments before they could handover patients to the hospital A&E staff. This meant that they could not leave the patient and get back on the road to answer more emergency calls. SECAmb were working closely with the hospital A&E departments to improve this situation. New procedures had been put in place to reduce the waiting time at the A&E departments.

The make ready operatives (MRO) were employed by an external company, Lightbridge Services, but one MRO told us that they felt that they was part of the Trust staff, as they were all so inclusive at the station.

The trust meets with the Local Involvement Network (LINk) group. We spoke to LINk and received a report about the trust. In the Kent and Medway areas there have been no concerns raised about the trust in the past six to nine months. They reported that the trust was actively engaging and involving with patients and the public.

**Our judgement**
The Trust co-operates with other providers so that people receive safe care and treatment.

Overall, we found that the South East Coast Ambulance NHS Foundation Trust was meeting this essential standard.
Outcome 07:
Safeguarding people who use services from abuse

What the outcome says
This is what people who use services should expect.

People who use services:
* Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

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<td>The provider is compliant with Outcome 07: Safeguarding people who use services from abuse</td>
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Our findings

**What people who use the service experienced and told us**
We spoke with and surveyed people who used the service. Everyone we spoke to said that they had felt safe and secure when they were being taken to hospital in the ambulances.
One person said "I arrived (at hospital) safe and sound. I felt safe throughout."

People said they were confident in the assessment of their condition and the advice they were given. They said that the ambulance crew advised that they went into hospital so they agreed "they know best".

People who used the PTS told us they thought the service was "Very good" and that the crew made them feel "very safe". One person said, "They always make sure I get safely into my house".

**Other evidence**
The trust has a safeguarding lead. There were policies and procedures in place for staff to follow in the event of staff witnessing or hearing of concerns.

Safeguarding Adults and the Mental Capacity Act was a module of the Induction training and staff were now also required to complete e-learning training to keep up to date. Paramedic Practitioners also received a comprehensive education in the Mental Capacity Act as part of their training. Another element of training was through peer learning at stations, utilising policy and procedures whereby senior members of staff would provide support to their less experienced colleagues.
Some ambulance crews had got key skills booklets which were pre-learning which they
had to validate on-line. They also attended a two day key skills course which had a
safeguarding element built in. This was tracked through the National Learning
Management system which was part of the ESR package for staff records.

Staff told us they received training regarding Safeguarding vulnerable people and the
Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. They spoke with
knowledge, when asked, about both subjects.

Therefore, people could be sure that any decisions were made in their best interests
and were reviewed in line with appropriate guidelines. However when we looked at the
training records for safeguarding vulnerable people we found that only 13% of staff had
completed this training at the required intervals.

Ambulance staff told us that they assessed every patient at the scene of the call. If the
person, who required care, did not want to be treated or transported to a place of
treatment, they would use the principles of the Mental Capacity Act (MCA) to decide
whether or not that person was capable of making that decision. They always tried to
involve relatives, friends and the person's G.P.

All ambulance staff we spoke to were confident in being able to recognise signs of
potential abuse in people, and were able to discuss the actions they would take when
presented with fictional safeguarding scenarios. All staff members were able to describe
the Trust's process for reporting safeguarding concerns, and knew how to access
further guidance if required in the form of the Trust's policies and safeguarding lead.
Ambulance staff from PTS told us that they had sometimes been to nursing homes and
"Seen things that shouldn't be happening". They told us how they had reported them in
line with the Trust's Safeguarding Vulnerable Adults policy and alerted the Local
Authority.

Crew members told us how they would manage violent or aggressive people, and
communicated with, and requested support from the local police for known violent
cases, or for people sectioned under the Mental Health Act. Crew members told us that
they had breakaway training and conflict resolution training. This included techniques
to calm a person down when they were agitated and upset. Staff told us that they did
face incidents of verbal aggression and violence. They told us they could seek support
and they said they were not expected to put themselves at risk and could always ask
for back up.

We saw that the trust had a whistle blowing policy and procedure in place. This had
been cascaded to all staff and told them how and where to report any clinical or non-
clinical concerns they might have. It explained to staff how this could be done
confidentially or anonymously with no repercussions. There were also meetings to
discuss how the trust would manage any safeguarding issues and how they were
improving this service. The procedures had recently been reviewed to reduce the
amount of duplication of work and to make sure the safeguarding went to the person
who could best deal with the issue.

More robust procedures were being implemented to make sure that safeguarding alerts
were sent to the correct outside agency for example the appropriate local social
services department.

**Our judgement**

Arrangements were in place ensure people were safeguarded from abuse and the risk of abuse but not all staff had received the necessary up to date training.

Overall, we found that South East Coast Ambulance NHS Foundation Trust was meeting this essential standard but, to maintain this, we have suggested that some improvements are made.
Outcome 10:
Safety and suitability of premises

What the outcome says
This is what people should expect.

People who use services and people who work in or visit the premises:
* Are in safe, accessible surroundings that promote their wellbeing.

What we found

Our judgement
The provider is compliant with Outcome 10: Safety and suitability of premises

Our findings

What people who use the service experienced and told us
We spoke to and surveyed people who used the services. Everyone we spoke to who had used the emergency ambulance said that they had a comfortable journey in the ambulance and that the ambulances were well kept and very clean and tidy.

One person was having difficulty walking into the A&E department so the ambulance staff used a wheelchair from the ambulance which helped them.

We observed ambulance crews arriving with patients at the A & E department at the William Harvey Hospital and QEQM Hospital, as well as make ready operatives cleaning and restocking the ambulances at the make ready station. We found that the ambulances were clean and sufficiently stocked, with a system of green tags to show the expiry dates of the contents of the cupboards in the vehicles.

Staff were impressed with the make ready system at the make ready stations. This system meant that ambulance crews no longer had to clean and re stock the ambulances. One person said "It saves us time so crews can spend more time with patients. It releases crews to do what they have been trained for".

Other evidence
We observed a make ready operative (MRO) cleaning and restocking ambulances at the Ashford station. The MRO told us that he had received sufficient training and support to do his job, and felt confident in his abilities.

Each ambulance was cleaned and stocked at the beginning of each shift with enough
equipment and supplies to last for a 12 hour shift. The operations manager at the station also told us that each ambulance would be stocked enough to last for at least two cardiac arrests, or a 12 hour shift they also gathered supplies from hospitals if needed. The equipment in the vehicles was also checked for battery life, calibration and viability.

The MROs also completed minor vehicle maintenance, such as tyre pressures, water top-ups and headlight bulb replacements. The MRO then filled in a form that detailed the fuel level of the vehicle, whether it was deep cleaned or had a standard clean, any additions or repairs to stock and equipment, and any other issues.

Ambulance crew members told us that if they had attended a call where a deep clean to their ambulance was subsequently necessary, they would radio ahead to the station and the MRO's would have cleaned and restocked an ambulance ready for them to take, and would start cleaning the dirty ambulance straight away, so it could be ready as a standby vehicle.

The station manager told us that she audited these forms regularly as a way of assessing the performance of the MRO's. She also conducted spot checks on vehicles which have been cleaned, to ensure the standard of work was maintained at the appropriate level.

The station manager told us about a recent issue with the vacuum mattresses on the vehicles. They were, able to trace the fault through the make ready record forms and address the issue.

The centre manager told us that there was a cleaning schedule for all vehicles, and the MRO's were informed which vehicles required deep cleaning each week. The MRO told us that each vehicle was deep cleaned once every six weeks or sooner if it was required. All vehicles were also given a standard clean every 12 hours.

The station manager showed us the file used to train new MRO's and refresh the skills of current staff. The file included colour photographs of the inside and outside of each vehicle, as well as the internal layout of cupboards and shelves, and which items went where. The manager told us that this ensured consistency in the restocking of vehicles, using the make ready programme, across the trust.

The same forms are also used by crew members to highlight any problems with the stock or equipment in the vehicle, and to explain any down time when the vehicle was not in active service. The vehicles were swabbed for healthcare acquired infections on a random basis, and the results made available to the relevant MRO if appropriate.

We saw records which confirmed the above procedures were taking place.

Every ambulance we saw looked clean inside and out. The make ready station was clean and well organised. All staff had uniforms and said they had plenty of personal protective equipment including gloves.

There were robust systems in place showing when vehicles were due for things like servicing and MOT's. Stores of spare parts were kept to ensure that any replacement parts were available to keep vehicles on the road. Faults with vehicles were found
quickly so they could be put right quickly. Vehicles were now being kept 'on charge' using new chargers when at the make ready station to enable vehicles to be ready to get to people quickly when needed.

We were told that at some of the SECAmb stations where the make ready facility was not available and there was no maintenance team on site that a times there was a resistance from some operational staff to release vehicles for servicing as it meant there might not have enough ambulances in service to answer calls.

There were suitable areas for staff including toilets, showers/changing rooms and a rest room. There were dedicated training rooms and safe storage areas for personal belongings.

Portable equipment such hand held radios and potentially dangerous items including oxygen cylinders were stored safely and securely.

Our judgement
At the ambulance stations visited people were transported and treated in safe, accessible surroundings that promoted their well being.

Overall, we found that the South East Coast Ambulance NHS Foundation Trust was meeting this essential standard.
Outcome 14:  
Supporting staff

What the outcome says  
This is what people who use services should expect.

People who use services:  
* Are safe and their health and welfare needs are met by competent staff.

What we found

<table>
<thead>
<tr>
<th>Our judgement</th>
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<tr>
<td>The provider is compliant with Outcome 14: Supporting staff</td>
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<tr>
<th>Our findings</th>
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<tr>
<td><strong>What people who use the service experienced and told us</strong></td>
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<tr>
<td>We observed crew members supporting each other at the make ready station and at the A &amp; E departments at the William Harvey Hospital and The Queen Elizabeth Queen Mother Hospital.</td>
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<tr>
<td>Everyone we spoke to who had used the service said that were satisfied with their care and treatment. They said that the staff were kind and considerate.</td>
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<tr>
<td>One person said &quot;They kept me informed and were very good indeed&quot;. Another person said &quot;They were really nice and helpful. We had a laugh, we were laughing and joking, which helped.&quot;</td>
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<tr>
<td><strong>Other evidence</strong></td>
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<tr>
<td>It was the responsibility of the Learning and Development Department (L&amp;D) to design, develop, deliver and monitor a range of learning activities using a variety of delivery methods. The department was also responsible for assuring all training was delivered, all staff had access to the relevant training and education, appropriate training material was provided. There was readily available advice and support to staff.</td>
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<tr>
<td>At the 'Make Ready' stations, there are three teams of staff: mechanics maintain the vehicles, make ready operatives clean and restock the ambulances and the ambulance/response crews. The ambulance crews consist of trained paramedics and assistants all with different levels of skill and experience that matches their grades and titles. The paramedics that go out in the response cars tend to be more experienced so that they can work independently to assess and treat people. Sometimes this means</td>
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an ambulance does not need to attend because response cars were able to get there quicker and attend to the incident.

There was a clear management structure with different managers for each of the teams and the organisation of the make ready centre.

When staff first started to work for the ambulance service they attended a Corporate Induction for their first three days which included an introduction to SECAmb, basic life support training, information governance, safeguarding, equality and diversity.

Staff then took a personal induction pack with them to complete during their first weeks at SECAmb. Their Line Managers monitored their progress and signed off tasks once completed. The line managers were informed of any non-attendance of the corporate induction. They either then addressed the training modules or enrolled the staff onto the next induction.

Once a staff member had completed their induction pack, they were supposed to tear off the back sheet and send this to the human resource department who would record this on the Electronic staff records (ESR) and Oracle Learning Management OLM. It was found that this was not happening consistently.

There was an annual review of the induction pack. This was where training figures were identified. There was no formal monitoring of the full induction taking place and there was no reporting to the Board. They only report was on Corporate Induction figures (the first three days).

We saw the trust had systems in place that identified the training needs of the staff who had direct and non-direct contact with patients. It showed what training was needed and when it needed to be updated. Staff received two days direct training per year for mandatory and statutory training. A variety of methods were used to deliver training, including classroom training, e-learning and learning packs. Some staff did not think this was a good way for them to learn. They were also having a problem with making time to complete the training as they were out in the ambulance the majority of their working time. In response to this the trust had recently introduced work books to the staff. The books contained the training courses and the test so that they could be completed at quiet times in the ambulance. From the records we saw that not all staff had received the work books to complete their training in this way.

All the crew members we spoke with told us that they received regular training from the Trust. They said it would be useful to have protected time for all training. Some practical courses were arranged and staff commented that they had enjoyed this. One comment was: "we are doing a practical job which needs practical training"

The records that the trust sent us indicated that a lot of the staff had not received the required training or were not up to date.

We found shortfalls in the training that staff had completed. For example between the dates of 01 January 2011 and 10 January 2012 only 19% of staff had completed Information Governance training. Only 13% had received safeguarding training in the same period. A& E Manual handling practical had been completed by 62% of staff between 1 April 2011 and 31 July 2011 and between 1 July 2010 and 20 December
2011 68% of staff had completed Non-ops key skills which included infection control.

The trust had recognised that more robust processes for monitoring and reporting on education, learning and development were required, especially with the introduction of e-learning. As a result, a new procedure had been developed which will be presented with a request for approval to the Workforce Directorate Operational Group on Thursday, 19 January 2012. At the time of the site visit The Trust was able to identify how many staff had been trained through e-learning; how many had not.

This information was monitored, followed up and reported on. The Trust was looking at different ways to improve the amount of training completed by the staff and the action they would take for those who had not completed the necessary training. Staff were regularly reminded in the trusts weekly bulletin and through direct e-mails to complete training courses.

The trust had a Clinical Supervision policy in place. Staff supervision and staff competency checks were carried out regularly and we saw records that supported this. Supervision sessions both observational and face to face meetings were carried out during routine performance management, investigations and return to work meetings.

There was a mentoring system in place where Practice based educators, which were usually clinical team leaders, (CTL's) were based at the stations. Crew members told us that they received regular supervision from their clinical team leaders (CTL's). Clinical team leaders were meeting regularly with staff and were identifying training needs.

There were operation managers who supervise the CTL's leaders and oversee the organisation and effectiveness of the staff. The team leaders and management staff have weekly team meetings and the information was then passed to the ambulance crews.

Any clinical supervision concerns or queries were usually raised through the appraisal process. If no needs were identified during this process, supervision was still provided. There was a roster system in place and CTL's have 20% of their time off the road and clinical supervision should fall into this time.

Ambulance crew members told us that they compiled a reflective practice folder with any calls which could be used as a learning experience, to discuss with their team leaders as part of their supervision. Crew told us that they had supervision regularly, although some said that since the new electronic roster system was introduced, they went out with their team leaders less often.

Crew members discussed unusual cases amongst themselves, and also at their annual appraisals with their team leaders. All crew members said their team leaders were approachable, and that further support was available in the form of counselling and mediators funded by the Trust.

Records confirmed that staff were receiving regular clinical supervision.

The Trust policies stated that every year staff were to receive annual appraisals every year.
The number of staff who had received their annual appraisal at the time of the compliance review was lower than the predicted target. Particular concerns were highlighted with staff working in the Patient Transport Services were the information we received indicated that no staff to date had received an Annual Appraisal. The Trust had identified the shortfall and were taking steps to make sure Annual Appraisals were being completed and recorded accurately on the system.

All the staff we spoke to said that they felt supported and were able to make suggestions about improving the service. One staff member said "Team leaders are very, very supportive". Another staff said "We all work as a team and it works smoothly. My line manager visits on a regular basis and is always available. The links between departments is good".

One crew member told us that morale amongst the crews had been quite low, but the new make ready stations had decreased their workloads and improved turnaround time for ambulances, which meant that they "Spent more time doing what the public wanted us to do, which is to be on the road". They now felt very happy to be working for the Trust, and thought that morale had improved generally across the Trust. Another staff member said "Morale was low following some local ambulance station site closures but it is getting better". Another staff member said "I feel supported and think that morale is a little better since the changes to the make ready stations".

One crew member told us that although they were supposed to take at least one thirty minute break in a twelve hour shift, sometimes they were too busy to do this. Another crew member told us that the breaks could be taken as long as crews informed the control centre that they were "not to be disturbed", which meant they could only be disturbed for high priority call.

We spoke with a range of staff in the Emergency Dispatch Centre (EDC) in the Coxheath Office. They reported that the team gets on well and they had relationship with management and would feel comfortable approaching management with a query or concern. They told us that every month a team of auditors come to the operations centre and quality assures a sample of calls. They then report back to the call taker with the results. Every month, 14 calls are audited. If there were any mistakes or concerns identified, staff received further training and mentoring.

A staff survey had been carried out by the trust and some issues of concern had been identified. The trust had investigated and the concerns and put into place systems for staff to use so any concerns they had could be dealt with confidentially and discreetly.

During the visit we met with a range of staff carrying out different roles. Staff were generally very enthusiastic about their job and they were keen to tell us what they do well and also what they could do better. It was clear from all staff that patient care was their priority. The majority of staff felt supported in their role.

Staff had access to an occupational health officer and a chiropractor for advice and support.

Our judgement
People received safe care and treatment from staff that were competent to do their job. There were some gaps in the monitoring of training at trust level and training records
did not show that all staff had received the required up to date training to enable the trust to be assured that they had a thorough knowledge of current best practise and understanding of current legislation.

Overall, we found that South East Coast Ambulance NHS Foundation Trust was meeting this essential standard but, to maintain this, we have suggested that some improvements are made.
Outcome 16: Assessing and monitoring the quality of service provision

**What the outcome says**
This is what people who use services should expect.

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

**What we found**

<table>
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<th>Our judgement</th>
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<tr>
<td>The provider is compliant with Outcome 16: Assessing and monitoring the quality of service provision</td>
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<tr>
<th>Our findings</th>
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<tbody>
<tr>
<td><strong>What people who use the service experienced and told us</strong></td>
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<tr>
<td>We spoke to a member of the public who had various involvements with SECAmb on their public and patient groups.</td>
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</table>

This was what they told us, "The trust bend over backwards to involve members of the public in their various groups". "They really listen to what you say and act on ideas, They make you feel really involved and you are making a difference". "They are respectful and always have time to listen to any ideas".

People that used the PTS told us that from time to time they were given sheets to fill out with their feedback on the service. They said "I always have positive things to say".

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<thead>
<tr>
<th>Other evidence</th>
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<tr>
<td>We looked at the information the trust sent us about how they monitor the quality and safety of the service they provide. The Trust told us that there was a robust clinical audit programme in place that includes regular audits of patient care notes to ensure the right care has been given at the right time. Regular monitoring of clinical performance indicators (CPI's) takes place at various meetings including clinical governance committee meetings, executive board meetings, trust board and operational meetings.</td>
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All untoward incidents and near misses were recorded on the Datix system. The person reporting the incident gets an acknowledgement to say their incident had been
Feedback was provided to staff members on the progress of the incident.

The Datix system produces monthly reports which were collated and forwarded onto the Local Health and Safety Working Group and the Central Health and Safety Working Group which meet quarterly. These groups report to the Risk Management Clinical Governance Committee. Analysis of this data was carried out and then the Risk Analysis reports were sent to all three groups. Trends were sought during this analysis.

The trust also contributes to national benchmarking data for all NHS ambulance trusts and uses benchmarking reports to assist to continually improve the service they provide. Learning from these audits was translated into action plans. When developing the plan, they liaise with the Clinical Quality Lead to ensure they are up to date with the National Institute of Clinical Excellence (NICE) guidelines and processes. They identify high risk areas, perhaps identified through for example their incident trend analysis or complaints analysis and also focus on the statutory areas. An example of where this analysis has effectively changed practice for the better was when, it was noted that a high number of muscular skeletal injuries were being reported. The trust responded by assessing the staff training and equipment being used for lifting. The trust re-evaluated their manual handling training, purchased more equipment and ensured staff were trained on the use of the new equipment. Analysis has now identified a drop in the number of incidents reporting muscular skeletal injuries.

In May 2010, we issued guidance to NHS providers relating to the new notification requirements for trusts under the new system of registration. That guidance document set out more detailed information for NHS providers in addition to the information already included in the CQC 'Guidance about Compliance' document for all essential standards. Both guidance documents set out what information Trusts must include when making statutory notifications either directly to us or via the National Patient Safety Agency (NPSA) reporting system.

In addition, the National Reporting and Learning Service (NRLS) (part of NPSA) recommends that NHS organisations should submit reported patient safety incidents regularly to the NRLS; regularly was defined by the NRLS as at least monthly.

Following our compliance review, we had concerns that, although patient safety issue had been identified and reported to the NPSA, it had not been done in a timely manner. We also had concerns about the numbers of notifications received. We asked the trust to investigate this.

The Trust sent us report to show that it did report patient safety incidents and in particular the Degree of Harm in line with advice received from the NRLS. They had identified were the shortfalls lay and had implemented new more robust procedures to deal with this issue.

Ambulance crew said that they were able to give their views and opinions to the Trust about how it could be improved. Staff we spoke to were aware of the Trust's five year plan for improvement.

There was analysis and reports to identify the strengths and weaknesses of the service and a plan of how they were aiming to improve services for patients in the future.

The Trust had carried out satisfaction surveys for patients who had used the service
and changes were being implemented as a result of this.

We were told by a clinical team leader (CTL) that he regularly reviewed patient clinical records (PCR) for accuracy. A paramedic told us that response times are available on the Trust's intranet, including individual response times.

The Trust informed staff about how the service was changing and improving to staff through a Newsletter. This newsletter was sent to all staff and contains advice on changing processes for the better. Staff also received a weekly bulletin to keep them up to date about what was happening within the Trust.

Line Managers were responsible for disseminating new Clinical instructions to staff. There were clinicians in all the teams. Team leaders ensured that information was kept in the team folders and that staff were made aware. Some changes were often built into their audit programme. An example of when this happened was when it was identified that staff were not complying with the administration of morphine requirements. This prompted a recent audit which has lead to a change in practises to make sure that controlled drugs were administered safely.

We saw records to show that the trust were identifying their shortfalls and had changed practises to make sure that they improved the service offered to people.

Our judgement
The provider has ensured that people who use the service are safe and that the quality of care provision is risk managed and there is a culture of improvement.

Overall, we found that the South East Coast Ambulance NHS Foundation Trust was meeting this essential standard.
**Action**
we have asked the provider to take

## Improvement actions

The table below shows where improvements should be made so that the service provider maintains compliance with the essential standards of quality and safety.

<table>
<thead>
<tr>
<th>Regulated activity</th>
<th>Regulation</th>
<th>Outcome</th>
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<tbody>
<tr>
<td>Transport services, triage and medical advice provided</td>
<td>Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010</td>
<td>Outcome 07: Safeguarding people who use services from abuse</td>
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<tr>
<td>remotely</td>
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<td></td>
</tr>
<tr>
<td>Transport services, triage and medical advice provided</td>
<td>Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010</td>
<td>Outcome 14: Supporting staff</td>
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<tr>
<td>remotely</td>
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**Why we have concerns:**

Arrangements were in place ensure people were safeguarded from abuse and the risk of abuse but not all staff had received the necessary up to date training.

People received safe care and treatment from staff that were competent to do their job. There were some gaps in the monitoring of training at trust level and training records did not show that all staff had received the required up to date training to enable the trust to be assured that they had a thorough knowledge of current best practise and understanding of current legislation.

The provider must send CQC a report about how they are going to maintain compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 14 days of the date that the final review of compliance report is sent to them.

CQC should be informed in writing when these improvement actions are complete.
What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called Guidance about compliance: Essential standards of quality and safety.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

**Improvement actions:** These are actions a provider should take so that they maintain continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

**Compliance actions:** These are actions a provider must take so that they achieve compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

**Enforcement action:** These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.
Information for the reader

<table>
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<tr>
<th>Document purpose</th>
<th>Review of compliance report</th>
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<tr>
<td>Author</td>
<td>Care Quality Commission</td>
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