South Central Ambulance Service NHS Foundation Trust

Evidence appendix

Unit 7-8 Talisman Business Centre
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This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

Facts and data about this trust

Locations at the trust

The trust's headquarters are based in Bicester, Oxfordshire with a regional office in Otterbourne, Hampshire. Each site houses a clinical co-ordination centre where 999 and NHS 111 calls are received, clinical advice provided and emergency vehicles dispatched if needed.

The trust service a population of over seven million people across the six counties. They employ 3,300 staff who, together with over 1,000 volunteers, operate 24 hours a day, seven days a week.

A breakdown of the locations of the services provided by the trust is shown below:

Service	Location	Area/Team name
Trust HQ	Northern House Headquarters	
Clinical Co-ordination centre	Southern House regional office	
Air ambulance	Hampshire & Isle of Wight Air Ambulance	Hampshire
	RAF Benson Air Ambulance	Oxfordshire
Education	Bicester Unit 2 Talisman Business Centre	
	Newbury Bone Lane	

HART team	Winchester & Eastleigh Resource Centre (HART)	HART
ICT	Berrywood Data Centre	
Emergency and urgent care	Basingstoke Resource Centre	SEOCN
	Hythe Resource Centre	SEOCS
	Lymington Resource Centre	SEOCW
	North Harbour Resource Centre	SEOCE
	Nursling Resource Centre	SEOCS
	Petersfield Resource Centre	SEOCE
	Reading Minster	U&EC NEOCS
Emergency and urgent care/ Patient transport service	Adderbury Resource Centre	U&EC NEOCW PTS Thames Valley
	Bletchley Resource Centre	U&EC NEOCN PTS Milton Keynes
	Bracknell Resource Centre	U&EC NEOCS PTS Thames Valley
	Didcot Resource Centre	U&EC NEOCW PTS Thames Valley
	High Wycombe Resource Centre	U&EC NEOCE PTS Thames Valley
	Hightown Resource Centre	U&EC SEOCS PTS Hampshire
	Kidlington Resource Centre	U&EC NEOCW PTS Thames Valley
	Maids Moreton Resource Centre	PTS Thames Valley
	Milton Keynes Resource Centre	U&EC NEOCN
	Newbury Resource Centre	U&EC NEOCS PTS Thames Valley
	Oxford City Resource Centre	U&EC NEOCW PTS Thames Valley
	Portsmouth Resource Centre	U&EC SEOCE PTS Hampshire
	Reading Resource Centre	U&EC NEOCS PTS Thames Valley
	Ringwood Resource Centre	U&EC SEOCW PTS Hampshire
	Stoke Mandeville Resource Centre	U&EC NEOCN PTS Thames Valley
	Wexham Park Resource Centre	U&EC NEOCE PTS Thames Valley
	Whitchurch Resource Centre	U&EC SEOCN PTS Hampshire
	Winchester & Eastleigh Resource Centre	U&EC SEOCN PTS Hampshire
Patient transport services	Abingdon PTS Base	Thames Valley
	Amersham Resource Centre	Thames Valley
	Andover Resource Centre	Hampshire
	Basingstoke PTS	Hampshire
	Bicester ASAP	Thames Valley
	Camberley	Surrey & Sussex
	Chalfont ASAP / PTS	Thames Valley

	Chipping Norton Fire Station	Thames Valley
	Dorking Community Hospital PTS	Surrey & Sussex
	Durrington PTS	Surrey & Sussex
	Eastbourne PTS	Surrey & Sussex
	Egham PTS	Surrey & Sussex
	Gosport Resource Centre	Hampshire
	Havant Resource Centre	Hampshire
	Hellingley PTS	Surrey & Sussex
	New Haw PTS	Surrey & Sussex
	St Marks Hospital ASAP	Thames Valley
	Thame ASAP/CFR	Thames Valley
	Totton Resource Centre	Hampshire
	Wallingford Fire Station	Thames Valley
	Wantage Fire Station	Thames Valley
	Witney Hospital PTS	Thames Valley

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

Is this organisation well-led?

Leadership

The leaders had the skills, knowledge and integrity to run the organisation. There was strong support and constructive challenge among the leadership team and the trust board. The leaders were visible and approachable and they understood the challenges the trust faced.

The trust board consisted of eight non-executive directors (NED) including the chair and seven voting executives. The executive team was a mix of long standing directors with organisational memory and stability and new directors bringing new insight and challenge. The chief executive officer (CEO) had been with trust for 12 years since four trusts merged. The finance director had been with organisation for 11 years. The director of patient care and service transformation (a registered nurse) had been with the trust a year, this was a key role with a focus on the patients, care and compassion and clinical life. With the chief operating officer joining the organisation two years ago. The medical director had been with the trust for eight years and had a role in a local acute trust working in emergency medicine. A new director of strategy was due to join the organisation.

The director of patient care and service transformation had a large portfolio which included safeguarding, patients experience, clinical governance, clinical risk, infection control and demand management. They were supported by four assistant director who held corporate responsibilities. There was a risk the transformational work had not progress as planned due to the challenges on their time from other work. There was some evidence from discussion there was a reactive culture in dealing with issues, rather than functioning at a strategic level.

The new chair initially joined the organisation in 2017 as a non-executive director before becoming the chair, which was a planned development, following a three-month induction process. Consideration had been given to recently made NED's appointments to ensure they bought a mix of skills and experiences which had been identified as those required by the trust. The board of governors had also been involved in the recruitment process and considering the skills required. The NEDS came from a variety of backgrounds including commercial business, business development and clinical. A NED who was a qualified accountant was the chair of the audit committee.

The NEDs we met with were positive about their induction which was a structured process including spending time with staff in the different areas of the business. It was said this had helped them in their understanding of how the trust ran and the challenges it faced.

The medicines and research manager led on medicines optimisation for the trust. They were line managed and professionally accountable to the medical director, to allow communication directly to the board.

The trust had a council of governors who were a mix of staff, public and appointed governors. Most governors were elected members with an induction process similar to the NEDS to help them understand the trust and the role of the governor in holding the trust to account. There was a new external facilitated council of governor's development plan.

Governors were aligned to geographic areas to ensure there was representation across the area covered by the trust. Governors told us they had a key role talking with people and feeding back into the organisation. The trust chair told us the governors' voice had improved, with challenge from them at board. Governors also talked about the positive change of having a new chair and being able to ask questions at the end of board meetings. The NEDs each had two thematic areas of focus plus a geographical patch to cover with the aim of achieving whole organisation cover. This was aligned with health and social care providers across the area. The NEDs also buddied with governors to help them understand the role of the NED.

All members of the board talked about taking part in planned 'walkabout sessions.' These were said to be a positive opportunity to meet and talk with staff. Giving them, the board members, an opportunity to be visible and more importantly to try and understand what was going well, as well as the issues and challenges faced by staff in all areas of the trust.

Fit and Proper Person checks were in place. Responsibility for ensuring compliance with Fit and Proper Person Requirement (FPPR) (Regulation 5, HSCA, 2014) sat with the chairperson who said there was a thorough process in place and having recently completed this process themselves they had first-hand experience. This view was also held by a newly appointed NED. Members of the board told us they had been through a thorough recruitment process with detailed checks and processes. A review of director and board level appointment checks and human resource files supported this. People were clear they were unable to start in their role until the checks were completed and yearly reviews of relevant checks took place.

Leadership development opportunities were available. The trust had an organisational development strategy which included leadership development. They took advantage of the leadership programmes offered by local leadership academies, by partners in local systems and those offered nationally. It was also said they had delivered a range of local leadership development interventions depending on need. These had included executive level events involving for example Myers Briggs Type Indicator and 360 feedback which was validated by the finance director. Other events included a series of leadership development days with the senior operations team which covered effective team working, the importance of trust and dealing with conflict. There was an executive level succession plan, which included emergency cover and for most roles succession plans which were reviewed periodically.

Existing staff identified as potential team leaders were being supported through a pilot talent management program. The program had two parts An existing manager discussed how they had received training about having capacity and constructive conversations with staff about their potential and future careers. Those staff identified through the talent conversation would be invited to development centres to help them identify and focus on the areas they will need to develop to become leaders.

The trust's leadership development priorities for the next 12 months were described as to ensure leaders at all levels understand and communicate the trust vision and objectives; to embed the trust's values and behaviours; to continue to develop and deliver a suite of leadership interventions which could be used for different groups; to deliver the aspiring Team Leaders Talent Management and Operational Team Leader Development Centre pilot; to build their capacity in operational development and leadership development.

There was an external review of the trust board every three to four years influencing the board development program. The next review was being scoped at the time of the inspection. Board seminars took place every other month. All board members took part in an appraisal process. A senior independent director would conduct the chair's appraisal who would then conduct those for the NEDS which included feedback from the governors. Development objectives would be agreed and monitored by the chair.

The trust had a full-time mental health lead who had been in post for six years. They represented the trust on local groups and linked with local partners. They along with the CEO had been instrumental in setting up the national mental health group for ambulance services. They also sat on the national panel and worked with others to improve support for staff in dealing with patients with mental health issues and the effects this has on staff. The trust had developed mental health guidance for ambulance staff which had been adopted nationally and was now include the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) clinical practice guidelines. There was also a paramedic who was a trained dementia Lead (Alzheimers Society). Both leads delivered training and support to staff.

Board Members

Of the executive board members at the trust, none were Black Minority Ethnic (BME) and 29% were female.

Of the non-executive board members 38% were BME and 50% were female.

Staff group	BME %	Female %
Executive directors	0%	29%
Non-executive directors	38%	50%
All board members	20%	40%

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

Vision and strategy

The trust had a clear vision and set of values with quality and sustainability as the top priorities. They had aligned the strategy to local plans in the wider health and social care economy and had developed it with external stakeholders. This included active involvement in sustainability and transformation plans. The needs of the population the trust serviced had been considered.

The trust had just entered a new five-year strategy cycle. Their strategy had been refreshed taking in to account those of the of the local system. Over the last five years, the trust had been exploring ways to offer the right care, first time for each individual patient, rather than simply transporting them to the nearest hospital. The trust also now provided clinical assessment, sign-posting and advice services for people who are ill, injured or concerned about their health. They work closely with clinical networks and trauma teams with the aim of providing the best possible care for those with life threatening conditions, both on scene and during their journey to the most appropriate unit.

Looking ahead, the key challenges were described as to improve patient care, and to support local systems in managing the rise in demand, within the context of tightening finances and increased competition. The strategy and associated transformation programme, had been designed to enable the trust to rise to these challenges over the next five years.

This strategy was first developed in 2014 and refreshed in 2017, through discussion and engagement with a wide range of staff and stakeholders. Discussions with staff groups and information provided by the trust showed these included the trust executive and non-executive directors, senior leaders and clinicians within the trust, input from a range of commissioning and provider partners, the council of governors and specific working groups for key areas of the strategy. There was a focus on the trust's role in the provision of integrated urgent and emergency care services. The CEO had written to all staff describing the 5-year strategy and they told us they planned to attend every trust induction course for new starters to outline the trust vision and ensure visibility and familiarity with the executive team.

A review of board meeting minutes showed the overarching strategy and other supporting strategies and progress was discussed in this forum. There was also evidence of discussion about partnership working including sustainability and transformation plans and integrated care systems, covering both the potential impact of change on the trust and how they could manage this and the role the trust had in making plans successful and the link to the trust strategy. Staff were aware of the trust's vision and values and informed about the direction the trust wished to take with future developments.

The trust's vision was "Towards excellence, saving lives and enabling you to get the care you need." With a mission "we are with you when you need us, providing help and professional mobile healthcare to you and your community."

This were underpinned by a set of core values which were:

- Teamwork – delivering high performance through an inclusive, and collaborative approach which values diversity.
- Innovation – continuous improvement through empowerment of our people.
- Professionalism – setting high standards and delivering what we promise.
- Caring – for our patients and each other.

The HR director told us the trust's values were embedded within the recruitment and appraisal processes and the associated management training has been refreshed to include the values. Staff we spoke with confirmed the appraisal process had been updated and was aligned with trusts values and behaviours.

The trust also had six strategic themes:

- Clinical excellence – improving clinical outcomes, ensuring patient safety, and providing a positive patient experience.
- Operational excellence – achieving response time performance standards, resilience and efficiency.
- Effective stakeholder relationships – developing whole system solutions and seamless pathways of care.
- Sound governance, value for money and a strong financial standing.
- Leadership, staff engagement and a learning culture – developing the workforce, motivating and enabling our people to deliver excellence.
- A network of profitable and high quality non-emergency contracts.

The trust aimed to achieve these by helping people access appropriate care by assessing individual needs and directing people to the most relevant service; dispatching emergency

clinicians to treat people with life-threatening injuries or conditions and providing specialist care whilst transporting those people to the most appropriate healthcare facility; enabling people to stay safe and well in their own communities by providing mobile healthcare closer to home; supporting whole system healthcare by working with partner organisations to assess needs and plan care for local communities and individual needs.

With the goal to enable patients to get the care they need; the trust planned to achieve this through an integrated approach. They were seeking to enable people to access the right care, first time while saving lives and improving outcomes and supporting people in their own homes

The trust also had a service strategy which identified four future service lines:

- Care Co-ordination and Integrated urgent care;
- Mobile care and emergency responses;
- Expanded Patient Transport and Logistics
- SCAS as a partner in local care systems

Underpinning the strategy and describing how staff were expected to conduct business and interact with others were the trust values: Caring, Professionalism, Innovation and Teamwork.

There were seven role relevant behavioural value sets for staff groups providing examples of effective and ineffective behaviours expected at work. These were:

1. The Executive Team
2. Corporate Managers
3. Managers
4. Corporate Staff
5. Team Leaders & Clinical Mentors
6. Front Line Patient Facing Staff
7. Front Line (Contact Centres) Staff

The trust leadership said they were confident the behavioural guidance contained within these sets would positively impact on the organisations culture by providing guidelines for how staff will behave at work in accordance with the trusts core values.

The trust had in December 2017 introduced an operational development (OD) strategy. This had been developed to set the strategic direction for the way the trust would develop as an organisation to achieve their key strategic business objectives. The trust was investing in its own future, promoting integrated working. A review of the strategy showed OD objectives were aligned with the trust strategy, the service strategies and the trust values. Other already existing strategies were said to be enablers for the delivery of the OD strategy. A review of the OD implementation plan found it to be a well-structured clear plan, with identified leads, time scales and expected outcomes. Each step was linked to one of the OD ambitions.

The trust had a medicines optimisation strategy which included compliance with the EU falsification of medicines directive, changing the culture around medicines errors and working with other ambulance trusts to reduce duplication of patient group directions.

Culture

Staff felt respected, supported and valued. The trust's strategy, vision and values underpinned a culture which was patient centred. Staff felt positive and proud about working for the trust and their team. The trust recognised staff success by staff awards and through feedback.

The NEDS we met with told us they were able to challenge the executive team and they were listened to. The chair and observation of the board meeting confirmed this.

All staff had the opportunity to discuss their learning and career development needs at appraisal. The trust had a high compliance rate with annual appraisals and a new appraisal tool had been introduced aligning the process with the trusts values and behaviours. The trust had development pathways for emergency care assistants to progress to paramedic and for paramedics to progress to a specialist role.

NED and governor integration was seen as important. Governors had completed a survey on their role and the support they needed. This had showed there were gaps in understanding and support so support was put in place in place and a framework designed to help support development.

Staff had access to support for their own physical and emotional health needs through occupational health. Staff told us their team leaders were supportive and debriefs took place following incidents. Staff also spoke positively about the support they could access from the trust's TRiM practitioners. TRiM is a trauma-focused peer support system designed to help people who have experienced a traumatic, or potentially traumatic, event.

Success was celebrated with job well done cards, service awards and annual 'Ambies' where nominations for awards came from the work force and were awarded through a judging panel of staff members and governors. Award ceremonies took place for the presentation of awards. The patient experience team were very proud of the fact they had been 'support team of the year'

Information provided by the trust demonstrated 37 members of staff had been suspended and 32 placed under supervision from January 2017 to April 2018. The longest time for a suspension at the time of the report was 360 days.

There were avenues for staff to speak up, although the trust had not yet appointed a Freedom to Speak Up Guardian. There were systems to ensure Duty of Candour was applied appropriately. However serious incident investigation reports did not clearly detail the family or patient involvement. Following the inspection, the trust informed us interaction and involvement with patients and their families was recorded on the electronic reporting system. They said this included records of telephone calls, face to face visits and letters.

Duty of Candour (DoC) policy was available on the trust intranet and was up to date. It contained information on what level of incident would trigger a DoC response, what process needed to take place, who would be responsible for leading the process, and the other policies that were important to consider. The patient experience team would determine if a complaint triggered the DoC process. The clinical governance leads would ensure the DoC process was followed for incidents and would ensure this information was shared with serious incident review group. Patients and staff would receive support from the clinical governance lead. Commentary received from the trust stated where DOC is triggered the investigator will immediately seek to involve the patient or patient's relative in the investigation and will ensure that they are kept informed of progress and provided full and honest feedback at the closure of the incident. However, a review of four serious incident reports did not contain clear information to demonstrate any patient or family involvement in the investigation. This was the only part of the DOC process not consistently followed.

The trust had not to date appointed a Freedom to Speak Up Guardian (FSUG), we were told there were lots of avenues for staff to speak up with a good speaking up culture. The director of human resources HR) was the executive with responsibility for freedom to speak up. A new NED had recently taken on responsibility as the NED for freedom to speak up, although had not completed training specifically relevant to this role, they were able to describe how the skills and knowledge from other roles would assist them with this one. We were told by the two leads the trust was

refreshing their approach with plans to undertake a relaunch of communications with staff about the role of the FSUG and the established routes staff could use to voice concerns. The established routes were described to us as using the incident reporting system, talking with directors during walk arounds, governor drop in sessions as well as talking with line managers. Trade unions representatives told us they encouraged people to raise concerns with their line manager.

Staff we spoke with were not all clear about the role of the FSUG, and there was some confusion about whether or not the trust actually had a FSUG.

The organisation was described to us as three distinct businesses without a culture continuum with some differences across the emergency services, patients transport services and the NHS 111 service. We were told that because of this careful consideration was being given to identifying the right person with credibility to speak with staff from all areas of the trust. Additional consideration was also being given to how they would ensure full cover of the geographical patch. There were no clear plans as to how this was to be achieved.

A review of the freedom to speak up policy was taking place and this would be followed by internal ratification before consultation and ratification by the staff unions through to board approval. A self-assessment was also to be completed.

Information provided by the trust showed there had been two whistle blowers in a 12-month period, with no themes and no action required following investigation. It was not clear how concerns raised by staff using other pathways were monitored and collated as one.

Staff were encouraged to be open and honest about potential fraudulent activity, through the antifraud and corruption strategy, standards of business conducted, conflict of interest policy and anti- bribery policy. All which were reported to be covered as part of the trust induction process. Any cost improvement programs were required to go through and quality impact assessment process which included sign off a director.

Staff Diversity

Staff felt equality and diversity were promoted in their day to day work and when looking at opportunities for career progression. Staff networks were either in place or being developed promoting the diversity of staff. The trust had an enthusiastic equality and diversity lead as well as a local LGBT network with representation on the national ambulance network. A disability network was in the early stages of development. The governors felt the equality and diversity committee was effective in ensuring this issue remained a focus for the trust. Training was provided for staff.

The trust had adopted the Equality Delivery System (EDS) 2 designed by the Equality & Diversity Council to support NHS commissioners and providers to deliver better outcomes for patients and communities and better working environments for staff, which are personal, fair and diverse. There are four outcomes goals:

1. Better Health Outcomes
2. Improved patient access and experience
3. A representative and supported workforce
4. Inclusive leadership

EDS grading system has four overall goals and 18 outcomes; each outcome provides a criterion against which performance is assessed and graded. Three community panels received training to undertake the trust's initial assessment. The outcome of which was an overall rating of achieving with a combined excelling and achieving score of 89% and a combined developing score of 11%.

A review of meeting minutes confirmed the equality and diversity agenda and the objectives/ action plans contained in the EDS were reviewed on an ongoing basis by the Equality and Diversity Steering Group. The Steering Group met six times per year and reported directly to the trust board. The trust equality and diversity lead told us with the action taken, the trust was now achieving 99% of the EDS requirements and that outstanding actions were based around identifying and recording a patient's needs. We were told these required a national agreement and discussion were on going

The equality and diversity lead thought the work force reflected the community the trust served and there had been an increase in the number of paramedic from a BME background from 21 to 38. Representatives from the trust had been part of a national group who had produced information cards for all staff about how to communicate with transgender patients.

Support was available for those staff requiring reasonable adjustments and assessments would be paid for. The equality and diversity lead represented BME staff on the trust disciplinary panel. They also provided training in recruitment bias and having difficult conversation, which came about from a complaint where a transgender patient was referred to as 'sir' when then had identified themselves as a female.

The trust provided training for all staff to help them understand the importance of meeting the needs of patients according to their protected characteristics. Managers, the drivers of trust policy received additional training to ensure staff adhere to the needs of their patients. There was good compliance with the trusts equality and diversity training in all areas.

As of March 2017, South Central Ambulance Service employed 3,333 people, of which:

- 49.7% are women.
- 14.19% are aged 26-30 years and 13.98% aged 41-45 years. 0.42% are aged over 71 years and 0.45% aged under 20.
- 4.7% of staff have disclosed they consider themselves to have a disability, 78.7% of staff don't consider themselves to have a disability with the remainder either unspecified or have chosen not to disclose.

(Source: Routine Provider Information Request (RPIR) –P78 SCAS Annual Report 2017)

The trust provided the following breakdowns of qualified ambulance service staff and support to ambulance service staff by Ethnic group.

Ethnic group	**Qualified ambulance service staff (%)**	**Support to ambulance service staff (%)**
A – White -British	77.70%	84.50%
C – Any other white background	7.50%	4.88%
G – Any other mixed background	1.06%	0.83%
L – Any other Asian background	0.63%	2.03%
P – Any other Black background	0.43%	1.66%
S – Any other ethnic group	0.20%	0.28%
Z – not stated	12.22%	5.81%

(Source: Routine Provider Information Request (RPIR) – Staff Diversity tab)

Most staff felt valued and supported. Staff we met and talked with were committed to their roles and proud of the work they delivered. The trust, overall, had a good 2017 NHS Staff Survey with many of the key indicators being above the national average for ambulance trusts.

Managers told us results of the survey had been discussed with support from HR to assist them in interpreting the results and identify any areas for focus for further action. Managers had then or had plans to have team meetings or workshops with their teams to develop local staff survey engagement action plans and pledges.

Questions where respondents returned a less than 50% positive response included questions around quality of appraisals and communication between senior managers and staff. The executive team pledges focused on improving the quality of appraisals, continued investment in leadership development, rota alignment to maintain opportunities for work life balance and improved communication and feedback between staff and senior leaders. Progress against all these plans were being reported to the executive team via the health and well-being forum.

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

The trust has 22 key findings that exceeded the average for all ambulance trusts in the 2017 NHS Staff Survey:

Key Finding	Trust Score	National Average
Appraisals & support for development		
KF12. Quality of appraisals	2.95	2.65
KF13. Quality of non-mandatory training, learning or development	3.93	3.90
Equality and diversity		
KF21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	75%	65%
Errors & incidents		
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.59	3.41
KF31. Staff confidence and security in reporting unsafe clinical practice	3.68	3.49
Health and wellbeing		
KF18. Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves	59%	62%
KF19. Organisation and management interest in and action on health and wellbeing	3.60	3.25
Job satisfaction		
KF1. Staff recommendation of the organisation as a place to work or receive treatment	3.55	3.44

KF4. Staff motivation at work	3.71	3.65
KF7. Percentage of staff able to contribute towards improvements at work	53%	45%
KF8. Staff satisfaction with level of responsibility and Involvement	3.67	3.59
KF9. Effective team working	3.42	3.23
KF14. Staff satisfaction with resourcing and support	3.17	3.16
Managers		
KF5. Recognition and value of staff by managers and the organisation	3.29	3.01
KF6. Percentage of staff reporting good communication between senior management and staff	26%	20%
KF10. Support from immediate managers	3.85	3.44
Patient care and experience		
KF3. Percentage of staff agreeing that their role makes a difference to patients / service users	89%	88%
KF32. Effective use of patient / service user feedback	3.36	3.24
Violence, harassment & bullying		
KF22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months	32%	33%
KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	23%	28%
KF27. Percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse	42%	38%
Working patterns		
KF15. Percentage of staff satisfied with the opportunities for flexible working patterns	35%	34%

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

The trust has two key findings that were worse than the average for all ambulance trusts in the 2017 NHS Staff Survey:

Key Finding	Trust Score	National Average
Errors & incidents		
KF28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month	36%	35%

Working patterns		
KF16. Percentage of staff working extra hours	87%	85%

(Source: NHS Staff Survey 2017 - http://www.nhsstaffsurveys.com/Page/1074/Latest-Results/Ambulance-Trusts/)

Workforce race equality standard

The scores presented below are the un-weighted question level score for question Q17b and un-weighted scores for Key Findings 25, 26, and 21, split between White and Black and Minority Ethnic (BME) staff, as required for the Workforce Race Equality Standard.

Note that for question 17b, the percentage featured is that of "Yes" responses to the question. Key Finding and question numbers have changed since 2014.

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

			Your Trust in 2017	Average (median) for ambulance trusts	Your Trust in 2016
KF25	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White	43%	50%	43%
		BME	37%	39%	49%
KF26	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White	23%	27%	22%
		BME	30%	32%	29%
KF21	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	White	76%	71%	76%
		BME	74%	48%	69%
Q17b	In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues?	White	10%	10%	10%
		BME	7%	18%	14%

Of the four questions above, there were two questions where BME staff at the trust reported a worse experience than white staff:

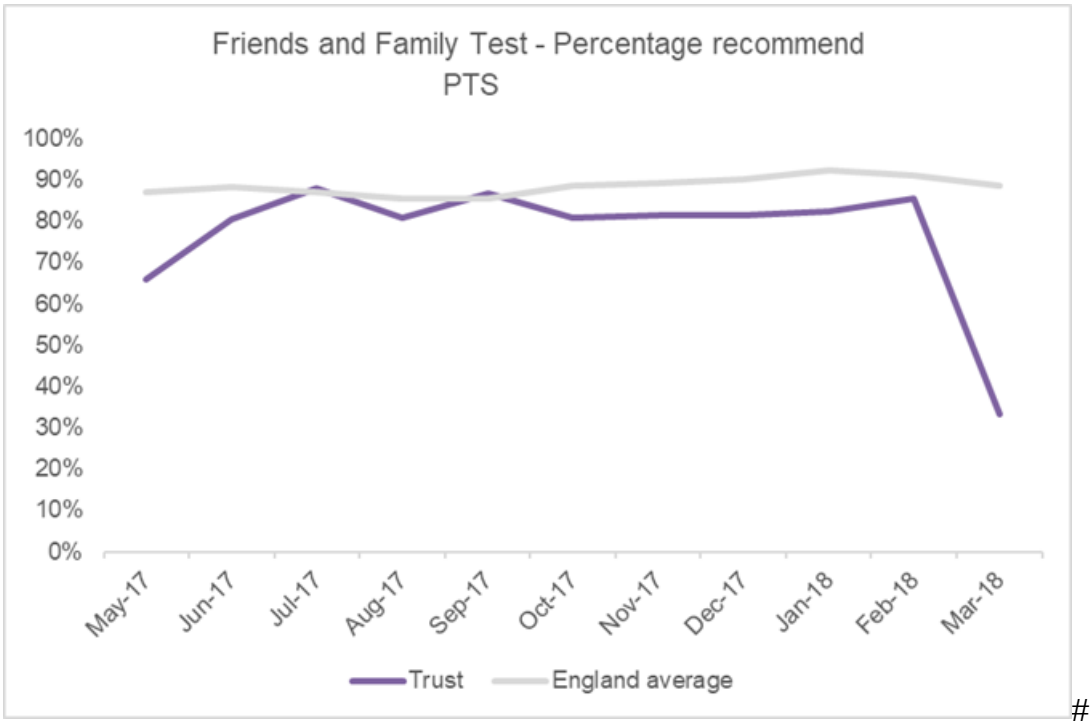
- Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months.
- Percentage of staff believing that the trust provides equal opportunities for career progression or promotion.

The trust has seen an improvement in experience for BME staff in three of the four questions compared to the previous year.

(Source: NHS Staff Survey 2017 - http://www.nhsstaffsurveys.com/Page/1074/Latest-Results/Ambulance-Trusts/)

Friends and Family test

The Friends and Family Test was launched in April 2013. It asks people who use services whether they would recommend the services they have used, giving the opportunity to feedback on their experiences of care and treatment.



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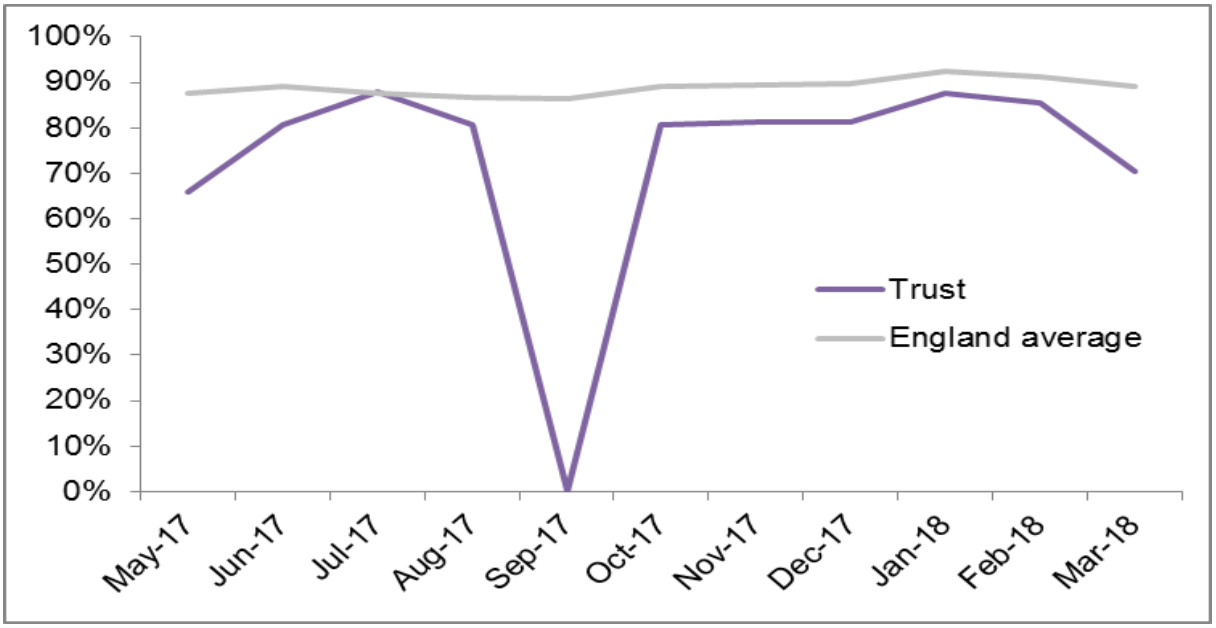
Month	South Central percentage recommend	England average percentage recommend
January 2018	91%	92%
February 2018	86%	91%
March 2018	90%	91%

From May 2017 to March 2018 the trust generally scored worse than the England average for recommending the trust as a place to receive care with regards to patients transport services activity. It scored particularly poorly in March 2018 although there was a particularly low response rate in that month. Generally the response rate for patients transport services has been lower than the England average throughout the period described.

The trust scored similar to the England average for recommending the trust as a place to receive care with regards to it's see and treat activity in January and March 2017 and received a slightly lower score in February 2017. Data prior to January 2017 was not available for see and treat friends and family test. The response rate for these three months was similar to the England average

Month	South Central percentage recommend	England average percentage recommend
January 2017	91%	92%
February 2017	86%	91%

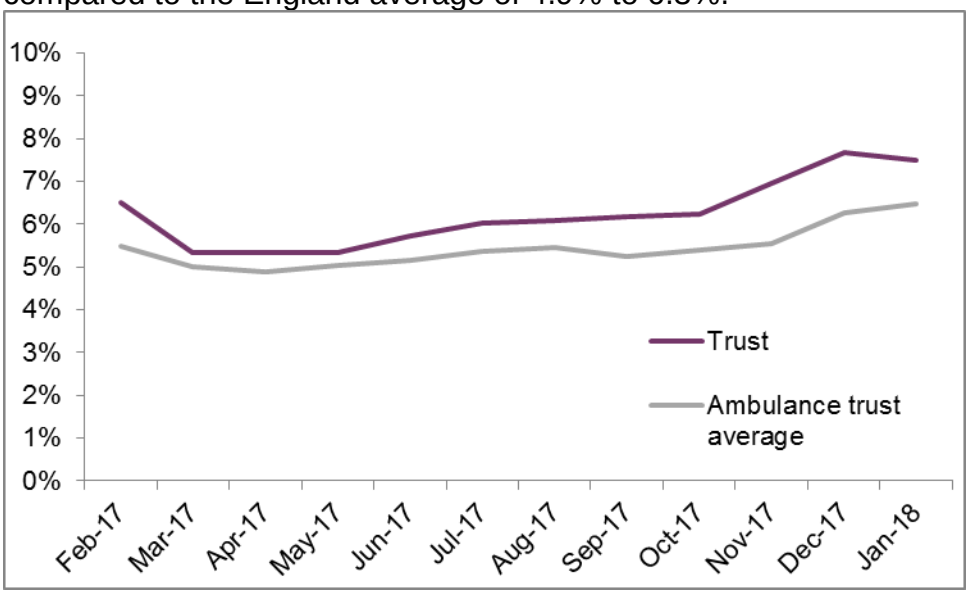
(Source: NHS England Friends and Family Test)



(Source: Friends and Family Test)

Sickness absence rates

From February 2017 to January 2018 the trust's sickness absence levels were higher than the England average for ambulance trusts in all months in the period, ranging from 5.3% to 7.7% compared to the England average of 4.9% to 6.3%.



(Source: NHS Digital)

Governance

The trust had structures, systems and processes in place to support the delivery of its strategy. Non-executive and executive directors were clear about their areas of responsibility. Papers for board meetings were of a reasonable standard and contained appropriate information. Minutes

from some of the other committees such as the quality and safety committee lacked detail with actions not always clearly defined meaning there was a risk actions may not be followed up.

The meeting structure provided an upward reporting mechanism to the trust board and there was triangulation of information through the board sub committees. The non-executive and executive directors we spoke with were clear about their areas of responsibility. The board committees had terms of reference, and in general were clear about their responsibilities and accountabilities. Terms of reference were regularly updated.

There was a rolling program for the board meeting agendas managed by the company sectary with agendas being agreed by the chair and CEO. Directors had a time line for submitting papers with a standard framework and style guide. Our review of board minutes found them to be detailed and informative with clear action plans which were followed up at the next meeting.

There were four main committees two of which were operational. These were the audit committee and the quality and safety committee. The further two committees were remuneration and charity funds.

The audit committee had a role in providing assurance to the accounting officer with a focus on how the business was operating and complying with legal requirements. The committee chair told us they was clear about their role and the role of the committee. The chair was clear the committee used information from internal and external auditors as part of their assurance process which was supported by a review of meeting minutes. The audit plan was developed through interviews with executives and considering known risk and concerns. The audit committee also had a key role in ensuring any recommendations from reports were followed up.

The quality and safety committee had a new NED chair who demonstrated good insight into the challenges and the need for the committee's approach to be strengthened. This included the introduction of a formalised work plan, which was not currently in place. Without a work plan it was not clear how they were ensured all areas in their remit was given sufficient over sight. Minutes of these meetings we reviewed were lacked some detail with actions not always clearly defined, meaning there was a risk actions may not be followed up.

There was no finance committee, this was managed through the executive team and the board. Everyone was clear 'quality and finance were given the appropriate balance of priority so the quality of care was always kept central to any decision. The audit committee had a role in reviewing financial systems although budget reviews and account management happened through the board. A review of board minutes confirmed finances were discussed at the public board meeting with any sensitive matters discussed in the private board. Financial roles and responsibilities were delegated via the trust's standing financial instructions issued in June 2017. Responsibilities for budget holders were clearly laid out in these instructions. There were clear arrangements for reporting the cost improvement programs. All schemes had an executive sponsor and a work stream lead. Arrangements were in place to manage the delivery of the programmes.

The remuneration committee was chaired by a NED and met at least five times a year with a verbal report given in the private part of the board meeting.

All sub committees and groups reported direct to the executive management group, and each subcommittee also had a responsibility to keep the sub committees of the board informed. These included workforce development; health and safety; patent safety; clinical review group, patient experience review group and the risk management, assurance, and compliance committee (RAC).

The clinical review group (CRG) was a standing group of the executive management group. The role of the group was to review the clinical activity provided by the trust and ensure underlying processes fully supported staff to provide high quality care. They provided reports of clinical standards and risk to delivery to the executive management team and the quality and safety committee.

The medicines group monitored the medicines optimisation within the trust and reported to the quality and safety committee. The trust quality and safety committee received an annual update on medicines optimisation via the medicines governance report.

The trust had an anti-fraud and corruption strategy which was issued in October 2015 for review in November 2018. This was led by the nominated local counter fraud specialist, an external company.

Members of the patient experience (PE) team told us the governance processes around patient experience had improved and the size of the team has increased. The team had a new lead and the team had been built, supported and processes changed to improve governance and oversight. Clinical governance leads had been brought into core services to provide departmental / operational ownership with close working with the PE team.

The integrated performance report contained indicators which were nationally mandated; contractual and some local. This was the tool the board had determined they needed to monitor performance, the executive team reviewed the information, to assure the accuracy of the information, before it went to the board. The IPR was seen by the board as a developing document. The clinical indicators were those considered to be important for the trust to monitor. The executive team had agreed on the key performance indicators.

Policies would be reviewed by the audit committee and the quality and safety committee depending on the purpose of the policy, clinical or organisational. Which policies the trust had was reported to be an executive team decision. There was a policy review group, an executive process for policy review who had authority for ratification of policies.

There was a new safeguarding group which reported to patient safety group. Some policies were reviewed and approved by this group, however we found an out of date safeguarding policy on the trust public facing intranet. This raised concerns about the trust version control system. When we bought this concerns to the trust attention, the policy was immediately removed, we were later informed human error appeared to have resulted in the error with an incorrect version being published.

Board assurance Framework

The trust provided their Board Assurance Framework (BAF) which details their six strategic objectives and accompanying risks. A summary of these with the rag rating of risks (as of February 2018) is below.

Strategic objective	Number of risks rated		
	15-20	8-14	7 or less
1. Clinical excellence, quality of care, patient safety and experience	1	2	1
2. Emergency performance	3	1	1
3. Stakeholder perceptions and trust reputation	0	0	1
4. Sound governance	1	3	0
5. Leadership and culture	2	1	0
6. Commercial viability	0	0	0

Total	**7**	**7**	**3**

The BAF related to strategic themes rather than a direct coloration to strategic objective. We were told the themes were long standing and the risks were grouped around the themes. There was an operational focus to the BAF. There was said to be a day to day focus on performance as this was the daily issue. The CEO acknowledged they worked in a short term operational business delivering targets and part of assurance was delivering this performance consistently. Real time data would be reviewed and a forward look undertaken to make sure business as usual was performing as expected and could continue to do so. The BAF was important for oversight but not the main working document, this was the integrated performic dashboard.

It was not clear from interviews with directors they were all clear on how the BAF drove the board agenda / discussion or how it provided assurance against the delivery and attainment of the trusts strategic objective. The BAF was immature and it was not clear how it drove the assurance of the organisation. The minutes of board meetings did not fully capture discussion or actions relating to the BAF.

The seven highest risks scoring 15 or above are detailed below:

Strategic objective	**Risk**	**Score (as of Feb 18)**
1. Clinical excellence, quality of care, patient safety and experience	Risk to patient safety, patient confidence and Trust reputation due to issues at an acute trust. Lack of assurance for patient safety in ED and ED queue at the acute trust, associated impact on PTS due to late planning of discharges. The acute trust's inability to deal with demand in this locality in a consistent way. We have removed the name to maintain confidentially.	**20**
2. Emergency performance	Risk of NEPTS Surrey contract not meeting KPI's	**16**
	Risk of contract for NEPTS in Sussex not meeting KPI's	**16**
	The risk of non-achievement of NHSE ARP response standards will affect safe delivery of services to patients and impact negatively on the organisation's reputation. This could then result in formal NHSE / CQC monitoring on the Trust's actions to deliver expected improvement.	**16**
4. Sound governance	Risk of not achieving CIP's.	**16**
5. Leadership and culture	Risk of not meeting clinical and organisational statutory and mandatory training requirements	**16**
	Non-effective management of sickness absence and staff absences	**16**

(Source: Routine Provider Information Request (RPIR) P97- BAF)

Management of risk, issues and performance

There was a board assurance framework (BAF), a corporate risk register (CRR) and risk management process in place. Senior management committees and the board reviewed performance reports. Leaders regularly reviewed and improved the processes to manage current and future performance. While the trust had processes for monitoring risk and performance the role of the board assurance framework (BAF) was less clear. The BAF was not being used as a tool to drive the board agenda or it was not clear how it provided assurance against the delivery and attainment of the trusts strategic objectives.

The board received annual risk management training as part of a board seminar. Staff received training in risk management which included identification, management and reporting if risks. Staff had access to the risk register and could effectively escalate concerns as needed. Concerns generally matched those on the risk register. Arrangements were in place for identifying, recording and managing risks, issues and mitigating actions. Although the standard of documentation was not always robust.

The trust's risk management strategy encouraged visibility of risks and mitigation through flow of departmental risk registers to the corporate risk register and through to the BAF. This was reviewed at the risk management, assurance, and compliance committee (RAC). In general directors were well informed, with a good knowledge of the organisation and were aware of the risks. However, the link between the risk register and BAF in relation to escalation and de-escalation was not robustly understood by all senior leaders we spoke with.

All the executive directors we met with were clear about their role and their portfolio. The directors took responsibility for risks according to their portfolio areas, this included ensuring any risks were escalated when required and considered for inclusion the corporate risk register. Risks would be discussed at the RAC which enabled peer challenge and for any integration with risks from other areas.

The trust board had sight of the most significant risks and the mitigating actions through the corporate risk register and to some degree the BAF. A review of the corporate risk register identified the approach to risk focused predominately on reactive risk management. The corporate risk register had no defined review dates. It stated time scales which defined when risks were likely to occur, which may lead to documentation not being updated and reported in a timely manner. For example, one risk had not been reviewed since April 2018 despite variation in compliance against the target. The narrative of the actions recorded on the corporate risk register did not always fully address the risk identified.

The audit committee and the quality and safety committee had a role in providing assurance to the board on how well risk was managed. The audit committee would review the corporate risk register and would take deep dives to review risk and how they were being mitigated and managed.

The trust had independent internal and external auditors. The program was agreed by the executives considering national audits, those required by contract and local agreed audits including quality improvement audits. A review of committee meeting minutes showed audits results were considered but the detail of discussion and decisions made were not always clearly captured.

The trust used an integrated performance report to monitor performance, the executive management group and the board reviewed this. The report was broken down into key areas with a lead director for each area. These included clinical performance; patient experience; risk and safety management; the NHS 111 and PTS services; HR and work force and finance and cost saving. Each indicator was RAG rated with an overall month and year to date rating. It was possible from a review of the report to see the ambulance quality indicators (AQI's) were monitored under clinical performance and in April the trust achieved all six of the 999 response time standards, sustaining a high standard through May achieving five of the six targets. When an indicator was not being met this was reported by exception with the key issues along with any identified action and the progress made described. In addition to the above the report also included a quality impact assessment of the cost improvement programme which enabled the board to have clear oversight of the trust position. A review of board papers demonstrated that the IPR was further supported by more in-depth papers from the directors for their key areas of responsibility.

A review of information showed the trust had not been performing well against the return to spontaneous circulation following a cardiac arrest indictor. When this was discussed with the medical director it was clear they had over sight of this and the trust performance had improved in the last month.

It was clear from discussion with directors, the trust while keen to take part in new ventures which would enable them to deliver their strategy and vision, they would not do so if this also carried a significant financial risk. It was also evident the NED's could provide appropriate challenge in these discussions. The finance function had a clear plan for improving financial management processes. When looking at business change the trust would look at financial and work force implications. Asking themselves did the trust have the right people to do this or how quickly could they could obtain the required resource. All such projects would be considered through the transformation board and the trust board. Board members were able to describe times when they had considered projects or business ventures and then due to financial or resource issues had decided against taking part in the venture.

Incidents were reported by frontline staff on the online reporting system. There was a mixed picture of the robustness of reporting. The trust's adverse incident and reporting and investigation policy (2014) included but was not limited to definitions, reporting procedures, investigation, analysis and improvement. There was no reference to learning from deaths in the document or a link to another document. However, the serious incident requiring investigation policy August 2017 did make reference to avoidable death or serious harm to patients or staff being investigated. The policy was clear about responsibilities, reporting, investigating and the sharing of learning. The clinical governance leads and staff in the risk department monitored the incident reporting system daily to ensure incidents of concern were immediately actioned and escalated to senior managers accordingly. Risk themes and harm levels were aggregated and reported into the patient safety group and upwards into the executive management committee along with the quality and safety group and to the board. This was confirmed by a review of the board papers.

While the trust had not adopted a formal learning from deaths process a mortality and morbidity group had been formed with clear terms of reference. Information provided by the trust indicated a deep dive would be undertaken for any event which met the criteria for inclusion. These included a presenting complaint category of cardiac arrest or a recorded time of cardiac arrest as being after the ambulance arrived. Other cases would be considered where they had been a long wait for an ambulance, there had been a previous attendance within the last 48 hours plus had contacted NHS 11 in the previous 48 hours. Discussion with a member of the group confirmed

deep dives take place and learning is shared. This had included the reissuing of guidelines relating to the management of sepsis and high flow oxygen for patients with chronic obstructive pulmonary disease.

There was a system in place to monitor the quality of service provided by private providers. A dynamic framework had been introduced for private providers working under contract for the trust. All private providers were required to meet the same standard for qualification, equipment, communication system and electronic paper record compatible with the trust system. To assure only those staff who met the trust standard could book shifts these were managed through 'skills stream.' Staff would not be able to work if there was a gap in the required information. The trust worked with private providers to oversee any investigation and were working with the private providers to improve the quality of reports and the timeliness. Quality monitoring meetings took place quarterly where key performance indicators were discussed along with action plans, capacity, shift fulfilment and a review of records. Contract managers also undertook spot checks. Medicines optimisation within independence ambulance sub-contractors was monitored on an annual basis via a medicine check list.

The directors we spoke with identified staffing as a key risk to the business. There was a workforce development board led by executive directors. They reported to the board with an integrated workforce plan. An integrated workforce planning group monitored compliance with the integrated workforce plan ensuring actions were taken to ensure the trust met the training and head count requirements within the plan.

Recruitment and training plans were developed reflecting organisational and demand need. A clear view of how many staff were planned to be employed versus what was required was mapped every week and any gap between the two outsourced to private providers to ensure service levels were maintained.

An investment in education had been made to build capacity with a view to improving retention. Some paramedics had been supported to develop into specialists and new ways of working had been introduced, with a view to help with retention, with specialist paramedics splitting their time between the trust and community providers.

Trust objectives and those within the medicines optimisation strategy formed the basis of the medicines and research manager objectives. These were monitored through the medicines group, regular one to one's and annual appraisals. Medicines incidents were reported through the electronic recording system. The medicines and research manager was also the medicine safety officer (MSO), a role created following the NHS England patient safety alert. A multidisciplinary team at the medicines management group reviewed these incidents and acted on them.

Through peer benchmarking data, the trust was aware of their position compared to other NHS ambulance trusts with respect to common concerns within NHS ambulance trusts. An educational update had been developed following concerns raised by staff when the dosage guidance for patients with seizures had been increased.

There was an internal medicines audit programme. Audits included security of medicines and medicines related stationary. The medicines and research manager undertook an annual ambulance station visit. The objective was to hold meetings with front line staff to discuss and clarify the medicines optimisation systems and undertake a site audit.

The trust medicines group worked with individual receiving NHS hospitals to optimise the transfer of patients, their medicines and information about their medicines. The medicines optimisation group worked with the pharmacy teams in adjacent trusts through networking groups including chief pharmacist, local and area prescribing committees. Within one health economy non-medical prescribing pharmacists from another trust will be working within their call centre to respond to calls where patients have run out of prescribed medicines.

Finances Overview

	Historical data		Projections	
Financial metrics	**Previous Financial Year (2016/17)**	**Last Financial Year (2017/18)**	**This Financial Year (2018/19)**	**Next Financial Year (2019/2020)**
Income	£183.5m	£215.7m	£215.6m	£222.1m
Surplus (deficit)	£701,000	£1.3m	(£764,000)	£100,000
Full Costs	£182.8m	£214.4m	£216.4m	£222.0m

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

Information management

The trust was aware of its performance through the use of KPIs and other metrics. Information was in an accessible format, timely and accurate.

The trust had an information governance policy (June 2018). The policy described four key interlinked strands openness about information being available to members of the public; legal compliance describing the trust legal responsibilities; information security linked to how information is managed securely and information quality assurance. The director of finance was the senior information risk owner and the executive director of patients care the Caldicott guardian. The information governance steering group monitored delivery of the information governance strategy and had a role in identifying information governance risks and mitigating them to an acceptable level and agreeing the policy. Information governance steering group reports to audit committee

The trust had received support to prepare of the implementation of the General Data Protection regulation (GDPR). A review of minutes from the information governance starring group showed this had been tracked and discussed. At the time of the go live date the trust was 80% complaint and we were told was now looking into how becomes 100% compliant. A review of minutes demonstrated the trust had consider and participated in the information governance tool kit assessment.

Operational (activity and clinical) data and information quality was generally good within the emergency an urgent care (999) and 111 service areas. This was primarily because most of the data and information was generated from automated processes, including the introduction of an electronic paper record solution within the 999 fleet, operational processes being standardized, and active use of the information for operational and management processes which rapidly identify any potential issues. PTS was reliant on the use of manual mobile systems based on PDA type devices, though data quality was actively being monitored. External reporting was primarily driven

directly from the transactional systems, and therefore the quality was in line with operational information.

The trust was moving into the second phase information maturity where the data quality focus was moving from service delivery systems to support (back office) systems and integration to enable enhanced management decision making, for example standardised reference sets, enhanced costing etc. This phase will emphasise information literacy and organisational decision-making culture.

The electronic patent record (EPR) solution had been active across the emergency and urgent care service for circa 18 months and the data provided was not only used for direct patient care (including partner integration), but was also now being used for management of clinical quality within the organisation and the wider health community. This had included work on clinical demand segmentation to help better profiling of the appropriate clinical resource requirement, emergency operation centres advanced clinical triage pilot, joint working with an acute trust on trauma which had identified demand patterns and issues that were not previously known, and providing intelligence to both commissioners and partner agencies.

Ambulance quality indicators (AQI's) and other relevant information (performance and clinical) was available with time frames of 15 minutes to 24 hours. The system enabled the trust to monitor the quality by various dimensions including crew, area, CCG, time, response category.

The trust had developed an IM&T strategy with a focus on the provision of solutions that enhance clinical quality at the point of care and the concept of the Ambulance as a hub. This included enhanced IM & T integration with partner agencies and the enhancement of diagnostic processes to improve pathway management.

Engagement

The trust had a structured and systematic approach to engaging with people who use services, those close to them and their representatives. Communication systems such as the intranet, internet and newsletters were in place to ensure staff, patients and carers had access to up to date information about the work of the trust and the services they used

The trust covered four counties with a population of over four million, with the addition of services in Surrey and Sussex they now covered 6 counties and a population of over 7 million. The trust had established service level agreements with three community voluntary sector organisations, one in the north of their patch one in the centre and to the south. These organisations were contracted to assist the trust in reaching all sections of the communities it served.

The trust had several avenues for patients to provide feedback, including comment cards, online survey, twitter and face book. Representatives from the trust attended several events where they met with members of the public and provided information about the trust's services and listened to their views. These had included health watch meetings, local clinical commissioning groups (CCG) engagement events and visiting schools. Governors told us they had undertaken roadshows with engagement staff to talk to patients and service users. The trust was visible in groups externally to the organisation with representation on groups in the local health economy e.g. A&E delivery board.

All information relating to the patient's experience was now managed by one team- the patient experience team (PE). The trust electronic reporting system was used to capture patient experience (positive or negative). Timeframes for response were a focused but not to the detriment of quality. Frontline investigation were led by an operational manager with support from PE and the team also provided quality assurance checks for responses and the quality of the

investigation. Training was provided for operational leads covering investigating a concern, writing a response, communication, and first line resolution.

The trust had received feedback from a transgender patient about communication issues and 'pathways' not being tailored for this group of patients. Members of the patient experience team told us they had acknowledged the issues, reviewed and changed process, and cascaded these changes via governance leads to those working on the front line in all services. The patient safety group also reviewed the actions before they were signed off.

A review of minutes and attendance at a board meeting showed patient and staff stories presented, we told this was to provide a "dip test" and insight into frontline issues. Quality and safety issues reported through these mechanisms were said to be tested through the leadership walk round programme,

The head of operations managers in the emergency and urgent care service has an externally facing role. They told they actively engaged with stakeholders and were the accountable managers for their area. They had frequent meetings and discussion with CCG's and they attended delivery boards, met with representative of acute trusts and had lots of engagement with primary care providers. There was general agreement amongst the leaders we spoke with one of the advantages of being such a large organisation was they could give constant messages and share learning and good practice across the whole geographical area.

The trust achieved its highest ever staff engagement score of 3.55 on the staff survey. A positive change from their 2016 score which was 3.52. This is above average when compared to the average engagement score for Ambulance Trusts which is 3.45.

With a view to keeping the staff and public informed the trust produced a quarterly magazine called working together. This was circulated to staff and accessible to others on the trust internet. There was also a member's publication foundation times produced quarterly and accessible through the trust internet page.

Learning, continuous improvement and innovation

The trust had systems in place to identify learning from incidents, complaints and alerts and make improvements. The governance team regularly reviewed the systems. Staff had time and support to consider opportunities for improvements and innovation and this led to changes.

Complaints process overview

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months.

Question	In days	Current performance
What is your internal target for responding to complaints?	3	Target 95% Performance 97%
What is your target for completing a complaint	25 days or an agreed extended timescale	Target 95% Performance 72%

If you have a slightly longer target for complex complaints please indicate what that is here	Timescales are agreed with complainant.	N/A
Number of complaints resolved without formal process in the last 12 months? (April 17 to March 18)	1707	

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

Number of complaints made to the trust

From April 2017 to March 2018 South Central Ambulance trust received 453 complaints. Over 50% of all the complaints related to patient transport services. Transport was the subject with the most complaints, accounting for 57% of all complaints.

A breakdown of the number of complaints by core service is shown below:

Core service	Number of complaints	Percentage of all complaints
Patient transport service	237	52.3%
Emergency & urgent care	104	23.0%
Emergency operations centre	75	16.6%
NHS 111 service	37	8.2%
Total	**453**	**100%**

Of the 453 complaints, 28 were still open at the time the trust submitted their RPIR. Of the closed complaints the trust took an average of 36 working days to complete, which is not in line with their complaints policy which states complaints should be closed within 25 days (unless an extended timescale has been agreed).

The trust has a target of 95% for completing complaints within 25 days, at the time of submitting the RPIR the trust reported they were achieving 72%.

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

A dashboard had been built so operational staff had visible data relating to complaints which could be accessed all the time to see numbers, responses, timelines. This was initially for the urgent and emergency care service and now included the PTS and 111 services.

We reviewed 10 complaint files. All files had a complaint identification number and were logged on the complaints system. The complaints included the following themes: attitude of staff, clinical incidents and delayed transport. Eight out of 10 complaints were answered within the 25-day target time frame, with the quickest response time being eight days. Two complaints were answered outside of the target timeframe with one being 48 days and one 36 days. Both complaints over the timeframe included extension letters informing those concerned of the delay and the reasons why.

All complaints reviewed had an initial acknowledgement letter and detailed response letters which gave the complainant information on the service, details of the investigation and findings including if the complaint was upheld, partially upheld, or not upheld. Further information in the letters outlined action taken and learning that had been cascaded after the investigation.

Where required complaints included input from other people and organisations such as the acute hospital the patient had been taken to, or community services. Complaint responses were also reviewed and approved by the clinical commissioning group when necessary.

The trust participated in the sharing of NHS ambulance benchmarking medicines data and information. This provided benchmarking data and analysis of the trusts safe and effective use of medicines. The trust rationalised and restricted the packaging of two infusions to reduce miss selection incidents. E-learning packages were developed and rolled out in response to a few incidents where injectable medicines were administered via the wrong route. End of life guidelines were underdevelopment to help ambulance staff support people to die at home, where preferred.

The finance director participated in the ambulance sector finance director network where they discussed emerging issues and shared best practice. The trust used benchmarking to identify potential efficiencies. This included NHS England performance reports for the ambulance response programme and the Carter data produced by NHS Improvement.

The trust did not have a formal quality improvement process. However, some staff had received training about lean thinking with an emphasis on ensuring they had efficient processes and reducing waste. Through discussion it was clear not all staff clearly understood this process, with some staff not hearing the message about efficiency being about doing the best thing for the patient. Work was being undertaken looking at how crews could be smarter on scene to reduce call cycle time and what was the ultimate time. The aim was to free up resource for the next patients, doing the best for the current and the next patient.

The trust also had bright ideas deposit on the intranet, where staff could submit where suggestions. A member of staff, through the bright idea's scheme developed the trauma app and the clinical pathways app which is now available across the trust. There were many examples where staff had been able to be innovative and changes had been made. One of these had resulted in the introduction of a frailty/falls service in the south of the region.

The trust was actively participating in clinical research studies. There was a research and development lead who reported to the medical director. The lead told us the trust tended to support or partner with others. For example, the paramedic one and two trials where the trust worked with a university. For each project the trust would ensure they had their own risk assessment in place as well as an impact assessment which would be considered by the patient safety group. A research and development strategy was under development.

Within the past year the trust had been one of 33 employers to receive an Armed Forces Covenant Gold Employer Recognition Scheme award. This is a Ministry of Defence prestigious badge of honour, awarded in recognition of work to support the armed forces community, particularly to support veterans with developing second careers.

The trust had in excess of one thousand community first responder volunteers alongside their co-responder's scheme to help them be more responsive to patient needs. They had been working with this group to roll out new initiatives such as responding to 'silent alarm' calls. There was also a cohort of responders who had enhanced skills to be able to respond to a wider range of patients, such as those who had fallen.

Resilience

Facts and data about this service

The trust's resilience service provides major incident planning and response as a Category 1 provider under the Civil Contingencies Act 2004 (Part1).

The trusts resilience services include the Hazardous Area Response Team (HART), the Resilience and Specialist Operations service and the management of business continuity. The HART team provide NHS paramedic care to patients in a hazardous environment, that would otherwise be beyond the reach of NHS care. This includes provision of care within the inner cordon or 'hot zone' of incidents such as chemical, biological, radiological, nuclear and explosive (CBRN(E)) incidents and marauding terrorist firearms attack (MTFA) incidents as well as support reaching, providing care and treatment and extracting patients from difficult to reach environments, such as confined spaces and patients injured at heights. The resilience and specialist operations service is responsible for planning for and responding to other major emergencies, as well as including preparedness for, and the support of events and mass gatherings. The business continuity service, manages the continuity of service, both when it is only the provider affected, such as loss of facilities, or as a wider event such as adverse weather or pandemic influenza.

In the period 1 April 2017 to 31 March 2018 the SCAS HART team attended 989 HART related incidents. Out of these 39 were incidents where mutual aid was provided to areas outside the SCAS geographical area.

Is the service safe?

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Data provided by the trust showed the HART paramedics were fully compliant with the requirements of the trust's mandatory training. This included training about conflict resolution, dementia awareness, equality & diversity, fire safety, health and safety, infection control, information governance, manual handling, safeguarding adults and safeguarding children.

The NHS service specification 2016/18 for Hazard Area Response Teams (HART) requires all HART paramedics to be competent in specialist skills specific to their role. A breakdown of compliance rates by role specific training module is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate
IRU (Incident response unit)	41	41	100%
PRPS (Powered respirator protection suit)	41	41	100%
BA (Breathing apparatus)	41	41	100%
Tactical Medical Operations	41	41	100%
Civil Responder 1	41	41	100%
Swift Water Rescue	41	41	100%
SWAH (Safe working at heights)	40	41	98%
Confined Space	40	41	98%
Urban Search & Rescue	28	41	68%

Although no targets were required for completion of the role specific training, the HART team achieved 100% compliance in six of the nine modules.

(Source: Trust Provider Information Request – Mandatory training)

Discussion with staff, review of rotas and review of training records evidenced HART paramedics had no less than 37.5 hours protected training time every seven weeks. This met the national guidance of the NHS service specification 2016/17 for Hazard Area Response Teams (HART).

To maintain a workforce in sufficient numbers to attend to major incidents involving chemical, biological, nuclear, radiographical (Explosive) (CBRN(E) or marauding terrorist firearms act (MTFA) incidents, the trust was required to have a number of paramedics (Specialist Operations Response Team (SORT)) trained in the delivery of paramedic care and treatment in these instances. Processes were followed to ensure those staff trained for this, completed the required mandatory training in these specialised skills. At the time of the inspection there were 193 SORT staff trained to respond to a CBRN(E) incident and 107 specialist responders trained to respond to a MTFA incident. In addition, all commanders were trained to respond to both CBRN(E) and MTFA incidents.

Staff across the trust (including emergency operations centre (EOC) staff, emergency and urgent care (EUC) staff and patient transport service (PTS) staff received training about the resilience function of the trust and responding to major incidents during their induction training and through

their team training sessions. All staff across the trust received basic training about CBRN(E) incidents.

Safeguarding

Staff understood how to protect patients from abuse.

Records and conversations with staff evidenced all HART operatives had completed level 2 training in safeguarding children and adults. PREVENT training, female genital mutilation (FGM) and sexual exploitation was included in the safeguarding training. PREVENT is part of the UK's counter terrorism strategy and aims to stop individuals getting involved in or supporting terrorism or extremist activity.

Staff were familiar with safeguarding. Staff reported safeguarding concerns through the trust electronic patient record (EPR) system. Staff gave examples when they had made safeguarding referrals through the EPRs system. However, they rarely received feedback as to whether the referral was accepted as a safeguarding concern and whether any action was taken to safeguard the individual they were concerned about.

Cleanliness, infection control and hygiene

The service controlled infection risk well.

The HART paramedics were responsible for maintaining the cleanliness of the HART vehicles. Each vehicle was cleaned after use, or as a minimum weekly. HART paramedics followed a work schedule to ensure all HART vehicles were deep cleaned once every seven weeks. Review of the cleaning schedule evidenced staff deep cleaned the HART vehicles once every seven weeks. HART vehicles included a specialist off road six by six vehicle. Staff deep cleaned this vehicle weekly.

The trust had resilience vehicles, to be used in the event of a mass casualty incident, located at ambulance stations other than the HART station. These vehicles were deep cleaned by the 'make ready team' dedicated to the resilience service. The 'make ready team' was a service subcontracted by the trust to ensure each vehicle had the right equipment that was in date and that the vehicles were deep cleaned at regular intervals. Our inspection of a sample of these vehicles showed there was a logbook in each vehicle that evidenced the make ready team had deep cleaned the vehicle after use. The 'make ready team' also kept paper and electronic records of their completion of deep cleaning and equipment checks of the resilience vehicles.

We inspected a sample of HART and resilience vehicles. The HART vehicles were visibly clean. The resilience vehicles were clean, but some were slightly dusty. On both types of vehicles, all equipment was stored in closed bags and packaging, which ensured all equipment was clean. We checked the expiry dates on the packaging of some of the sterile equipment on the vehicles, all of which showed the equipment was within its expiry date.

Hand sanitisers were available for staff to use on all vehicles.

Appropriate and specialist personal protective equipment (PPE) was available and used by the HART team, some of which was personalised to the individual member of staff. This included specialist breathing apparatus and protective suits that HART paramedics wore when working in highly contaminated environments. The HART training schedule including working in the breathing apparatus and protective suits. This meant the HART paramedics were skilled in delivering care

and treatment in this equipment, which included reducing the risk of accidently tearing and breaching the protection from contamination provided by this equipment.

Processes were in place and followed to clean or destroy equipment and PPE used after working in contaminated environments. This included specialist tests to check the effectiveness of face masks. Processes were in place and followed to ensure specialised breathing apparatus and suits were checked regularly and after use to ensure staff where fully protected when using them.

Resilience vehicles held stocks of PPE for other ambulance staff to use in the event of a major incident. This included gloves, face protection and protective suits. Both the HART vehicles and resilience vehicles contained equipment to provide decontamination facilities at major incidents.

The trust was required by NHS England to complete an Emergency Preparedness, Resilience and Response self-assessment annually. This included reference to the management of working in contaminated environments and the management of infectious disease outbreaks such as pan influenza and Ebola. The trust's most recent self-assessment (dated February 2018) showed the trust was fully compliant with these requirements in all their services (emergency and urgent care, patient transport services, emergency operations centre, the 111 services, resilience and the HART service).

Environment and equipment

The service had suitable premises and equipment and looked after them well.

HART vehicles met the NHS specification 2016/17 for Hazardous Area Response Teams. They had three primary response vans, three secondary response vans, two crew carriers, one welfare vehicle and one vehicle that transported a six-wheel drive multi terrain vehicle. This meant that always there were sufficient vehicles with the appropriate equipment to respond to major incidents or mass casualty incidents and met the requirements of the National Ambulance Resilience Unit (NARU). This included equipment to manage casualties in chemical biological nuclear and radiological (explosive) (CBRN(E) situations, hazardous materials (HAZMAT) situations and fire arms situations. The vehicles also included equipment to enable the HART paramedics to work in confined spaces, such as a collapsed building and in inland water. Staff followed processes to check all equipment was present on all the HART the vehicles at the beginning of their shifts.

All HART vehicles, when not in use, were kept in a secured garage at the HART station. Only HART team members had access to the HART garage. Access to the general compound, where emergency and urgent care (EUC) and patient transport services (PTS) crews worked out of and where the HART garage was located was via a key coded gate. At the time of our inspection we found the HART vehicles were left unlocked, keys in ignition and the HART garage doors open. At that time the HART training team were carrying out an exercise in and around the garage area. Staff told is that when HART staff were not near the garage the garage door was always locked and only HART staff had access to the garage. HART vehicles were always left unlocked with the keys in their ignition, so the team could access and deploy promptly. Although the HART team had assessed this practice as a low risk practice, there was no formal assessment completed to identify it was low risk practice. A formal assessment of the risk was completed the following day and submitted to CQC.

The service had four different types of resilience vehicles, two ambulance intervention team (AIT) vehicles with equipment to support an incident involving weapons or explosives, eight incident support vehicles with equipment to support the management of a mass casualty incident, four CBRN(E) lorries with equipment, including decontamination equipment, to support a CBRN(E)

incident and one logistic lorry that carried equipment such as additional lighting and tents. The number of resilience vehicles in addition to the HART vehicles was planned on the national guidance which assumed a service may need to deal with three simultaneous incidents. The vehicles did very little mileage and were serviced and inspected in line with manufacturers guidelines. We saw records that evidenced this occurred.

The resilience vehicles were stationed at ambulance stations throughout the SCAS operating area. The resilience 'make ready team 'checked and restocked each resilience vehicle. There were effective practices for ensuring all equipment on the vehicles were within their expiry date. Each vehicle had a stock list which detailed the expiry dates for all equipment. Each equipment pouch had the expiry date for the piece of equipment that was next due to expire. The amount and type of equipment on the resilience vehicles was planned in line with the Department of Health equipped mass casualty vehicles. This meant there was appropriate equipment in sufficient numbers to safely manage casualties at large scale incidents. For example, there was equipment to set up and manage casualty clearing stations and generators with the appropriate fuel to run them so lighting could be made available at major incidents. Maintenance of equipment such as lighting, generators, tents and heaters were managed under a maintenance contract with the manufacturer. There was evidence that learning from national incidents influenced the number of and type of equipment on these vehicles.

Records evidenced all vehicles were maintained and serviced in line with national and manufacturers recommendations. Review of service stickers on electrical and mechanical equipment evidenced these were checked, and serviced annually or more frequently as required There were processes and staff followed them to report faulty equipment.

HART paramedics had equipment, including their various PPE equipment, allocated to each individual HART paramedic. This ensured all HART paramedics had equipment that met their individual physique and offered them effective protection in any of the situations they might have to work in.

The HART station was secure and met the requirements of the NHS Service Specification 2016/17 for HART teams. This included a gym facility, training rooms and rest facilities.

We spoke with PTS staff. They explained all vehicles had to be left with a half full tank of fuel, to ensure that in the event of a major incident they could assist with conveying walking wounded patients and supporting hospitals to discharge patients.

Assessing and responding to patient risk

Staff identified and managed risks to patients.

HART paramedics followed SCAS processes for identifying and responding to deterioration in a patient's health. This included use of the national early warning signs (NEWS2), a nationally recognised tool for monitoring, identifying and managing a deteriorating patient.

For specialist clinical advice, HART paramedics contacted the trust's clinical support desk, which was available 24 hours a day.

At the scene of major incidents and mass casualty incidents, HART paramedics followed processes to identify patients who needed urgent treatment and those who did not. Once they had triaged a patient, they followed nationally agreed processes and attached labels to patients to identify they had been triaged and whether they required treatment or not. This meant paramedics

and other clinical staff could prioritise treatment to those who needed it most. The service had further developed this process and had added 'not injured cards' to the process. This meant time was not wasted on reassessing patients who had already been assessed as not requiring any intervention. Across the trust, all team leaders and tactical commanders had packs of the patient prioritisation tags to use in the event of a major incident or mass casualty incident.

In the event of a major incident the PTS service had a role to support front line staff by conveying walking wounded patients and supporting hospitals to discharge patients. All PTS crews were trained as first responders, which meant they could provide basic emergency assistance to casualties prior to emergency ambulance staff arriving at the scene of an incident.

The location of the different types of resilience vehicles was planned on a risk based approach and the local road network. This meant there could be a swift response to major incidents within the SCAS area, as well as swift provision of mutual aid to regions outside the SCAS geographical area, for example providing support in the event of a major incident in London.

Staffing

The service did not fully meet the national requirements for Hazardous Area Response Teams staffing numbers.

Planned vs actual

The national staffing requirements for HART services, is set by the NHS Service Specifications 2016/17: Hazardous Area Response Teams (HART). This details that organisations must maintain a minimum of six competent HART staff on duty for live deployment at all times. The service did not consistently meet this national requirement. However, all HART staff were qualified paramedics which met the national staffing requirements.

The service shared the findings of the most recent National Ambulance Resilience Unit (NARU) inspection carried out in August 2017. This identified the HART staffing levels did not meet the requirements set out in the NHS service specification. Although the service was commissioned to employ seven teams of six HART paramedics, staff leave and other work commitments meant there was not always six HART paramedics on duty and available to be deployed. The service had submitted a business case to national commissioners to employ additional HART paramedics to ensure they could always deploy six HART paramedics to a HART incident.

For the six months prior to our inspection of the service, out of 197 day shifts there had been 108 shifts where there were six HART paramedics on duty, 70 shifts where there were five HART paramedics on duty and 19 shifts where there were only four HART paramedics on duty. For the same period, out of 197 night shifts there were 91 shifts where there were six HART paramedics on duty, 76 shifts where there were five HART paramedics on duty and 30 shifts where there were only four HART paramedics on duty.

Processes, that included a recall to duty system, were used to ensure six HART paramedics could be mobilised to a significant event. Review of the staff rota showed this was effective, with a team of six paramedics attending a significant event for several days, leaving a day and night team of paramedics still available at the HART station for ongoing activity.

The NHS Service Specification requires ambulance trusts to have additional staff (SORT) trained and available to support HART responses to certain situations such as Marauding Terrorist Firearms Attack (MTFA) incidents and contaminated environments. The service specification requires that trusts should have the ability to yield a minimum of an additional 10 MTFA trained

staff on duty always. The number of additional ambulance staff trained to work in MTFA situations and the trust's recall to duty standard operating procedure meant that the trust was assured that if needed a minimum of a further 10 members of staff trained to work in a MTFA environment were available. The trust had an additional 107 specialist responders, plus all commanders, trained to work in a MTFA environment. Staffing data available at the emergency operations centre, meant dispatchers knew where the MTFA trained staff were working.

The NHS service specification requires ambulance trusts to have additional staff with extra training on duty always to support response to chemical. biological, radiological, nuclear or explosive (CBRN(E)) incidents and assist with the decontamination of casualties. The NARU inspection carried out in August 2017 identified the trust met this requirement. At the time of the inspection. The trust had 193 SORT staff, plus all commanders, trained to respond to a CBRN(E) incident

The trust had sufficient and appropriately trained staff and processes to ensure there was 24-hour availability of gold, silver, bronze commander, National Inter-Agency Liaison Officers (NILOs), CBRN(E) and MTFA officers.

Vacancy rates

At the time of the inspection the HART paramedic team had two vacancies, with another member of the team leaving at the end of that month. The service had recruited three new staff, who were due to commence their training on 13 August 2018. The service was developing a recruitment pool of staff who were successful in the recruitment process, but there were no posts available now. This meant that when a member of the HART team resigned, the process of replacing that member of staff was done in a timely manner.

Records

Staff kept records of patient's care and treatment.

The HART paramedics used the trust's electronic patient record (EPR) to record the care and treatment deliver to patients. This meant the front-line teams that the HART team handed patients over to for ongoing care and treatment and conveyance to hospital could continue the record started by the HART paramedics. The EPR system also allowed staff at receiving hospitals to view the patient information prior to their arrival so they could commence planning treatment for the patient prior to their arrival.

Medicines

The service followed best practice when giving, recording and storing medicines.

The trust's policy gave clear guidance about which medicines and which grades of staff could administer under a patient group directive or the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidance for Health Professions Council (HPC) registered paramedics. HART paramedics had additional training to enable them to administer ketamine for pain relief under a patient group direction.

Medicines were stored in tagged bags on the vehicles. Tags were colour coded so staff could identify bags that had been opened and used since they were dispensed by pharmacy. Bags that required restocking were sealed with a red tag and returned to the used medicines store cupboard within the ambulance centre. Each vehicle had a log where staff recorded the numbered tag and the medicines bag to which it was attached. The HART vehicles were always left unlocked, at the HART station, with the keys in their ignition, so the team could access and deploy promptly. Although the team had assessed this practice as a low risk with regard to the security of

medicines, there was no formal assessment completed to identify it as so. A formal assessment of the risk was completed the following day and submitted to CQC.

All safes and medicines storage areas had swipe card assess allowing a full audit trail of who accessed which safe and when. The HART station had a controlled drugs record book and a system for tracking orders. Processes were in place to return out of date medicines to a central location for disposal. There was secure storage for ketamine, a pain relieving medicine, that only the HART paramedics could administer.

Controlled medicines were locked in the safe of the HART vehicles which was accessed with staff swipe cards. This ensured there was an audit trail of which staff accessed these medicines. Staff checked the controlled medicines at the start and end of the shift. All records we reviewed were correct.

Safety performance

Incidents

The service managed patient safety incidents well,

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From March 2017 to February 2018 the trust reported no incidents classified as never events for resilience.
(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported no incidents which met the reporting criteria set by NHS England from March 2017 to February 2018 occurring within resilience.
(Source: Strategic Executive Information System (STEIS))

Conversations with the HART staff showed they knew how to report incidents using the trust electronic incident reporting system.

Feedback and learning from incidents was discussed at HART team meetings. Discussions with HART staff, evidenced learning from local and national incidents was used to improve the service. For example, following the Manchester arena attack in 2017, discussion identified there had been a lack of patient carrying equipment. In response the HART team purchased additional light weight stretchers to be included in major incident response vehicles. Discussions following this incident also identified there had been a lack of effective communication between the different emergency services. In response the trust had reviewed the command structure for all emergency services to ensure there was effective communication between the emergency services in a major incident situation. Learning from local incidents included working with the EOC to ensure all relevant information was passed onto the HART team, after the risk of asbestos at a site was not relayed to the HART team.

Business continuity

Business continuity was embedded into the running of the organisation.

The trust had a business continuity management system policy dated September 2017, review date October 2018. This included (HR/C15) Business Continuity Policy (Human Resources), SCAS Incident Response Plan V1.1, SCAS Winter Capacity Strategy, SCAS Winter Resilience including Extreme Weather Operational Plan, IM&T Disaster Recovery Plan and SCAS SIRI Policy. This policy set out the actions the trust must take to meet its legal obligations under the Civil Contingencies Act (2004) to maintain plans to ensure they could continue to deliver their critical services and respond to emergencies in the event of a disruption to its normal business processes.

The trust's business continuity manager, who was part of the resilience and specialist operations team, supported all departments of the organisation to complete business continuity impact assessments and business continuity plans. All departments had a business continuity lead. At the time of the inspection all departments had completed their business continuity impact assessments and all were in the process of completing their business continuity plans, with some having completed this task. There was an annual programme that meant by the end of March 2019 all services would have a completed a business continuity plan that would be reviewed annually.

The resilience and specialist operations department had a completed business continuity plan that was next due review in April 2019. This stated the trust's plans, as required under the Civil Contingencies Act (2004), to ensure they could continue to deliver their critical services and respond to emergencies in the event of a disruption to its normal business processes.

Is the service effective?

The service provided care and treatment based on national guidance.

There were no specific care pathways exclusive to the HART service. For the provision of clinical care and treatment they referred to the Joint Royal Colleges of Ambulance Liaison Committee (JRCALC) national guidelines, clinical protocols and care pathways readily available on an app on their smart phones. This allowed staff to quickly identify the most appropriate best practice guidance to follow.

Staff also had access to a clinical pathway app which gave yes or no questions and other choices which helped confirm clinical decisions in difficult and complex situations for all age ranges of the population. This information also provided staff with details of the nearest hospital with the right levels of expertise to manage a patients' health condition. However, this feature was rarely used by the HART team, as conveyance to hospital was usually carried out by the front line (999) ambulance teams.

Staff had access to up to date clinical advice, via the clinical support desk in the call centre if they required advice about treatment choices

Clinical updates were sent to clinicians via email in a 'Hot News' format.

Staff had access to the National Ambulance Resilience Unit (NARU) action card set, which provided guidance about the actions staff needed to take in a major incident situation. However, we found on some front line EUC ambulance vehicles the action cards were not the most recently published cards. The trust acted and resolved this during our inspection.

The trust routinely collected and monitored local and national information about people's care and treatment. The annual clinical audit plan for 2018/2019 included the National Clinical Performance Indicators Trust Board Monthly 50 Febrile Convulsions, MAPSAF (Manchester Patient Safety Framework) Audit, Sepsis Audit and Medicines review amongst many others.

The HART team did not routinely convey patients to hospital, so did not covey patients with mental health conditions to a place of safety under Section 136 of the Mental Health Act 1983. However, there was guidance available about conveying mental health patient to a place of safety under Section 136 of the Mental Health Act 1983 and staff received training in its use.

Training provision for the HART team, and the resilience function of the trust met national guidance. This included assessing whether HART paramedics followed national guidance when carrying out roles such as safe working at heights and urban rescue and search procedures. However, the HART service did not always meet the national guidance that there should be six HART operatives available to deploy to a major incident.

Pain relief

Staff managed patients pain levels effectively.

The HART operatives were trained and able to give a range of pain medicines that included Entonox (a gas used for pain relief) and morphine. They received additional training and completed competency assessments to administer ketamine, an alternative pain relieving medicine that was administered only after administration of other pain relieving medicines were not effective.

The HART team audited the number of times they administered ketamine. The audit included the type of injury, whether it was a HART incident or requested by the front-line crew and whether the

patients pain was controlled by the administration of ketamine. Audit results showed the HART team administered ketamine on 21 occasions in the period June 2017 to July 2018. On all occasions pain relief was achieved with the administration of ketamine.

Staff recorded the medicines they had administered on the EPR system.

Response times

The NHS Service Specification 2016/17: Hazardous Area Response Team (HART) set out the required response times for HART teams. This set out four requirements for HART teams response times.

- Four HART staff must be released and available to respond locally to any incident identified as potentially requiring HART capabilities within 15 minutes of the call being accepted by the provider.
- Once HART capability is confirmed as required at a scene, the provider should ensure six HART paramedics are released and available to respond within 10 minutes of that confirmation.
- Organisations maintain a HART service capable of placing six HART paramedics on the scene at strategic sites of interest within 45 minutes. (These sites are defined within the Home Office Model Response Plan).
- On duty HART teams maintain a 30 minute 'notice to move' capability to respond to a mutual aid request from other organisations.

Processes were followed to ensure the HART team deployed to incidents within the timescales stipulated in the national guidance. The location of the HART ambulance station was predetermined nationally in relation to the distance and travel times to national strategic sites of interest.

The HART staffing numbers at the time of the inspection, meant they could not always deploy the number of staff to meet the national requirements. However, processes such as the 'recall to duty' meant that for those deployments that required the full six members of the HART team, this was achieved.

Competent staff

The continuing development and maintenance of staff skills, competence and knowledge was recognised as being integral to ensuring high quality care and treatment.

Appraisal rates

The trust set a target of 95% for appraisal completion.

From April 2017 to March 2018 the trust reported 78% of all staff in resilience (HART team) had received an appraisal.

This did not meet the trust target and is also a slight deterioration on the previous year (April 2016 to March 2017) where 84% of staff had received an appraisal.

(Source: Trust Provider Information Request – Appraisals)

Following our visit the trust reviewed their figures and submitted confirmation that after a data cleanse to remove those staff on maternity leave and sickness or secondment the appraisal rate was 85%. While still below target this showed a slight improvement on the figure for 2016-17.

Records held by the HART team showed the HART paramedics all received protective training time equating to the nationally required 37.5 hours every seven weeks. In some instances, this amounted to over 37.5 hours training every seven weeks. Training weeks were structured with set training programmes and training records were maintained.

However, the National Ambulance Resilience Unit (NARU) inspection report from August 2017 identified some inconstancies in the provision of training, which related to the fact there was no dedicated trainer. Present specification details each HART unit should have a dedicated trainer to plan and coordinate training specific to the HART team. The SCAS HART unit did not follow this guidance. Instead each HART team had an identified team educator within each of the seven teams, who planned and coordinated the training for their team, The NARU report had found inconsistencies, such as access to venues and variance in the quality of facilities and opportunities gained from training as well as inconsistencies with the recording of staff training. However, the report found there were examples of excellence and team educators and instructors were committed and well qualified.

Because of these findings, the HART manager had reviewed the process for monitoring the training delivered and received by all the HART operatives. He identified where improvements were needed with the recording of the training delivered to provide assurance that all operatives received high quality training. The monitoring and review process for training had been revised. This had identified that additional resource was needed to ensure there was an effective quality assurance process for the training provision. As a result, a business case had been submitted to national commissioners to fund a dedicated HART educator which would bring the service in line with the national guidance. Most HART paramedics staff were qualified Powered Respirator Protective Suit (PRPS) instructors. HART paramedics were supported to complete teaching and education courses.

Major incident training was provided to all SCAS staff during their induction training. Ongoing training about resilience functions, of the service and major incident processes were delivered during individual team training sessions and where required, were supported by the resilience managers and HART operatives. This included training about emergency preparedness, resilience and response (EPRR) and marauding terrorist firearms attacks (MTFA) to control room staff, so they could manage calls from the public and dispatch teams in a safe and effective manner.

Training about certain subjects were delivered directly to staff. For example, all UK frontline staff were required to be trained in initial operations response (IOR) to a chemical, biological, radiological, nuclear, explosive (CBRN(E)) incident. The resilience and specialist operations department were rolling out “remove, remove, remove” training, to all SCAS staff, including non-front-line staff. This training instructed staff about the actions they needed to take to protect themselves and the public in the event of a suspected deliberate or accidental exposure to a hazardous substance (powder, vapour or liquid) and an acid attack. The end date for the roll out of this training was September 2018.

CBRN(E) training for frontline ambulance staff who took on the additional responsibilities as part of the Specialist Operations Response Team (SORT) was provided by HART trainers. Data showed that across the trust there was a total of 193 staff, plus commanders, trained to respond in a CBRN incident and a total of 107 staff, plus commanders, trained to respond in a MTFA incident.

Both the HART team and front line (emergency and urgent care) ambulance staff who had received additional training to support in the event of MTFA incidents had to complete physical assessments to confirm they were physically fit to carry out their role. HART paramedics were assessed every six months and the front line (emergency and urgent care) staff team annually.

We viewed a sample of the HART paramedic physical assessments to evidence these were carried out.

Records evidenced control centre staff received training about the actions they needed to take in the event of a suspected major incident. This included training about the Joint Emergency services Interoperability Principles (JESIP) and the associated joint doctrine. Both these provided a common way for teams and services to work together with saving life and reducing harm at its core.

Multidisciplinary working

The resilience service, (HART, resilience and specialist operations and business continuity), was committed to working collaboratively with staff across their organisation and from different organisations to benefit patients and support the resilience of the service.

The trust took account of the national standards set out on the UK Ambulance Services National Memorandum of Understanding Concerning the Provision of Mutual Aid, the Joint Emergency Service's Interoperability Principles (JESIP) and the Local Resilience Forum(LRF).

The HART and resilience and specialist operations service worked closely with other organisations such and the police, fire and rescue and military services. For example, a multiagency intervention team consisting of a representative from the police, fire and rescue and the HART team often went out in one car to assess an incident and plan their individual and combined actions in response to the incident.

We received positive feedback from the police service, the fire and rescue service and the military about joint working with both the HART team and the resilience team. The feedback included, "My professional view of SCAS Resilience colleagues is that they are extremely co-operative, have an excellent and sound knowledge base and they always deliver on project work allocated by the Local Resilience Forum. We have very strong relationships with the team here in Hampshire which bodes well for planning and response.", regarding resilience, "SCAS are seen as a trusted and respected partner within this arena with an excellent level of engagement and contribution both in the planning and response stages. SCAS are proactive and professional in their involvement and are a vital member of the LRF planning team" and "In the operational arena I have always had positive interaction with HART personnel both at incidents and in training. The benefits of this collaborative working enhances organisational learning and informing response in the future." Regarding planning for significant events, one of the external organisations said "the SCAS team are trusted and engaged from the outset, attending police led meetings and supporting successful delivery of the multi-agency plan.

The resilience and specialist operations team received correspondence from overseas security agencies for the effective and supportive way they worked with overseas security teams during visits to the UK from foreign dignitaries.

Voluntary Aid services were considered an integral part of the trust's resilience planning for large events and in major incidents. This included working with the voluntary ambulance and health care providers. This included the voluntary sectors role of providing emergency treatment centres, in the trust's mass casualty framework. Planning records showed close involvement with the voluntary sector in the provision of medical and conveyancing support to events such as Royal Ascot.

The HART and resilience and specialt operations team worked and shared information with the counter terrorist unit. The HART team provided examples where they had worked alongside the

counter terrorist unit to deliver safe extraction, care and treatment of patients in suspected terrorist incidents.

The trust worked in partnership with other emergency services, the military and sites such as airports to provide co-responders who volunteered and undertook training to support people and provide emergency care in their community. These were staff employed by their own organisations who received accredited training from SCAS to equip them with skills to provide emergency care in their local environment.

The trust always had two National Interagency Liaison Officers (NILOS) on duty always. A NILO is a trained and qualified member of staff who can advise and support Incident Commanders, police, medical, military and other government agencies on the ambulances services operational capacity and capability to reduce risk and safety resolve incidents at which an ambulance service attendance may be required. This meant there was always a member of staff available to liaise and coordinate response with other emergency services.

Major incident processes included the involvement of the patient transport service (PTS) to support conveyance of low risk patients or the discharge of patients from hospitals to a make capacity for casualties from incidents.

The HART and resilience and specialists operations services worked across the geographical boundaries of SCAS, to provide mutual aid to other areas. The service positioned resilience vehicles at strategic locations, so they could provide prompt support to other regions. They supported planned events, such as visiting dignitaries to the country and high-profile weddings. The location of the HART team, meant they were located geographically closer to some areas of other ambulance services. This meant they often attended incidents outside their own geographical area. They had recently attended a suspected terrorist incident for several days in a neighbouring ambulance trust area, as they were geographically closer to the incident site.

The service worked closely with the two Local Resilience Forums (LRFs) in the trust's geographical area. LRFs are multi-agency partnerships made up of representatives from local public services, including the emergency services, local authorities, the NHS, the Environment Agency and others. LRFs also work with other partners in the military and voluntary sectors who provide a valuable contribution to LRF work in emergency preparedness. The LRFs aim to plan and prepare for localised incidents and catastrophic emergencies. They work to identify potential risks and produce emergency plans to either prevent or mitigate the impact of any incident on their local communities. The service had set up regular joint working days between the two local resilience forums and themselves. This supported the development of shared processes between the two LRFs in the SCAS region to improve the resilience of services for the local population.

We spoke with the lead representatives from the two LRFs within the SCAS geographical area. They both commented on the commitment of the service with working with the LRFS, with members of the HART and resilience and specialist operations team contributing to various LRF work streams.

The Joint Emergency Services Interoperability Principles (JESIP) were embedded across the emergency services within SCAS's operational area. In Hampshire joint command assessments (between police, fire and ambulance) took place using JESIP. Weekly Airwave tests were conducted across all three emergency services' control rooms. Also, since August 2016 an agreement between the airwave tactical advisers across the police, fire and rescue and ambulance services meant if any service asked for an airwave tactical adviser, any tri-service tactical adviser can be used. These last two examples were identified as good practice by Her Majesty's Inspectorate of Constabulary (HMIC) during their inspection last year.

There were examples of how the trust supported and worked with a local integrated NHS trust. The trusts business and continuity manager was a shared appointment with this local integrated NHS trust. This integrated trust did not have capacity to have a full resilience and specialist operations capability or a HART capability. The SCAS HART and resilience and specialist operations service provided support and advice to this trust as and when needed.

Frontline EUC staff commented positively about working with the HART team. An example of comments received by the HART team from colleagues working elsewhere in the trust included, “great inter-operational working by all.”

Health promotion

There was limited opportunity for staff working in resilience services to deliver health promotion to the public. However, the HART team did deliver education session to students from local schools and colleges and had an active social media account including health promotion posts..

The SCAS website provided information about the role of resilience and specialist operations and provided some education advice for the public. For example, at the time of the inspection, which was during a period of hot weather, there was education information on their website about the dangers of swimming in open water.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Discussions with HART paramedics, the HART manager and resilience and operations manager, showed they all had a good understanding about their roles and responsibilities about the Mental Capacity Act 2015. This included seeking consent from patients prior to delivering care and treatment.

Consent was recorded on the electronic patient record (EPR). This included recording best interest decisions when the patient did not have capacity to consent to their own care and treatment.

Is the service caring?

We inspected but did not rate ‘caring’ as we were unable to collate sufficient evidence. We were unable to observe the interaction between staff and patients and there was limited feedback about patients’ experiences relating to the resilience and specialist operations, HART or business continuity services of the trust.

However, we did review the limited number of thankyou comments received from both patients and partner organisations. These all indicated staff treated people with kindness, dignity and respect. Comments from patients and their family members included “Dear everyone, I can’t thank you enough, thank you for helping my friends”, the HART paramedic “showed my mother kindness, care and compassion”, “the personalised, professional and good-humoured care I received at the road side and on route to hospital made a huge difference to me and stayed with me since” and “first class job in difficult circumstances.”

Comments received from police services that the HART and resilience and specialist operations teams had worked with included, for the retrieval of deceased persons following a major incident, the comment that the “commitment of all the emergency services to get the men home with dignity and respect they deserved.” This indicted that staff considered the dignity of people always during an incident.

Is the service responsive?

Service delivery to meet the needs of local people

The service was planned to meet the needs of the local and national population.

The location of the HART station was determined nationally by the Home Office. The decision of the location of the HART site was based on the need to respond to major incidents at government defined sites of strategic importance.

The HART team had three primary response vans (PRV) that could be used as a rapid response vehicle (RRV) to support normal front-line operations. There was a standard operating procedure for this, which detailed the types of calls the HART PRVs could respond to, what locations they could attend and included the requirement that they had to be released from standard operational duty within 10 minutes if they were required on a HART job.

Location of the resilience vehicles was determined by road infrastructures and assessment of risks. They were located at ambulance stations that had larger numbers of staff working out of them, so there would be quicker access to a crew able to transport the vehicle in the event of a mass casualty or major incident.

Meeting people's individual needs

Where possible, the resilience service took account of patient's individual needs.

There was limited scope for the resilience and HART service to take account of patient's individual needs, as they were attending high risk incidents and their main priority was the safety of patients, themselves and the local population.

However, there was evidence that the service provided staff with the skills to take account of people individual needs, this included training about supporting people with dementia and training about managing conflict and challenging behaviours.

Access and flow

The service was planned to deliver care and treatment to patients when they needed it.

The HART service was required to meet the response times set out on the NHS Service Specification 2016/17: Hazardous Area Response Team (HART). This ensured patients who needed the support of the specialist HART team, received it in a timely manner. The location of the resilience vehicles was planned to ensure additional support for mass casualty and major incidents was provided in a timely manner.

Learning from complaints and concerns

Summary of complaints

From April 2017 to March 2018 South Central Ambulance trust received no complaints relating to the HART team or resilience.

(Source: Trust Provider Information Request – complaints)

There were processes for staff to follow in the event of a complaint being received about the service. Although no complaints had been received about the HART team or the resilience service, discussion with staff and managers showed there was a positive culture of learning from events and incidents. This indicated that if a complaint was received staff would act appropriately to investigate and take any learning form the results of the investigation to improve the service provided.

Is the service well-led?

Leadership

Managers at all levels had the right skills and abilities to run the service and provide high quality sustainable care.

There was a clear leadership structure for the resilience and specialist operations department. The head of resilience and specialist operations had overall leadership responsibility and reported to the trusts assistant director of operations. Four resilience and specialist operations managers, who were responsible for the management and delivery of the trust's marauding terrorist firearms attack (MTFA) and mass casualty service, reported to the head of resilience and specialist operations. The HART manager had responsibility for the management and leadership of the seven HART team leaders reported to the head of resilience and specialist operations. This manager and the HART team leaders were responsible for the management and delivery of the trust's chemical, biological, radiological, nuclear and explosive (CBRN(E)) service and completion of hospital CBRN audits. The business continuity manager, was a joint appointment with a local integrated NHS trust, reported to SCAS's head of resilience and specialist operations and had responsibility for coordinating the business continuity assessments and plans for all the service provided by SCAS.

External organisations spoke positively about the skills and abilities of both the HART manager and the resilience and specialist operations managers. This included the "managers' contribution is pivotal, valued and respected immensely."

HART paramedics worked closely with the HART and resilience and specialist operations managers

Vision and strategy

The service had a vision for what it wanted to achieve and were actively working towards achieving the vision.

The HART service had a published vision that was displayed in the HART station. The vision was to become a centre of excellence, contribute to further development, promote innovation, demonstrate effective team culture, share education with colleagues, engage successfully with multiagency partners and be the leading HART in the UK.

Conversations with staff evidenced they knew and understood the vision of the service and their work ethos indicated they were engaged with the delivery of the vision of the service. They expressed their commitment to improving the service by attending training that beyond the national requirements, developing strong working relationships with multiagency partners and taking an active part in the national development of HART and resilience services.

Culture

Managers had an inspiring shared purpose and strove to deliver and motivate staff to succeed. Conversations with managers demonstrated their commitment to delivering a high-quality service that met the needs of the local population and supported staff to develop.

Staff were proud of the organisation as a place to work and spoke highly of the culture. HART paramedics spoke positively about the support and guidance provided by the HART manager. They told us that the manager listened to their ideas for changes and improvements and in most instances, he supported them to put their ideas into practice. They said the manager was a great advocate for the staff. For example, the manager asked staff what they wanted on the welfare vehicle, so it was fitted with a generator and a couple of induction hobs so they could cook meals when on protracted incidents, rather than having to depend on the standard issued ration packs. They commented that the manager cared about them and "he pays into the emotional bank of goodwill". Staff described the level of good will between HART paramedics, the HART manager and the resilience and specialist operations managers as high.

Senior managers listened to the views and opinions of staff. In response to staff views and opinions the HART manager had made four pledges to the staff that were displayed at the HART ambulance station, these were

"Quality – staff supported to challenge and report errors.

Support – eliminate all forms of harassment.

Engagement – encourage to promoter positive physical and mental health.

Knowledge – provide opportunities to have two-way communications with senior managers."

The HART and resilience and specialist operations mangers felt highly respected by the trust's executive team. The executive board did not pressurise the service to use HART resources in a way HART was not designed for. They felt the chief executive held them in "high regard" and that the trust board listened and trusted what advice they gave them. They told us, "senior management know we are the insurance policy for a major incident."

Candour, openness, honesty, transparency and challenges to poor practice were the norm. Post incident debriefs provided opportunity to reflect about the actions taken and what could have been done differently to make the management of the incident more effective or safer. Staff expressed there was a no blame culture, with the emphasis being on learning from mistakes. Staff had a good understanding of their responsibilities towards the Duty of Candour legislation, but had not had to carry out a duty of candour process.

The wellbeing and welfare of staff was a priority for the service. Staff one to one sessions incorporated welfare checks. The trust trained team leaders to carry out stress risk assessments to help them identify staff who might be struggling and need additional support. There was a team of Trauma Risk Management (TRiM) practitioners in the HART service. These were paramedics who had received additional training to equip them with the skills to support staff who had experience work situations that had affected their wellbeing. Staff had access to an external occupational health provider who could provide support and counselling services for staff. An annual HART capability review, managed by a private provider on behalf of NARU, was used to monitor and manage the psychological health of the Hazardous Area Response Team (HART). The trust had a Health and Well Being team who produced pamphlets for the Trust. These pamphlets and other posters detailing how staff could get support with managing their wellbeing were displayed in the communal areas of the HART ambulance station. There was also a

Quiet/Multi Faith room on base which had been designed as a safe and personal area for staff to relax in if required

There was strong collaborative team-working across the service. HART paramedics described working in close knit teams where they knew each other's strengths and weakness and worked to support each other. They described that by working with front-line staff during incidents and delivering training to frontline staff they had broken down barriers so front-line staff understood the role and capabilities if the HART service. The HART team and the resilience and specialist operations managers were proud of their collaborative work with partners such as the Local Resilience Forums(LRFs), the police, fire and rescue services, the military, local airports and docks and the coast guard.

There was a common focus on improving the quality and sustainability of care and patients' experiences. Staff were actively encouraged and supported to contribute to the national development of HART work by being members of various working groups at the NARU as well as making smaller changes at a local level to improve the working conditions for staff.

Governance

The service used a systemic approach to continually improve the quality of its services and safeguard high standards of care.

The service used the national annual EPPR self-assessment process to support the monitoring of their performance against national and local standards and identify areas for improvement. The trust had responded to areas for improvement that were identified at the previous assessment. These included the development of a trust EPRR oversight and delivery group to oversee see and drive internal work of the EPRR function, and the development of business continuity impact assessments and plans for all services and departments. The resilience team presented the findings and action plans from this assessment to the trust board annually.

The HART team and the resilience and specialist operations team provided regular updates about the performance of their specialities to the executive board. There was representation from the resilience and specialist operations service on the health and safety board and the trusts EPPR board. There was a non-executive director (NED) who had the resilience function on their portfolio and the HART manager confirmed he had met this NED at relevant meetings.

Several of the HART and the resilience and specialist operations team members were members of internal board committees and external committees. This meant there was direct representation from the resilience and specialist operations team and travel of information was direct to team members.

Management of risk, issues and performance

The service had effective systems for identifying risks, planning to eliminate or reduce them and coping with both the expected and unexpected.

The resilience and specialist operations team held their own risk register and the HART risks were included in the emergency and urgent care risk register. Staff knew the risks detailed on the risk register and confirmed they matched their own views about risks. Review of the risk registers showed that the risk register was reviewed regularly.

One of the resilience and specialist operations managers was responsible for writing and monitoring the trust's general risk assessments for emergency situations, both for the operations and analytical services and carrying our risk assessments for the local resilience forums (LRFs). SCAS had a number of sites in which there was deemed a greater risk to the public and therefore additional risk assessments and planning was undertaken. This planning for sites was done in collaboration with the Local Resilience Forum and partner agencies. This included the risks on the Community Risk Register and sites subject to the Control of Major Accident Hazards (COMAH) Regulations 2015. Risk assessments carried out on behalf of the LRFs were held on Resilience Direct. Resilience Direct is an online private 'network' which enables civil protection practitioners to work together, across geographical and organisational boundaries, during the preparation, response and recovery phases of an event or emergency.

Information management

The service collected, managed and used information to support its activities.

The HART service submitted data to the NARU database, which supported accurate monitoring of the HART performance. The HART and resilience and specialist operations service followed information sharing legalisation and guidance when sharing information with partner agencies and during mutual aid assignments.

Engagement

The service engaged well with staff and partner organisations to plan and manage services.

The close working nature of the HART service meant staff and the manager communicated at all time and staff were fully informed and involved with any changes to the service. HART paramedics reported there was a good flow of information about what was happening with the trust and nationally with resilience services. This was achieved through emails, briefings, one to one sessions every seven weeks and team meetings. Trust and national information posters were displayed throughout the HART ambulance station.

Staff working in other areas of SCAS reported good relations and engagement with the HART and resilience and specialist operations teams. Training provided for front line teams and delivered by HART and resilience and specialist operations staff, meant there was a good understanding about the role of both the HART team and the resilience and specialist operations team. Feedback from font line teams included, "The feedback from my team was very positive- looking through the vehicles helped visualise what HART does and can do."

The HART team and the resilience and specialist operations managers reported they had effective engagement with partner organisations they worked with. This was confirmed during our conversations with the local resilience forum representatives, who also observed the service's engagement with other organisations such as the police, fire and rescue and the military.

Learning, continuous improvement and innovation

The service was committed to improving the service by learning from when things went well and when they went wrong, promoting training, research and innovation.

There was a strong focus on continuous learning and improvements both at a local level and though influence at a national level. Many of the resilience team members were part of national

NARU improvements groups and influenced changes in protocols, processes, equipment and training. The HART manager was very proud of his “innovative” team. He said the team had lots of innovative ideas and were influencing national changes about HART and resilience practices. He described his staff team as having a “can do “attitude about innovations and improvements.

Within the HART team there were several staff who had been trained by manufacturers to service items of equipment such as the Detection Identification and Monitoring equipment. This sped up the process of checking the equipment.

The HART service used an electronic tool to hand over essential information between staff at the changeover of shifts. This included detail of incidents attended by the previous shift, any vehicle maintenance and equipment issues, the Joint Terrorism Analysis Centre (JTAC) UK threat level, weather forecast for the SCAS region, crew assignment i.e. which vehicles they were assigned to, and the duty officers for the shift, first and second on call for the ambulance tactical advisor and NILO and the medical advisor on call). The reminder and timeline for checking major items of equipment, as well as daily equipment checks, was also held within the handover tool. This tool was developed by the HART team and was not a national standard.

The HART manager had identified, time and money was wasted as teams had to travel to training venues to complete some of their essential training. The HART team monitored training hours to give an idea on how much time was spent for each subject as well as for incidentals such as travelling time. It was proposed to calculate how much travelling time over the year was conducted within the unit and give this a monetary value. From this the HART manager planned to approach the trust to calculate savings by building specific training venues closer to the HART unit and reduce wasted time such as travelling.

Emergency and urgent care

Facts and data about this service

South Central Ambulance Service NHS Foundation Trust (SCAS) is part of the National Health Service (NHS). The trust was established on 1 July 2006 following the merger of four ambulance trusts in the counties of Berkshire, Buckinghamshire, Hampshire and Oxfordshire. This area covers approximately 3,554 sq. miles with a residential population of over four million. On 1 March 2012, SCAS became a foundation trust.

The trust provides the ‘999’ service and handle around 500,000 emergency and urgent calls each year. There are around 1,700 operational staff working from 30 sites with 280 vehicles. Staff include specialist paramedics, paramedics, emergency medical technicians (EMT’s) and emergency care assistants (ECA’s) working on the front-line services.

In the last 12 months the trust dispatched a response to 565,000 calls to the ‘999’ service.

The trust currently owns or leases 30 ambulance stations (resource centres), two HQ/operation centres plus additional standby points, and support buildings. In addition to 280 front-line ambulances SCAS operates, a fleet of rapid response vehicles and supports the operation of two air ambulance helicopters which are operated by the Helicopter Emergency Medical Service (HEMS). These were all included in the emergency and urgent care core service inspection.

The service covers 10 acute hospital sites, two Major Trauma Centres, seven specialist sites and five mental health trusts.

The trust supports the work of voluntary community and emergency first responders across the region who give basic lifesaving interventions prior to the arrival of the ambulance crew; this is co-ordinated by the trust.

We spoke with 206 staff which included specialist paramedics including HEMS staff, paramedics, team leads, clinical mentors, EMT's, ECA's, administration staff, NHS staff from local trusts and members of the make ready teams.

We conducted focus groups with staff and governors prior to our inspection to hear their views about the service. This included frontline ambulance staff, call handlers and the trust's governors.

We inspected 27 ambulances including rapid response vehicles and reviewed seven patient report forms. We visited nine hospitals across each county where we observed interactions between ambulance and emergency department staff. We spoke with staff in the emergency departments and other areas of hospitals including the maternity units about their experience of working with the trust.

We spoke with 15 patients and relatives.

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.
*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Mandatory training completion rates

The trust set a target of 85% compliance for the completion of mandatory training for all modules except information governance, for which a 95% target was set.

A breakdown of compliance for mandatory courses for the year to date, April 2017 to 9 May 2018 for all staff in emergency and urgent care is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes /No)
Manual Handling - People	1,632	1,667	98%	85%	Yes
Equality and Diversity	1,616	1,667	97%	85%	Yes
Conflict Resolution	1,603	1,667	96%	85%	Yes
Dementia Awareness (including Privacy & Dignity standards)	1,597	1,667	96%	85%	Yes

Health and Safety (Slips, Trips and Falls)	1,580	1,667	95%	85%	Yes
Resuscitation	1,521	1,667	91%	85%	Yes
Infection Prevention (Level 2)	1,420	1,667	85%	85%	Yes
Information Governance	1,502	1,667	90%	95%	No
Fire Safety 1 year	1,394	1,667	84%	85%	No

Overall, for the current year to date, all staff in emergency and urgent care have already met the trust targets for mandatory training in seven of the nine modules.

(Source: Trust Provider Information Request – Mandatory training)

Figures provided by the trust during inspection showed that fire safety compliance had now risen to 93%.

The trust had an accessible, up-to-date electronic training schedule which team leaders could view to ensure staff maintained their professional knowledge.

Staff completed mandatory training and the trust provided protected time to complete the training. Some computers at standby points were available to use but staff reported they mainly completed it at the resource centres due to improved connectivity. Some staff we spoke with completed it at home as it was a quieter environment. No staff we spoke with expressed difficulties in completing their mandatory training.

The trust monitored compliance with mandatory training using an online training management system. This was a colour coded system which clearly identified when individual staff members required a training update. Team leaders monitored this information and discussed compliance at staff appraisals and one to ones. Most staff told us this allowed discussion regarding enrolment on relevant courses, which staff requested and completed in a timely manner.

We saw evidence of a structured induction programme all staff completed when they commenced employment, which included mandatory training, listed in the above tables.

Staff could complete mandatory training in a variety of formats including on line, face to face and through training groups. Most staff spoke positively of the training provided.

Guidance used to develop safety systems, processes and practices was from a range of sources. We saw the trust used guidance from the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) and the Resuscitation Council (UK). Staff learnt about changes, learning from incidents and updates in face to face training sessions, e-learning packages and through emails.

Clinical staff received mandatory training on how to recognise and provide a first response to patients with mental health needs, learning disabilities, or patients living with dementia. Staff reported this was helpful although would be interested in further learning around these subjects. The trust provided online learning courses and worked closely with dementia friends to produce additional learning.

All staff we spoke with had completed an externally provided blue light training driving course and trust staff were only required to repeat this if they were involved in driving incidents. This ensured

maintenance of staff's high-quality driving standards.

Safeguarding

Staff understood how to protect adults, children and young people from abuse and the service worked well with other agencies to do so.

At the last inspection in 2016 we identified compliance with safeguarding training had not reached the trust target of 95% across the trust with an average of 85% of front line staff completing. At this inspection we found staff were now achieving the trust targets for completion across all levels of safeguarding training.

Safeguarding training completion rates

The trust set a target of 95% for the completion of the safeguarding modules adults and children level 1, and 85% for the safeguarding modules adults and children level 2.

Below is a breakdown of safeguarding training compliance rates by module for all staff in emergency and urgent care:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Safeguarding Adults (Level 1)	1,632	1,667	98%	95%	Yes
Safeguarding Children (Level 1)	1,631	1,667	98%	95%	Yes
Safeguarding Adults (Level 2)	1,555	1,667	93%	85%	Yes
Safeguarding Children (Level 2)	1,526	1,667	92%	85%	Yes

Overall, for the current year to date, all staff in emergency and urgent care have met the trust targets for safeguarding training in all four modules.

(Source: Trust Provider Information Request – Mandatory training)

The director of patient care was the executive lead for safeguarding. The safeguarding lead was line managed by the assistant director of quality. The newly formed safeguarding group reported to the patient safety group which, in turn, reported to the quality and safety committee. The patient safety group monitored safeguarding activity and training compliance.

The trust had access to 14 safeguarding adult and children boards across seven counties within their operational area. Senior managers represented the trust at each of the boards which provided input from the ambulance service when discussing policies and procedures.

All staff identified as requiring level three and above had either completed a single agency level three course or a multi-agency level three, four or five courses, facilitated by either the Local Authority, NHS England or the Department of Health (DOH).

The trust had up to date policies for safeguarding adults and children easily accessible in paper or electronic form through the trust intranet. The policies outlined what safeguarding was and provided definitions to the different types of abuse including female genital mutilation (FGM), child sexual exploitation (CSE), and sexual, and psychological abuse amongst others. The policy

covered staff responsibilities regarding raising safeguarding concerns and the procedure by which to report these.

All staff we spoke with had a good understanding of safeguarding and could describe when they would report an incident. Staff were aware of the trusts safeguarding lead and said they completed safeguarding referrals routinely. A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Staff in local emergency departments (ED) confirmed the crews would handover if they had raised a safeguarding report relating to a patient and crews would record the referral in the electronic patient records (EPR).

At our last inspection in 2016, we identified possible delays in staff making safeguarding referrals as the trust required staff to submit the required documentation via administrative staff. The administration staff, however, were not available out of office hours. At this inspection staff told us, and we saw, staff completed safeguarding referrals on the trusts EPR system. This allowed for the immediate submission to the relevant authorities. A paper form was available if the EPR system was not working. This system facilitated 24 hours, seven days a week referral, ensuring the safety of vulnerable patients outside normal working hours

The EPR also had a prompt about identifying signs of radicalisation and prompts regarding female genital mutilation which assured us staff would be able to take the appropriate steps to protect patients.

Staff reported they did not receive feedback regarding the safeguarding referral's they had made. The trust explained it was difficult to feedback on each referral due to the volume of referrals and the number of local authorities involved. This could limit the learning around what was an appropriate referral.

Crews should be alerted to potential social services concerns via a flagging system on the ambulance dispatch screen. Some staff reported this sometimes was not the case or the control desk staff may not have the details to share with the crew.

Any learning identified for staff, following a safeguarding review was cascaded to staff via the trust newsletter (SCASADE) or a hot news bulletin and was included in face to face training. The trust was involved at a national level with the UK's ambulance services where learning and new developments were shared. Ambulance station notice boards displayed safeguarding contact numbers and safeguarding bulletins.

Cleanliness, infection control and hygiene

The service mostly controlled infection risk well. Staff mostly followed infection control processes to keep patients safe. The trust completed regular infection, prevention and control audits to ensure staff adherence to best practice guidelines.

The trust contracted out to an external company for the make ready teams. The make ready teams cleaned, prepared and replenished stock in ambulance vehicles and rapid response vehicles. There was a standardised check list in place to ensure the make ready team checked

each vehicle and its equipment appropriately. Most make ready teams worked early morning to midday to clean and prepare vehicles and most teams worked seven days a week. The trust dictated how many staff and how many hours each make ready team would have at each resource centre. We found the less hours the make ready teams were available in the resource centres the more issues there were with the ambulance stocking or cleanliness.

Make ready staff were responsible for cleaning and re-stocking vehicles from 4 am to 11.30 am. Outside of these hours ambulance staff would swap to another vehicle if theirs required a deep clean or presented an infection prevention and control risk. The Make Ready team placed a notice on the windscreen if a vehicle was not available operationally for any reason. Staff would place the keys for the vehicle into a secure post box at the resource centre to ensure staff did not use the ambulance. We saw this system in use and working well during the inspection.

Some staff informed us information was not always available about if the patient they were conveying had an infection at the time of transfer. A recent example staff gave was on discovery of a patient with c-difficile, the staff member went home, had a shower and the vehicle received a deep clean. This assured us staff followed the trust's infection control policy.

An emergency department (ED) consultant spoke positively of the trust's staff ability to manage people with potentially communicable illnesses. They said trust staff would call and advise if their patient had a potential communicable illness so staff could take proactive, preventative steps to ensure risks to other patients were minimised. This would include entering the ED department via a different route and taking the patient straight to an individual room where possible.

Crews were responsible for maintaining the vehicles during the day and between each patient interaction. We saw staff cleaning equipment with disinfectant wipes between patients, they had access to spare linen at the resource centres and ED's. Although it was not the trust's policy in Buckinghamshire we observed a paramedic wiping down all surfaces in the vehicle with disinfectant wipes which was their preference if they had time before leaving the resource centre.

Deep cleaning of ambulance and RRV vehicles occurred on a 12-week programme by the make ready teams. Make ready teams documented deep cleans on an electronic spreadsheet and the trust had access to the spreadsheet. Figures of deep cleaning audits provided by the trust showed a completion rate across the period of January to June 2018 at 97% – 100% of vehicles.

Three of the 27 ambulances we inspected had dusty drawers and dirty equipment. This posed an infection risk for patients. We discussed this with the resource centre team lead at the time of inspection who advised they would review the ambulance cleanliness at the end of the shift.

Staff had access to hand sanitiser gel in vehicles, however on two vehicles we observed the containers to be faulty or empty. All vehicles had routine personal protective equipment (PPE) such as gloves, aprons, hard hats and eye protectors.

Staff completed handwashing audits using peer reviews, and clinical mentors reviewed the audits to identify areas for improvement. Staff completed all infection control audits electronically and used the results for additional training if required. Frontline staff could wash their hands at the hospital's emergency departments and we observed most staff did this after each handover.

We found staff wore personal protective equipment when appropriate and staff uniforms were in good order, clean and well-presented uniforms. The trust provided staff with sufficient uniform, so they could change during their shift if necessary. A staff member, during the inspection, required a change of uniform due to contamination and we saw they had spares available at the resource centre. Staff had access to washing, locker and changing facilities at the resource centres visited.

The trust policy stated staff may wear wrist watches if they are fully washable and staff removed the watch prior to washing their hands. We observed staff to be adhering to policy and wearing plastic watches.

The trust had a service level agreement with each local ED with regards to needlestick injuries which ensured appropriate follow up for staff was available for example blood test results.

The trust lead for infection prevention control attended bi-monthly health and safety meetings where the meeting discussed present themes and trends from incidents. A recent example included a razor blade head that was too big for the small sharps boxes. The trust shared the manufacturer information with staff via the hot news bulletin about how to safely break the razor blade head from the handles for safe disposal. Figures provided by the trust show sharps incidents from razor blades have reduced from four to one since the bulletin's publication.

We observed sharps boxes stored appropriately and labelled as per trust policy and waste bins, including the sharps bin, locked to prevent unauthorised access. There was a disposal area for full sharps boxes in each resource centre however some of the disposal bins were overflowing which could cause a risk of needlestick injuries. We observed staff disposed of all clinical waste appropriately however some clinical waste bins contained general rubbish. This did not assure us all staff followed the trust's waste disposal policy.

The infection control lead emailed any areas of noncompliance to the relevant manager and teams. The lead reviewed compliance across the clusters and fed back to the team leaders with action plans.

The vehicles were also part of an electronic audit system where staff could complete an online audit and the system could send an automatic email to the resource centre team lead to address any infection control issues.

The trust employed an external contractor to clean the resource centres and we saw different levels of cleanliness across the trust. For example, north harbour in Portsmouth was clean throughout and Basingstoke had areas that were not clean. Oxford station's male toilets were dirty and the building in poor repair.

Ambulance staff were responsible for cleaning area's that the external contractor did not have access to, for example the drugs storage cupboards.

There was a colour code policy in place for mops and buckets to reduce the risk of cross-infection. In all ambulance stations we saw staff adhere to the policy.

Environment and equipment

The service maintained their older premises as best they could and their purpose-built resource centres well. The service looked after equipment well.

At our last inspection in 2016 we identified equipment was not always readily available or appropriate for use, this included dressings which were out of date. At this inspection we found consumable items at one Reading resource centre store room were out of date and not appropriate for use.

Equipment in ambulances and rapid response vehicles (RVV) we inspected were mostly clean and well maintained however we found five pieces of equipment that were out of range for their service dates on a RRV vehicle in Thruxton, and on one ambulance in Bletchley where blood stains were observed on straps and another ambulance did not have a paediatric harness on the trolley, the

longboard was not secured and the scoop stretcher straps had evidence of blood. This did not provide complete assurance the make ready teams were cleaning ambulances effectively.

If a member of staff or crew found a piece of equipment to be faulty at the start of a shift, or if a fault developed during the shift, they would call the operational support desk (OSD). This provided staff with the ability to talk through the fault with the OSD and carry out basic troubleshooting. If the faulty equipment was essential the OSD would divert the crew to the nearest resource centre to resolve the problem.

Resource centres had dedicated restock areas and cupboards. Make ready teams received training to restock vehicles and diagrams and guides informed the teams what equipment should be in each vehicle and response bag. The stations make ready team stored new items in their own secure storage area and replenished stock from the running stores. The make ready team rotated stock to prevent items expiring. However, we found over 30 consumables on the RRV's and ambulances across the service that had expired. We notified staff at the time of inspection and staff removed them from the vehicles.

The service had Make ready pouches which meant crews could replenish vehicle stock quickly. Make ready pouches included: paediatric resuscitation items; adult resuscitation items; trauma blast packs; first aid dressings; intubation and infusion packs which are all in sealed bags. Staff can return half use bags and replace with full bags at the resource centres.

The make ready teams cleaned and replenished equipment. This included all disposable equipment and medical supplies. When a Make ready team was not on duty, ambulance staff were responsible for restocking their own vehicles from top-up stores.

Staff had 30 minutes to make their ambulances ready once they had logged on for a shift and found the 'make ready' team invaluable. If staff found there was missing items or equipment team leaders encouraged staff to raise an incident and some staff reported they would tell the 'Make ready' staff to immediately resolve the issue.

We observed stock across the resource centres stored appropriately and off the ground limiting the risk of cross contamination.

Some stations stocked two types of defibrillator machines on ambulances. This could pose a risk staff would not be familiar with both types of machine. However, staff reported they fully understood and had received adequate training to use both machines.

Some resource centres were purpose built as ambulance stations. The resource centre at north harbour in Portsmouth was in the process of building a garden and had developed a prayer room in response to staff requests. Other resource centres were very old and run down and needed repair. For example, one resource centre in Hampshire had loose tiles which were a trip hazard in the garage area. Staff reported this hazard to the estates department but estates had not repaired the floor at the time of inspection.

The store cupboard in Basingstoke had an assortment of products such as biscuits and washing fluid. Basingstoke staff were working in a challenging working environment due to its age and concerns were raised to estates but there were no updates of timescales for any work planned.

We observed all ambulances to have the same lay out which ensured staff were familiar with each new ambulance used. Each contained a patient trolley, a foldable wheelchair, three seats with seatbelts, equipment for taking patient observations, cupboards which stored medical gases and consumables. Secured in the an easily accessible locker were additional stretchers for carrying

patients. Each ambulance had an external tail lift which staff lowered electronically and raised to get patients into and out of the ambulance.

An external company completed vehicle servicing in Oxford and Reading although there were plans to move them to one site in Didcot. The operational service desk (OSD) managed vehicles across the trust and staff reported faults with vehicles to the OSD and control room. Staff gave an example of a breakdown on night shift due to a lack of brake fluid. OSD took the vehicle off the road and found a replacement vehicle for the crew.

Vehicles were taken off the road for repair when needed, and labelled to ensure staff were aware. There was a rolling programme of vehicle replacements in place. We observed vehicles in stations with the vehicle off road signs in the front.

At our last inspection in 2016 we identified two of the 12 vehicles required in the event of a major incident would not have been ready if they had needed to be deployed quickly. At this inspection we identified an uncharged major incident vehicle based at Bracknell resource centre, making it unavailable for use. We alerted staff who placed the ambulance on charge immediately.

Staff reported updates to satellite navigation systems happened every six months. However, some staff in the Hampshire area reported the navigation systems did not show new housing estates that were up to four years old. Crews in this situation resorted to using smartphones to navigate. Other staff said if a newly built housing estate did not appear on the screen the guidance system correctly identified the patient's location with a marker which enabled staff to navigate safely to their destination.

There were provisions on most ambulances for the conveying of children. Children used seat belt straps on the rear facing seat and the stretchers were fitted with straps to secure children. We noted in the Bletchley station one of the ambulances did not have the additional child restraint straps available and raised this with the team lead. We observed one crew accept a child from their parent in their own baby carrier and secure it safely to the ambulance seat.

Most equipment carried on the ambulances was standardised across the trust. At the last inspection in 2016, we found paramedic response bags to be in varying degrees of repair. On this inspection we found the same and not all response bags were wipe clean and the old style had zips replaced but the straps were very dirty and posed an infection risk. The trust reported they had undergone a replacement programme for the older style bag and would investigate our concerns.

However, within the HEMS teams staff used wipe clean bags carry equipment and medicines and these were all in good condition and clean. Staff signed and tagged each pouch and compartment to confirm staff had checked them and the bag was ready to use. Staff checked all bags daily. Staff told us they emptied one of the four sets of bags completely each week and repacked, this ensured stock rotation provided further assurance all contents were in date.

There were satisfactory records of vehicle and equipment checks. For example, there were appropriate procedures to ensure ambulance vehicles were serviced and had Ministry of Transport (MOT) test certificates. The trust kept maintenance and service logs in line with legislation.

Assessing and responding to patient risk

Staff assessed risks to all patients, and managed and monitored them appropriately.

Staff used their training and clinical judgement to assess each patients' condition. We saw crews carry out observations and assessments of patients using Joint Royal Colleges Ambulance Liaison Committee (UK) (JRCALC) protocols.

Staff had access to care pathways which provided guidance to staff on the most appropriate action to take when managing a patient's presented symptoms. It also supported staff to recognise, treat and monitor a deteriorating patient. The trust had placed JRCALC protocols and care pathways on staff mobile phones which enabled crews to have immediate access to the information they required. Staff spoke positively of this available guidance and we saw staff follow these pathways throughout the inspection.

Following on from an incident in the ED where ambulance staff gave a patient the wrong name band, the trust distributed a memo to staff to remind them only the ED staff should place name bracelets on patients. However, in the Buckinghamshire area we observed a staff member placing a name bracelet on a patient. We raised this immediately with the head of operations for that area.

Crews stated they undertook risk assessments. If an incident happened they would ask control to put immediate notes, in real time, on to the EPR. Although crews could do an incident report on the EPR the crews told us they normally returned to base as the EPR system often crashed while mobile.

Staff could seek clinical support via the trust's clinical support desk (CSD) if required. The CSD was available 24 hours a day. Staff also contacted patient's GP and out of hours GP if they felt the GP needed to be aware of a patient's health episode but did not require a hospital admission. We observed a newly qualified paramedic contact an out of hours GP to seek guidance as they did not believe hospital was the most appropriate treatment option. This process meant staff spent additional time with the patient to manage their health and wellbeing. By appropriately not conveying a patient this allowed for staff to respond to another request for emergency assistance.

Each crew had access to a clinical mentor aligned to their team. Clinical mentors were immediately available to provide specialist clinical advice and were a deployable resource to support crews. We observed a clinical mentor during the inspection called to support a crew with a patient whose condition was deteriorating. Staff spoke positively about the support provided by the clinical mentors and CSD.

Staff were aware of the national early warning score (NEWS2) scoring for sepsis tool. The EPR had the NEWS1 tool embedded and provided an immediate score. We observed staff assessing Face, Arms, Speech, Time (FAST) (symptoms of a stroke) and NEWS when treating patients according to National Institute of Clinical Excellence (NICE) guidelines. All guidelines were available to crews on the EPR. Staff received clinical updates via email about any changes to pathways. Mandatory training days included face to face sepsis training.

On most ambulances, there was appropriate equipment to provide monitoring and assessment of patients. For example, patients could have a 12-lead electrocardiogram, oxygen saturations, non-invasive blood pressures, temperature and blood sugar recorded on the scent. There was also equipment to measure carbon dioxide in the blood. This allowed crews to be able to supply the CSD with detailed clinical observations to assist in getting the right urgent treatment for the patient.

The trust used volunteer community first responders, managed separately from the emergency and urgent care teams, to support patient's needs. Staff said volunteers had clear parameters

within which they could work to ensure they remained safe and were not undertaking work beyond their knowledge levels.

The trust command structure was defined as Gold (strategic), Silver (tactical) and Bronze (operational). Bronze command was the shift team leader and had their own response vehicle. Bronze command responded to all cardiac arrests and carried an automatic chest compression device.

The HEMS team were all qualified paramedics and doctors who had further training to equip them with the skills to identify and manage deteriorating patients in potentially hazardous situations. This meant there was appropriately trained staff to assess, identify and treat patients who were deteriorating.

Each emergency department had an advanced stroke practitioner and ambulance staff were aware to pre- alert emergency departments with any patients suspected of having a stroke via their red phone.

We observed staff to be able to recognise, treat and transport patients experiencing a mental health crisis, although they had not completed specific training on Mental Health disorders. Staff said they received conflict resolution training every three years which involved how to recognise and de-escalate aggressive behaviour. Staff said if a patient displayed behaviours which could challenge and potentially cause harm to themselves or the crew they would seek support from the police. Staff said they would pull over as soon as it was safe to do so, request assistance from the police and their team leader and try to keep the patient safe whilst remaining mindful of their own safety.

The trust Emergency Operations Centre (EOC) staff and the EPR flagged addresses where staff should remain additionally cautious when attending. This included addresses where occupants had previously displayed violence or aggression. Staff told us this system worked well and they could escalate concerns to ensure EOC placed a marker on the patients address when required. This allowed staff to remain vigilant when attending an address or seek additional support from the police prior to attending if required.

During the inspection we observed a patient becoming aggressive with staff, we saw staff remained calm and compassionate with the patient managing their pain needs until they were no longer presenting a risk to staff or themselves.

Staffing

The service had enough staff with the right qualifications, skills, training and experience, to keep people safe from avoidable harm and abuse and to provide the right care and treatment.

Planned vs actual

The trust reported their staffing numbers for emergency and urgent care as of March 2017 and March 2018.

As of March 2018, the trust reported an overall fill rate of 94.8% for all IWP* rota staff within emergency and urgent care, with 82.7 fewer WTE staff in post than the trust planned to provide safe and effective care.

This has deteriorated since the previous year (March 2017) where the trust reported 24.3 fewer WTE staff in post and a fill rate of 98.4%

Displayed below is a breakdown of planned vs actual staffing levels by job role within emergency and urgent care:

Job Role	As of March 2017			As of March 2018		
	Planned staff WTE	Actual staff WTE	Overall fill rate	Planned staff WTE	Actual staff WTE	Overall fill rate
Team Leader	79.6	86.0	108.0%	71.8	91.6	127.5%
Specialist Paramedic	76.0	59.9	78.8%	48.9	48.3	98.7%
Clinical Mentor	75.8	79.7	105.2%	72.6	86.2	118.8%
Paramedic 6	602.6	530.7	88.1%	635.8	607.8	95.6%
Student Paramedic	116.5	81.9	70.3%	81.3	107.0	131.6%
International Paramedic	16.4	49.0	298.8%	35.0	31.0	88.6%
Ambulance Technician	148.1	154.9	104.6%	171.4	147.6	86.1%
Trainee AAP	64.8	72.3	111.6%	61.2	52.0	85.0%
Emergency Care Assistant	377.1	418.2	110.9%	419.0	342.8	81.8%
Total IWP rota staff	**1,556.9**	**1,532.6**	**98.4%**	**1,597.0**	**1,514.3**	**94.8%**

Although the overall staff fill rate has dropped since last year there has been an increase in staffing numbers in many roles within emergency and urgent care, including student paramedics, clinical mentors and specialist paramedics. With team leaders, clinical mentors and student paramedics all reporting an over-establishment of staff as of March 2018.

However, other roles such as ambulance technician, trainee AAP and emergency care assistants have seen a reduction in staffing numbers compared to the previous year with fill rates at less than 90%.

* IWP – integrated workforce planning.
(Source: Trust Provider Information Request– Total staffing)

At our inspection in 2016 staff told us staffing levels were a concern. Staff said they were working longer hours, felt under pressure and were not receiving their allocated meal breaks until close to their finishing time which was causing a loss of morale. At this inspection the trust was completing a rota review looking at skill mix, staffing levels and shift patterns. Staff said this was to identify the most appropriate shift pattern which would meet staff needs for rest periods, meal times and ensure deployment of the most appropriate numbers of staff.

The trust's business intelligence, planning and forecasting team worked together to predict patient demand and aligned shifts to meet this need. This information plotted and displayed the minimum and maximum number of staff required to ensure people received a safe service. Records showed the teams predicted day to day patient demand to almost 98% accuracy and showed staff deployment aligned with the demands placed on the trust. For example, the leadership team were proactive in recruiting staff as they were looking to increase staffing in Milton Keynes due to growth of the town, and we saw evidence the trust was forecasting for the next two years.

Clinical and non-clinical staff were rostered over a 24-32-week period with four weeks scheduled annual leave and two weeks annual leave staff could request. Some staff complained of having to work 10 shifts in a row but more senior staff reported there was limited changes they could make. Staff reported the rota system was due for a review and some staff reported staff fatigue was a growing concern within the trust. Due to the concerns over staff fatigue the trust had enlisted an external agency to undertake a fatigue study where selected member of the teams wore wrist bound activity trackers which monitored their sleep patterns on and off shift. The outcome of the study would feed in to the review of the staffing rota's.

Each team across the service included emergency care assistants (ECA), paramedics, one specialist paramedic (SP) per team and ambulance technicians. Two SP's were normally working in the daytime in each area and one SP at night.

The HEMS teams consisted of one paramedic and one doctor in the helicopter and one paramedic in the car. During inspection we observed the car had one critical care paramedic and one doctor. Doctors and advanced paramedics enabled the service to bring a more experienced approach to sick patients by providing additional drugs road crews cannot carry.

Staff told us there had been an improvement in their ability to take their meal breaks during their shifts. The trust had increased staff meal allowances to encourage staff to take their meal breaks away from their resource centres, particularly in the more rural areas. This limited the amount of time staff spent travelling as they did not have to return to base to eat. It made staff more available to meet patient demand as they were not always travelling to and from a rural resource centre. The trust offered staff a standard payment and a specified period if they had their break at their resource centre or an enhanced payment and break time if they ate away. The trust was looking at the implementation of cool boxes in the cabs so staff could carry their food on the ambulances.

Across the service staff reported if they were late off duty they received overtime for the late finish or could come in late the next shift to ensure they had an 11-hour break between shifts. This ensured staff were safe and not excessively tired.

Vacancy rate

Emergency and urgent care has an annual vacancy rate target of 15.0%.

From April 2017 to March 2018 the trust reported an annual vacancy rate of 13.0% for all staff working in emergency and urgent care which was better than the trust target.

Below shows a breakdown by job role:

Job Role	Total vacancies (WTE)	Total number of staff establishment (WTE)	Annual vacancy rate
Specialist Paramedic	402.9	1,032.0	39.0%
Clinical Staff	1,626.7	10,800.0	15.1%
Non- Clinical Staff	691.7	7,356.0	9.4%
Clinical Mentor	64.1	1,032.0	6.2%
Team Leader	-22.4	1,032.0	-2.2%

Total	**2,763.0**	**21,252.0**	**13.0%**

* Negative figures indicate an over-establishment of staff.

Specialist paramedics were the only group of staff who didn't meet the 15% vacancy rate target, reporting an annual vacancy rate of over double the target at 39.0%. Team leaders had an over-establishment of staff throughout the year resulting in a negative vacancy rate of -2.2%.

(Source: Trust Provider Information Request– Vacancy)

Specialist paramedic (SP) vacancies were due to many SP's moving to GP surgeries. The trust was aware of this reason and action plans were in place to try and retain their SP's including discussions with GPs for the trust to provide but employ the SP's.

Turnover rates

Turnover:

Emergency and urgent care has an annual turnover rate target of 15%.

From April 2017 to March 2018 the trust reported an annual turnover rate of 14.7% which was better than the trust target.

Below shows a breakdown by job role:

Job Role	Total leavers (WTE)	Average number of staff establishment (WTE)	Annual turnover rate
Trainee AAP	4.0	73.4	5.5%
Clinical Mentor	4.5	80.7	5.6%
Student Paramedic	6.0	99.1	6.1%
Team Leader	6.8	87.9	7.8%
International Paramedic	6.0	45.8	13.1%
Paramedic	87.6	572.8	15.3%
Emergency Care Assistant	70.3	382.8	18.4%
Ambulance Technician	28.6	145.9	19.6%
Specialist Paramedic	12.7	52.4	24.2%
Total	**226.5**	**1,540.7**	**14.7%**

Three groups of staff had turnover rates higher than the 15%; emergency care assistants, ambulance technicians and specialist paramedics. Of these, specialist paramedics reported the highest turnover rate of 24.2%.
(Source: Trust Provider Information Request– Turnover)

Sickness rates

The trust has an overall sickness rate target of 6%.

From April 2017 to March 2018 the trust reported an annual sickness rate of 6.8% for all staff working in emergency and urgent care which was worse than the trust target.

Below shows a breakdown by job role:

Job Role	Total absence days	Total WTE days available	Annual sickness rate
Technician	7,425.4	95,586.3	7.8%
Specialist Paramedic	1,305.7	18,090.1	7.2%
Non- Clinical Staff	11,610.9	168,751.9	6.9%
Clinical Staff	18,141.4	277,438.3	6.5%
Management Team	135.0	5,164.0	2.6%
Total	**38,618.4**	**56,5030.5**	**6.8%**

All groups of staff apart from management team had annual sickness rates which were worse than the 6% target.

(Source: Trust Provider Information Request– Sickness)

Although staff sickness rates were worse than the trusts 6% target staff morale remained high and to mitigate staff shortages and ensure the service provision was safe, the trust subcontracted work to seven independent ambulance services.

Bank staff usage

The trust did provide data but unfortunately there were errors in their submission where the trust had copied figures over incorrectly, resulting in errors in certain fields. They have also only submitted the hours of work provided by temporary staff without also including the total hours available, so it has not been possible to analyse it.
(Source: Trust Provider Information Request – Bank and agency tab)

The scheduling team calculated when individual teams required extra shifts and would advertise via the trust's app (an application staff could place on their smart phones) and email for staff to do overtime and staff booked the extra shifts through the app.

The HEMS service had covered all their shifts and there was no evidence the HEMS team used bank staff. However, staff reported there were two bank Critical Care Paramedic (CCPs) both HEMS trained who did some shifts but also work full time on HEMS.

The trust had a framework of approved agencies who signed up to the crown commercial service agreement. These agencies agreed to submit applicants to roles with the following checks already completed: Right to work, three years of written references and any gaps covered, Occupational Health assessment and an enhanced DBS if required. Applicants could not start until the trust completed all checks and the agency audit team had issued a certificate of completion.

Teams had a skill mix of clinical staff and ECAs. A double crew of ECAs could attend category one calls but would require clinical staff back up. Staff reported paramedics and ECA's covered most shifts due to the reported shortages of ECAs currently.

We saw evidence the trust has developed a Resource Escalation Action Plan (REAP) which detailed mitigating actions and contingency plans with regards to staffing against various REAP

levels.

Records

Staff kept appropriate records of all patients care and treatment. Records were clear, up-to-date and available to all staff providing care.

At our last inspection in 2016 we identified one resource centre had not stored paper records securely before shredding. At this inspection we identified a confidential waste bin at Bracknell ambulance station was overflowing. The information was relating to crew control sheets for the month prior to the inspection which displayed details of staff rota's.

Staff updated the EPR system with patient clinical information and we observed them to be in accordance with the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) 2017 guidance. Staff had passwords to enable them to securely access the EPR. The EPR system prompted staff to record notes using the medical models.

Staff had access to paper forms to complete in the event of failure of the EPR system. Blank paper records were available at the resource centres and on the ambulances.

In the emergency department reception, we observed staff complete patient records during handover and liaise closely with the hospital reception staff for a comprehensive hand over.

Most EPR devices could link to the hospital emergency departments system which allowed staff in the ED to review the patient's condition before they arrived. Most ED's had charging stations for the EPR devices. If the receiving hospital did not have access to the EPR system the staff were able to print out the record with portable printing machines.

The EPR prompted the recording of triage processes and decision-making processes for declaring a major incident. This ensured staff were aware and prepared for dealing with major incidents.

The trust flagged addresses or patients where special action or precautions staff needed to be aware of. This included patients who had displayed behaviours which could challenge and patients who required only female or male staff attendance. Staff could ask the EOC to flag addresses and these remained live for 12 months unless there was an update which the EOC could remove or extend the flag.

The emergency control centre was also able to access the EPR system and could add specific details, for example if a patient was not for resuscitation and had the appropriate paperwork. This prepared the ambulance crews with knowledge about the patient's condition.

Patients clinical records followed a medical model. The format of the patient clinical record form was clear and followed JRCALC guidance. We reviewed 10 completed records. The documents were clear and followed the medical model.

Some clinical mentors told us they would review a random selection of EPR's and there was an EPR review group to look and provide assurance around patient records. Another specialist paramedic corroborated the EPR was audited monthly as was clinical performance indicators (CPI) compliance and the percentage of 'long waits'. The audits highlighted issues such as staff completing capacity assessments unnecessarily and informed some gaps in staff knowledge and understanding.

Medicines

Overall the service prescribed, administered, recorded and stored medicines appropriately. However, we found some expired medicines not disposed of in a timely or appropriate way and staff did not monitor the storage temperatures of medicines in resource centres which could affect their effectiveness.

There were four of the 10 medicine pouches we reviewed found to be out of date or with the wrong amount of medicine in them across the trust. During the inspection the trust issued an alert to all staff to check medicines before administration following many staff identifying issues with out of date medicines in the pre- packed bags. One team leader reported staff submitted incident forms due to medicines not matching the stock lists within the pouches but these never related to the cardiac arrest pouches.

We saw a message to all crews appear on the screen while we were in a vehicle to remind them to check expiry dates before administering drugs. We discussed this message with crew who advised this is normal practice and explained how they follow the five rights of medicine administration.

The trust purchased medicines from NHS hospital pharmacy services. These purchases included pre-packs of medicines to treat patients for specific conditions either as single doses or TTO (To Take Out) packs. At two locations make ready staff packed and checked medicines into five medicines pouches of different colours which identified medicines for resuscitation for example and sealed them with a tamper evident tag. Make ready staff via a “milk round” topped up the pouches held at resource centres and removed pouches that had red tags. Red tags signified the pouches either had run out of medicines or contained out of date medicines.

Bags were colour coded to allow staff to identify an opened bag. Staff sealed a bag with a red tag that required restocking and returned it to the used medicines locked store cupboard within the resource centres

Critical and primary care paramedics ordered specialist medicines from the central distribution hub. Depending on the distribution process either resource centre staff ordered and received controlled drugs on a weekly basis. Alternatively, individual ambulance crews obtained controlled drugs from a nominated hospital pharmacy. This ensured appropriate levels of CDs were always available to avoid delays in treatment.

There were Patient Group Directives (PGDs) for specific medicines that critical care paramedics (CCP’s) can administer, if the paramedic is in training to become a CCP, they can only administer medicines under supervision of the doctor as they cannot use PDGs until qualified.

We observed some medicines kept at room temperature, although they should have been in a fridge. Staff demonstrated, following advice of the lead pharmacist, how they revised the product expiry dates medicines stored at room temperature. Staff only monitored and documented medicine storage temperatures at the central distribution hub, two make ready centres and the medicines fridge at Thruxton. Therefore, we lacked assurance the trust was storing medicines within their recommended temperature ranges. However, the trust issued a hot news bulletin to staff on the third day of inspection with advice about what measures to take regarding storing medicines in the hot weather.

The HEMS service had two bags of O negative blood and two units of fresh frozen plasma kept on board the helicopter and Helicopter Emergency Medical Service (HEMS) response team cars. The service routinely kept blood products for 48 hours before going back into the system but currently only 24 hours due to the hot weather.

When the HEMS team administered blood or plasma we saw there were records of administration checked by two members of staff prior to administration. This followed the trust's medicine administration policy.

Safes on the vehicles and at resource centres contained schedule two controlled drugs. All safes and medicine storage areas had swipe card assess allowing a full audit trail of who accessed which safe and when.

Each ambulance station and vehicle had a controlled drugs record book and a system for tracking orders. Processes were in place to return out of date medicines to two central locations for disposal. Across the service we noted staff quarantined out of date medicines in specific boxes-labelled clearly out of date and stored in a locked cupboarded awaiting collection.

Other medicines were stored in tagged and tamper evident bags on vehicles. There was potential when staff left ambulances open at ED's, medicines stored in bags were at risk of unauthorised access.

Staff accessed CDs from the ambulance key lockable safes using swipe cards. This ensured an audit trail was available regarding who had accessed them. Staff checked the controlled medicines at the start and end of the shift. Most records we reviewed were correct however, on one RRV in Hampshire the recording of controlled medicines was incorrect and there was no evidence of the completion of carry forward balances and daily checks.

Staff we spoke with could describe the process for picking up and booking in controlled medicines. In some areas clinical managers and team leads had a log with photos of staff who could pick up controlled medicines. If crews ran out of controlled medicines over the weekend other resource centres would re-stock them.

Mostly staff disposed of controlled medicines appropriately and as per the trust's guidance however, some staff also suggested alternative disposal routes, for example down a road drain. This did not assure us all staff were following the trust's guidance of disposal of medications.

The manufacturer delivered medical gases to agreed locations. Management of medical gases was not always appropriate for example gas stores were internal and lacked ventilation, lacked appropriate signage, cylinders were incorrectly stacked or segregated. Medical gas delivery notes had accumulated in some gas stores. We noted in one RRV in Hampshire an oxygen cylinder left loose in the back of the vehicle. This did not assure us staff were following the trust's policy for safe storage of gases on and off the vehicles.

The trust supported Paramedics, Ambulance Technicians and Emergency Care assistants to administer medicines via trust policies, policies, guidelines and the UK Ambulance Services Clinical Practice Guidelines. Patient group directions authorised paramedics to administer or supply a wider range of medicines depending on their role, additional training and competency. Staff accessed these documents via the trust patient record system and a mobile phone app.

When call handlers dispatch staff to attend a call, they ask the person making the call to get the patient's' medicines ready for when the ambulance arrives. The trust has worked across their catchment areas with individual receiving hospitals to increase the transfer of patients own medicines or relevant information to hospital. Staff place patient's medicines in green bags, and ask for copies of current prescriptions, repeat request forms and medicines administration records from care homes. Trust staff can record a patient's medicines history on the EPR and send a summary including prescribed medicines to the receiving unit in advance of their arrival.

The trust's chief pharmacist produced anonymised redacted reflection on medicine errors which assisted teams with reflective learning.

Incidents

The service managed patient safety incidents well and responded appropriately to significant events.

At our last inspection in 2016 staff evidenced they knew how to recognise and report an incident appropriately however did not always have time to do so during their shift. At this inspection staff continued to evidence they knew when and how it was appropriate to raise an incident and had time to do so using the trust's online incident reporting system. Most staff told us they received feedback on actions taken when they had submitted an incident report.

Staff reported incidents using the EPR system. The team lead graded and decided using the trust's incident management guidance, if an incident investigation was required. All incidents were referred to the risk team for review which caused a delay in incident outcomes being fed back to staff.

Senior staff could not close incidents on their online system until team lead produced evidence identifying staff receiving feedback. The trust's risk team would return the incident to team leaders and request action. This ensured staff received feedback and were aware of actions taken to prevent a reoccurrence. However, staff reported delays in receiving feedback and learning as the review process was lengthy.

Air ambulance teams had an additional reporting process, they called occurrence's. Unlike an incident an occurrence is something which needs putting right. For example, during the heat wave bougie tubes (endotracheal tube introducer) were going floppy which made them difficult to insert. Staff raised an occurrence and a decision made to store bougie tubes in the fridge.

If there were incidents with the 'Make Ready' team the training and governance manager would meet with director of operations to complete an incident report together and audit quality at the same time. However, for example if there was a needle disposed of incorrectly in a waste bag, team leads would escalate it as a potentially serious incident.

A clinical mentor in Hampshire used learning from incidents for focused improvement teaching sessions such as abdominal assessment.

Resource centres across the trust had noticeboards where staff could post learning updates and reminders, for example, sepsis, bright ideas, falls referrals on EPR and chemical burns.

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From May 2017 to April 2018 the trust reported no incidents classified as never events for emergency and urgent care services.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

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

The breakdown by incident type was as follows:

Incident type	No. of incidents
Sub-optimal care of the deteriorating patient meeting SI criteria	4
Treatment delay meeting SI criteria	1
Diagnostic incident including delay meeting SI criteria (including failure to act on test results)	1
Medication incident meeting SI criteria	1
Total	**7**

(Source: Strategic Executive Information System (STEIS))

Some staff reported limited learning from incidents. The sharing of themes from incidents was not always effective across the trust and each team leader reported they were only aware of incidents from within their own teams. However, staff reported an example of learning from an incident where the crew responded to an unresponsive baby and it was the first-time staff had had to resuscitate a baby. They reflected and learned they should step back a little, be less physical and take note of the environment. Further learning included how to work in a crime scene without disturbing it and how to write a statement and witness in court. However, it was unclear if the trust disseminated the learning across the trust.

Another example of learning from a change of practice was regarding a patient with a head injury that a crew conveyed from one hospital to another (sedated and intubated). No anaesthetist was available to go with the crew and the patient woke up unexpectedly en-route and the immediate learning was that crews would in future insist on an anaesthetist accompanying them with the transfer of this profile of patient.

The trust emailed staff regarding changes in policies and procedures and teams discussed the changes in team meetings. We saw the outcome of changes placed on the staff notice boards in high foot traffic areas to act as continuing reminders of any change in working practice. Staff said they had regular monthly team meetings.

Staff told us they received debriefs following any serious incidents. An immediate debrief was available to staff when an incident occurred and used the Trauma Risk Management (TRiM) service to help support staff. This worked well and a paramedic gave an example, where staff had dealt with a distressing incident (child death) and senior staff immediately offered support which included sending staff home who had found the incident particularly traumatic.

The air ambulance team had an electronic awareness board, which displayed any new practice, learning, improvements and warnings. Staff who were required to read the updates turned red and once they have read and signed the new information it turned to green. Included in the file was the bougie storage, adrenaline dosages and a memo re oxygenation.

Staff across the service demonstrated their understanding of the duty of candour by articulating the different steps involved.

The trust produced root cause analysis reports after a serious incident and produced action plans to improve safety performance and results. We saw evidence all senior staff had received route cause analysis training.

The trust produced regular 'SCAScades' in response to clinical incidents and provided an interactive learning experience which staff could use to evidence continuing professional development. Trust newsletters, such as Staff Matters, Safety Matters and Onesie shared articles. These contained key information about specific incidents and the trust circulated information to all resource centres.

The trust developed ad-hoc training packages, for example head injury assessment and treatment. The trust delivered these packages as required in response to themes and trends from incidents, and statutory and mandatory training content changed as a result.

Is the service effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and provided evidence of its effectiveness.

Staff had access to a clinical pathway app on a smartphone which required them to give yes or no questions and other choices. This helped confirm clinical decisions in difficult and complex situations for all age ranges of the population.

Staff had Joint Royal Colleges Ambulance Liaison Committee (JRCALC) national guidelines, clinical protocols and care pathways readily available on an app on their smart phones. This allowed staff to quickly identify the most appropriate best practice guidance. We observed staff providing care in line with professional guidance including for example, the aseptic technique for cannulation.

The app provided staff with details of the nearest hospital with the right levels of expertise to manage a patients' health condition. Staff showed they could access the right acute facilities for their patient. For example, the app provided staff with the appropriate steps to provide the correct treatment for a patient suffering a heart attack. The app directed staff to the nearest specialist hospital most appropriate to meet the patient's needs. This ensured the patient had timely access to the correct medical care following initial treatment by staff.

The trust held bi-monthly stroke reviews to review if call results were not in line with national stroke targets. The meetings sought to identify the reasons why national targets were not met and if there were any lessons to learn to ensure the same situation was not repeated.

A clinical mentor in Hampshire reported they were writing team training on pathways with registrars and with consultant input from a local NHS trust using National Institute of Clinical Excellent (NICE) guidance to ensure evidence-based pathways.

Clinicians received clinical updates sent via email in a 'Hot News' format. Some staff reported they did not have time to read all the emails, however we observed the 'hot news' bulletins amongst others posted on staff notice boards in the resource centres. Staff had protected time for training although most reported this was not sufficient to complete training and review all emails.

The trust routinely collected and monitored local and national information about people's care and treatment. The annual clinical audit plan for 2018/2019 included the National Clinical Performance Indicators Trust Board Monthly 50 Febrile Convulsions, MAPSAF (Manchester Patient Safety Framework) Audit, Sepsis Audit and Medicines review amongst many others. The results were used at board and team levels to improve patient care.

Team leads used an app to monitor their compliance to audits of ambulance buildings, individual hand-hygiene audits and vehicle audits. This ensured a visual account of compliance and managers could share with staff via email and on notice boards.

The trust was participating in the PARAMEDIC 2 study which investigated if adrenaline was an effective treatment for patients suffering cardiac arrest. Staff collated evidence and the results were currently under evaluation.

At our last inspection in 2016 staff said they could not always seek clinical advice in a timely manner. During this inspection we saw staff had access to various methods of clinical advice such as GP's and medical registrars 24 hours a day. Staff told us they could speak with the clinical support desk (CSD) in the call centre if they required advice. Clinical mentors also worked alongside teams to ensure immediate access to specialist advice. During the inspection we saw clinical mentors attending emergency calls with their teams to offer guidance and support where required.

There was guidance available about conveying mental health patients to a place of safety under Section 136 of the Mental Health Act 1983. All staff we spoke with had had training in its use.

Senior staff told us they had a mental health lead they could approach or escalate concerns to if concerned about a patient. Most staff we spoke with however, stated they did not feel they had received sufficient mental health training to enable them to take the most appropriate course of action. Staff described how they would manage a patient exhibiting a mental health episode which evidenced they knew how to keep the patient and themselves safe however, most staff we spoke with said they would like additional training.

Staff demonstrated they could recognise when a patient was displaying signs of mental illness. During the inspection we observed a crew take a patient in obvious psychological distress to the emergency department (ED). Staff ensured, via the handover, they communicated with the ED staff that the patient required psychiatric assessment.

Pain relief

Patients had their pain assessed and managed effectively by staff. When required, staff administered medicines to patients in a safe and timely manner.

Staff used recognised tools (Abbey pain scale and Wong faces) to assess and record patient's pain levels. Staff we spoke with described how they would assess patient's pain for patients who were unable to speak by observing their body language and the noises they were making.

The trust trained paramedics to give a range of pain medicines that included Entonox (a gas used for pain relief) and morphine. Ambulance technicians were also able to give pain relief medicines (except for morphine). This meant that patients could receive appropriate pain relief when required.

When crews administered pain relief medicines to a patient, we observed them checking with the patient the medicine had been effective and then updated the patient's pain score. Staff recorded the medicines they had administered on the EPR system. This was available for staff within the local ED.

We observed many handovers between the trust's staff and ED staff where crews discussed the patient's pain levels and pain relief administered.

A local ED consultant spoke positively of staff's ability to meet patient's pain needs, they told us, "Paramedics are much better at it than we are, they follow protocols…they're really quite good at it really".

Response times

The service achieved the new ambulance response programme targets for response times.

The trust started reporting on the new Ambulance Response Programme (ARP) in November 2017.
All measures of ambulance systems performance were changed to reflect the new ways of working introduced.

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

The indicators below were in use prior to November 2017.

Category A calls

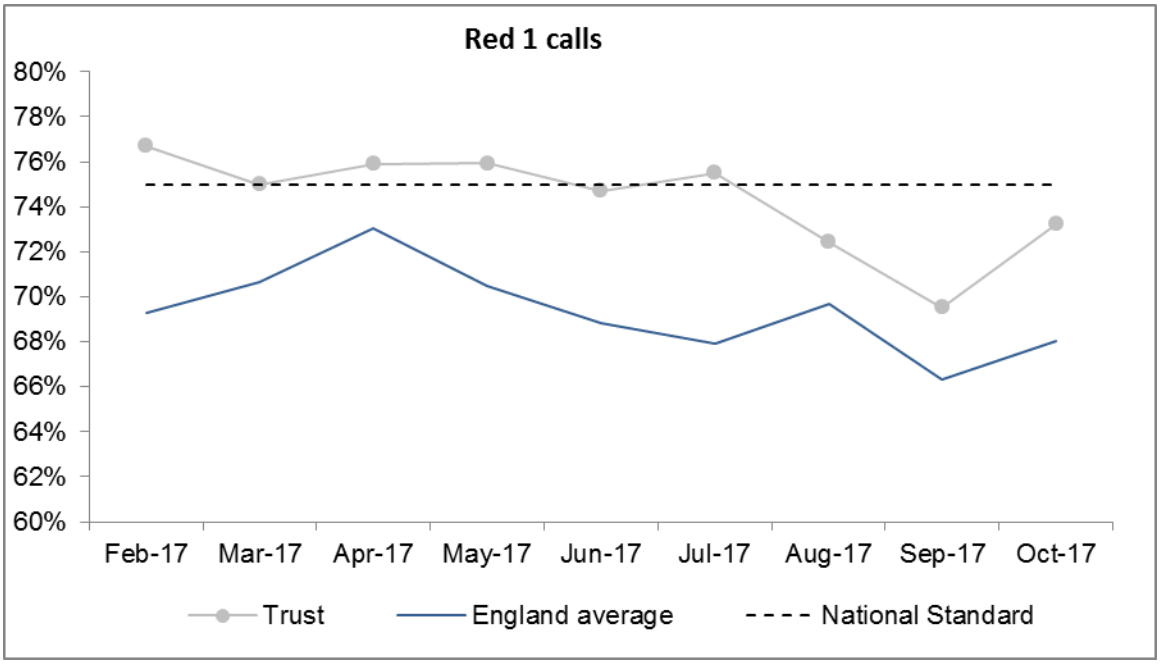
This indicator measured the speed of all ambulance responses to the scene of potentially life-threatening incidents and measured whether those patients that are most in need of an emergency ambulance got one quickly.

1. Category A, Red 1 (Cat A8 – Red 1): incidents may be immediately life threatening and should receive an emergency response within 8 minutes in 75% of cases.
   •
2. Category A, Red 2 (Cat A8 – Red 2): incidents may be life threatening but less time-critical and should receive an emergency response within 8 minutes in 75% of cases.
   •
3. Category A, Red 1 and Red 2 (Cat A19): incidents may be immediately life threatening and should receive an ambulance response within 19 minutes in 95% of cases.

The charts below show data for the three metrics above for the nine-month period from February 2017 to October 2017.

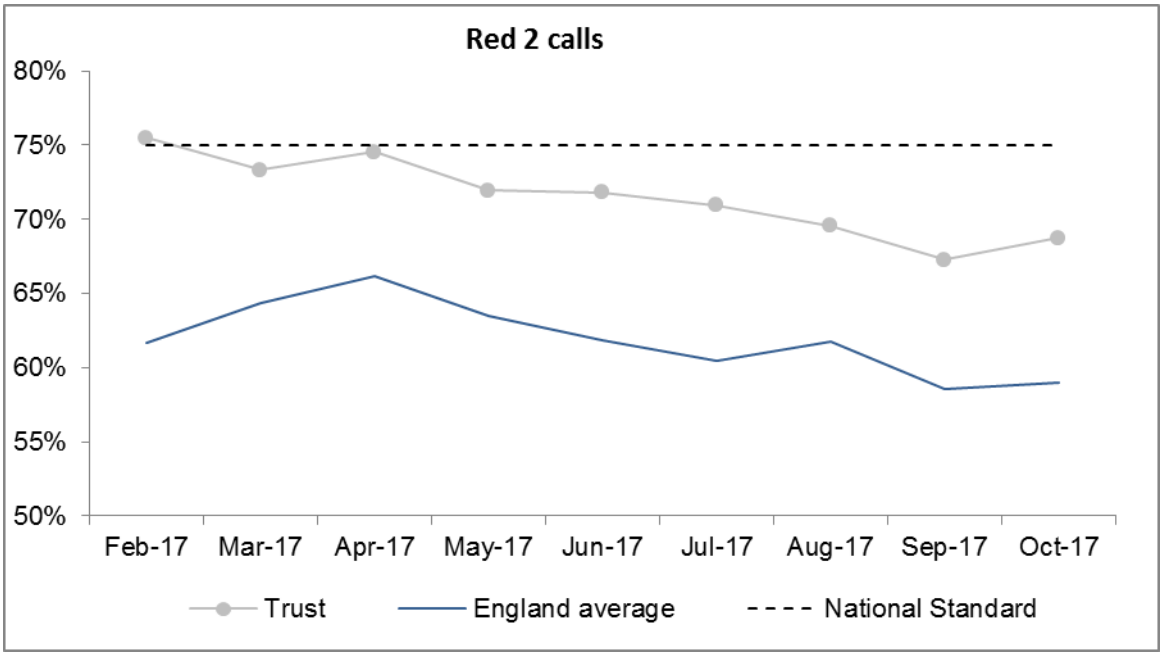
Please note that three NHS ambulance trusts did not submit data for any months over this period as they were participating in the Ambulance Response Programme clinical coding trial.

1. Proportion of Red 1 calls responded to within eight minutes



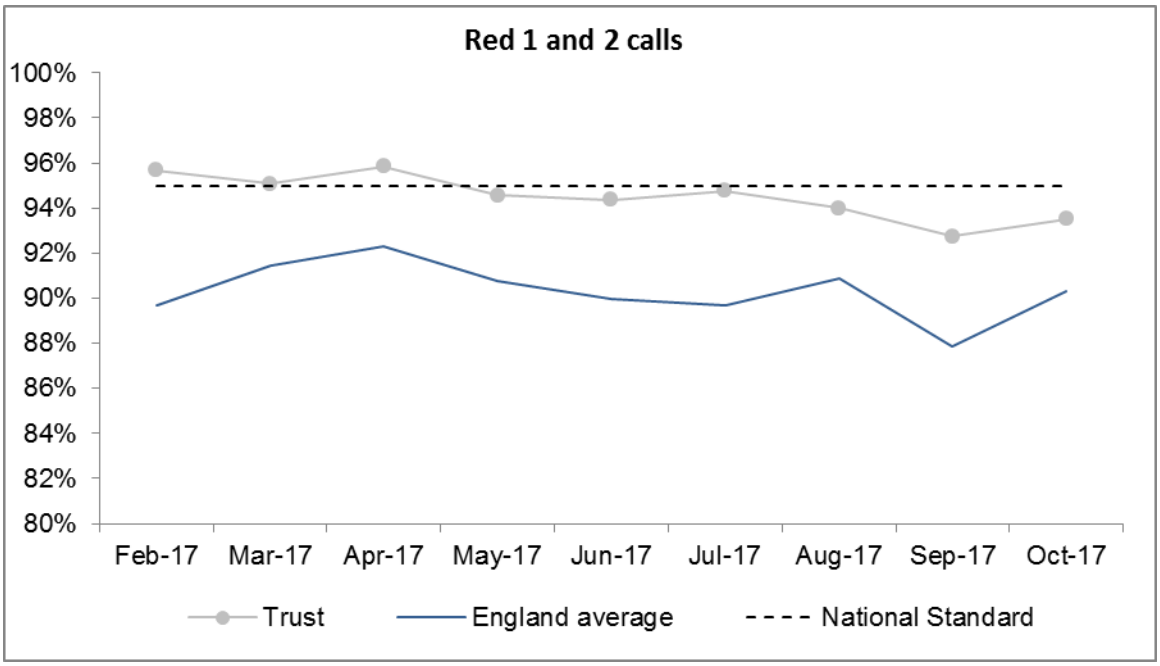
From February 2017 to October 2017 the trust met the 75% standard for Red 1 calls in five of the nine months. The trust saw a decline in performance from July 2017 to October 2017, however throughout the whole period performance was consistently better than the England average.

2. Proportion of Red 2 calls responded to within eight minutes



From February 2017 to October 2017 the trust failed to meet the 75% standard for Red 2 calls in all months except February 2017. The trust consistently performed better than the England average throughout the period.

3. Proportion of Red 1 and Red 2 calls responded to within 19 minutes



From February 2017 to October 2017 the trust met the 95% standard for Red 1 and 2 calls in February, March and April but failed to meet it for all other months in the period. The trust consistently performed better than the England average throughout the period.

Time to treatment of Category A calls

Time to arrival of a health professional dispatched by the ambulance service for Category A Red 1 and Red 2 calls, measured by median, 95th percentile and 99th percentile.

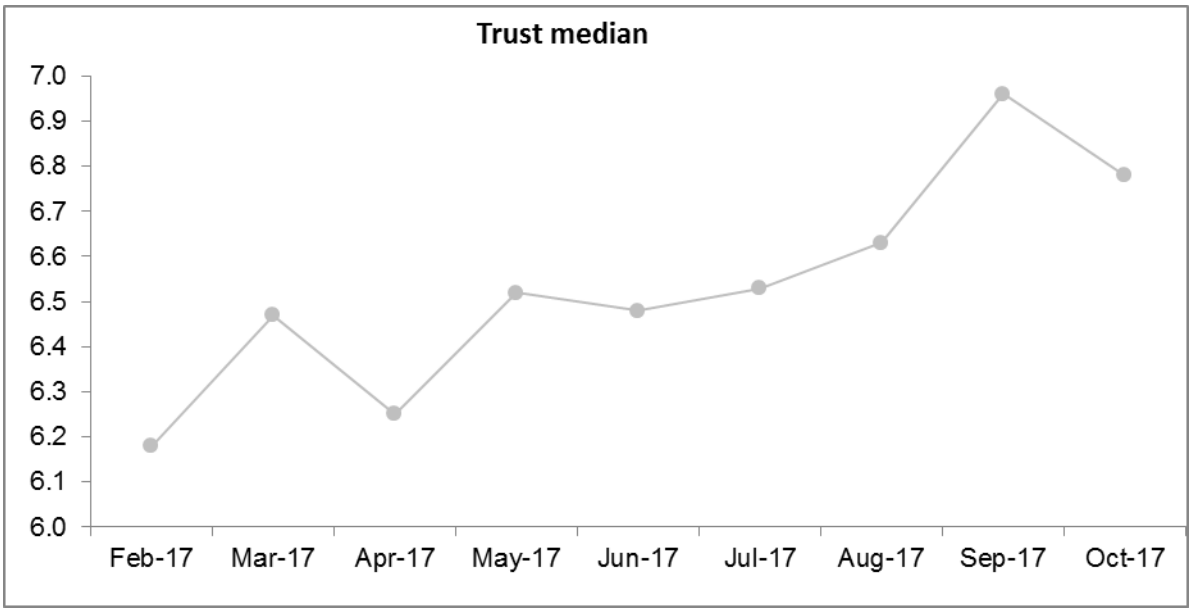
Time to arrival of an ambulance-dispatched health professional, measured by:

- Median time – the time below which 50% of incidents reported the arrival of an ambulance-dispatched health professional
- 95th percentile of times – the time below which 95% of incidents reported the arrival of an ambulance-dispatched health professional (for example “95% of incidents reported the arrival of an ambulance-dispatched health professional within [x] minutes”)
- 99th percentile of times – the time below which 99% of incidents reported the arrival of an ambulance-dispatched health professional (for example “99% of incidents reported the arrival of an ambulance-dispatched health professional within [x] minutes”)

The charts below show data for the three metrics above for the nine-month period from February to October 2017.

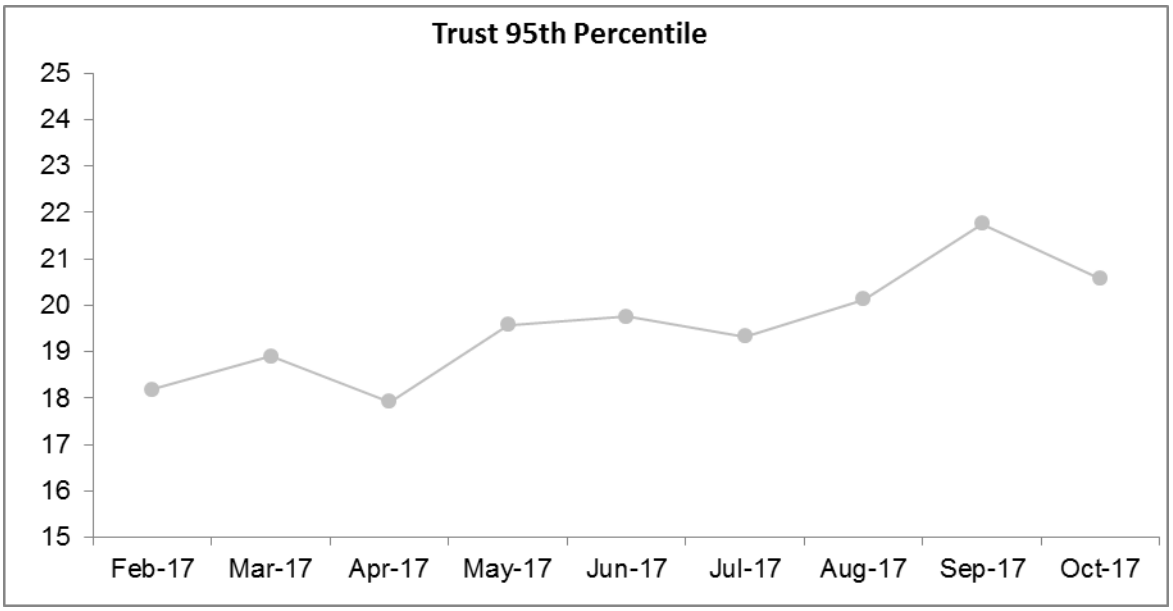
Please note that three NHS Trusts did not submit data for any months over this period. Therefore, NHS England did not calculate overall England medians and percentiles for any months during this period and these are not available for comparison.

Median



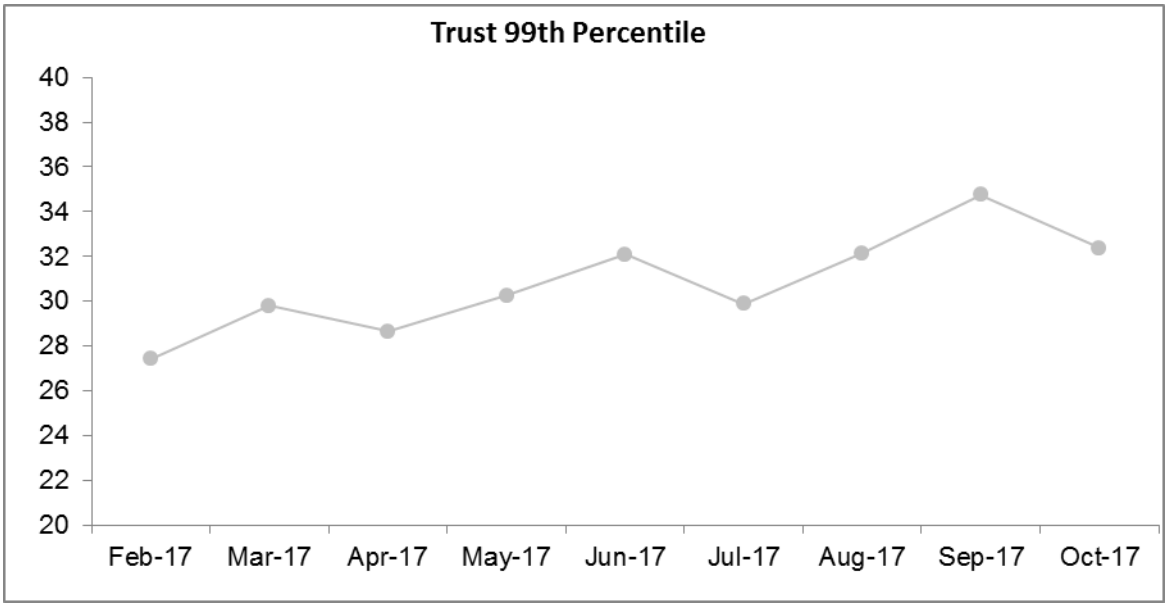
From February 2017 to October 2017 the trust's median time to treatment varied between 6.18 and 6.96 minutes. Throughout the period there was a general deterioration in performance. April 2017 saw a slight improvement in performance.

95th Percentile



From February 2017 to October 2017 the trust's 95th percentile time to treatment varied between 17.92 and 21.75 minutes. Throughout the period there was a general deterioration in performance, with April 2017 the best month's performance.

99th Percentile



From February 2017 to October 2017 the trust's 99th percentile time to treatment varied between 27.42 and 34.76 minutes. Throughout the period there was a general deterioration in performance.

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

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

The trust introduced the following measures in November 2017 to reflect the new way of working under the ambulance response programme.

Performance should be seen in the context of the new system which requires embedding into practice, and winter pressures. NHS England were due to review performance standards were due in spring 2018.

Response times

Under the ambulance response programme four new categories of call were introduced with new national standards. Mean (average) and 90th centile measures were introduced to help improve performance management of response times.

Please note for category 3 and 4 calls there are no mean response time standards, just 90th centile measures.

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

- **Category 1T: Life threatening illnesses or injuries with transport**.

  This is an additional category 1 transport standard to ensure that these patients also receive early ambulance transportation.

These calls should be responded to in a (mean) average time of seven minutes, with 90% of all calls responded to within 15 minutes.

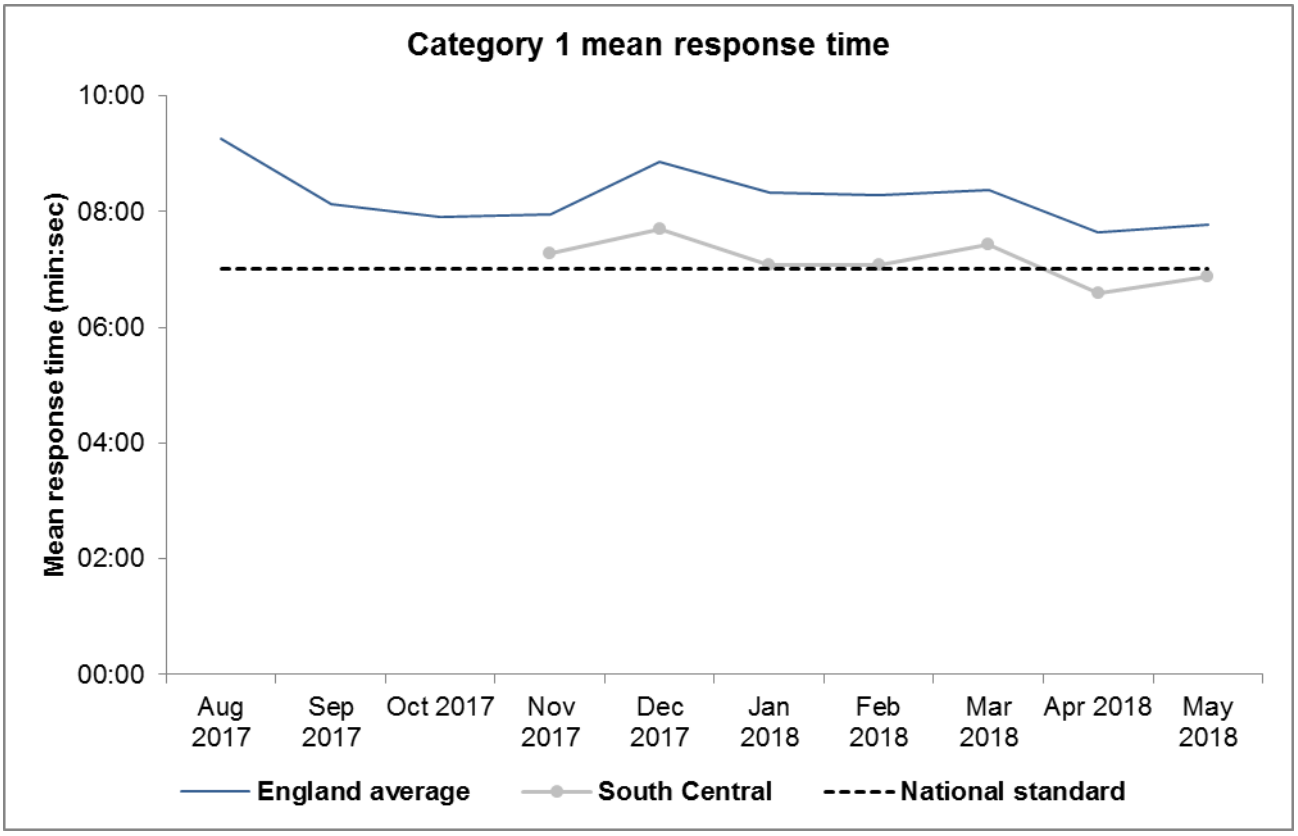
- **Category 2: Emergency calls** dealing with conditions and injuries such as strokes, epilepsy and burns.
  - These calls should be responded to in a (mean) average time of 18 minutes, with 90% of all calls responded to within 40 minutes.

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

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

Please note, despite the charts below showing England average data from August 2017, South Central Ambulance Service introduced the new Ambulance Response Programme measures in November 2017 so there is no data for the trust from August to October 2017.

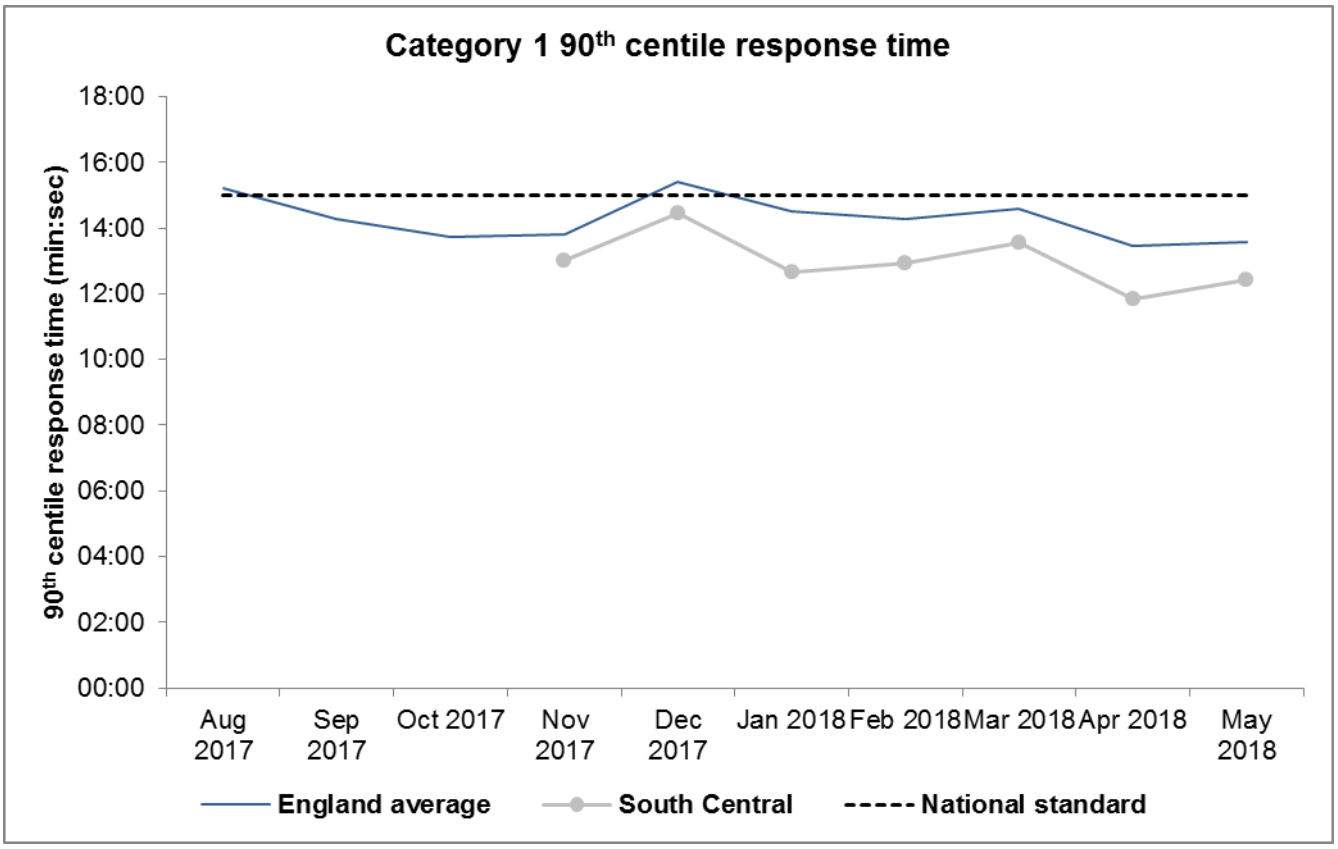
Category 1 calls:



From November 2017 to May 2018 the mean response time for category 1 calls to the trust ranged from 6.35 minutes to 7.42 minutes. The trust met the 7-minute national standard twice in April and

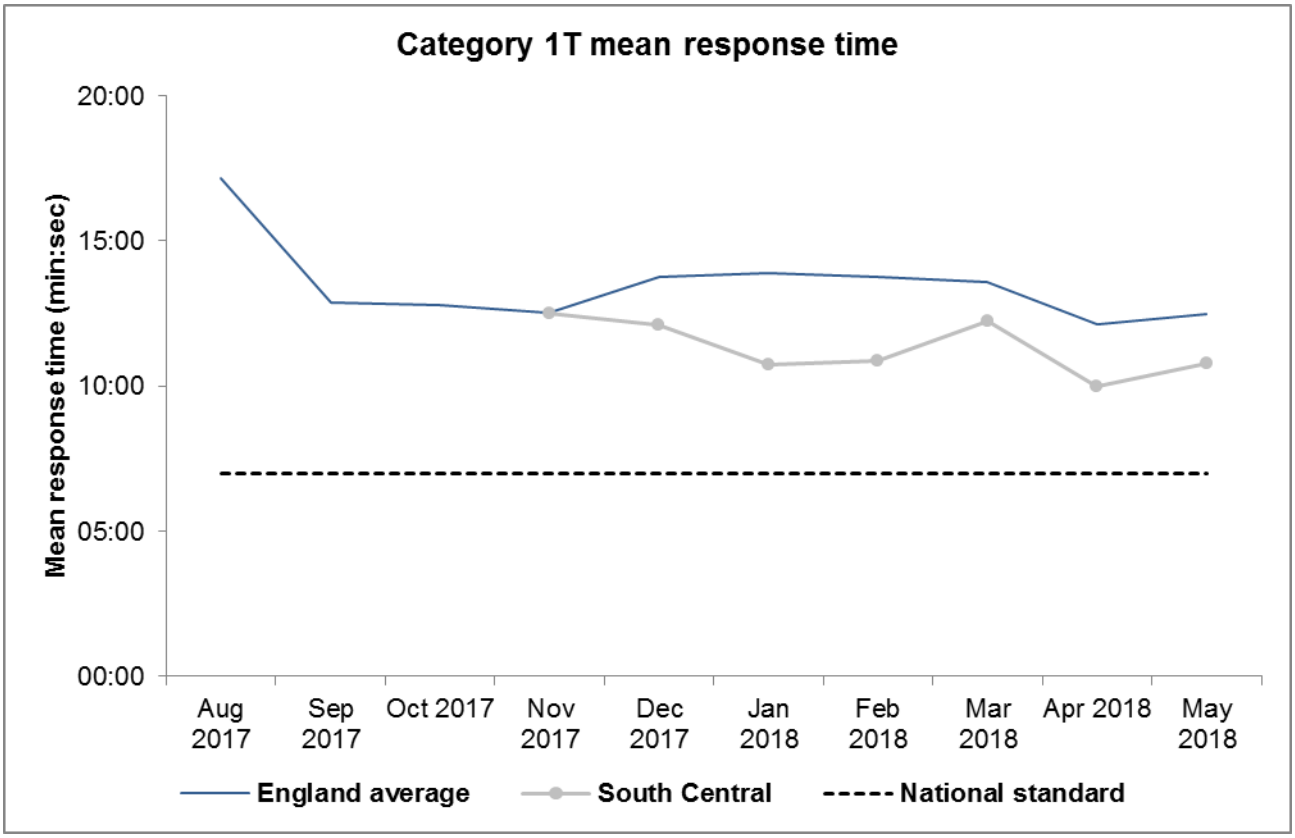
May 2018, and consistently performed better than the England average for all months in the period.

In the latest month, May 2018, the trust met the national standard and performed better than the England average. In the same month, four trusts (36%) met the national standard.



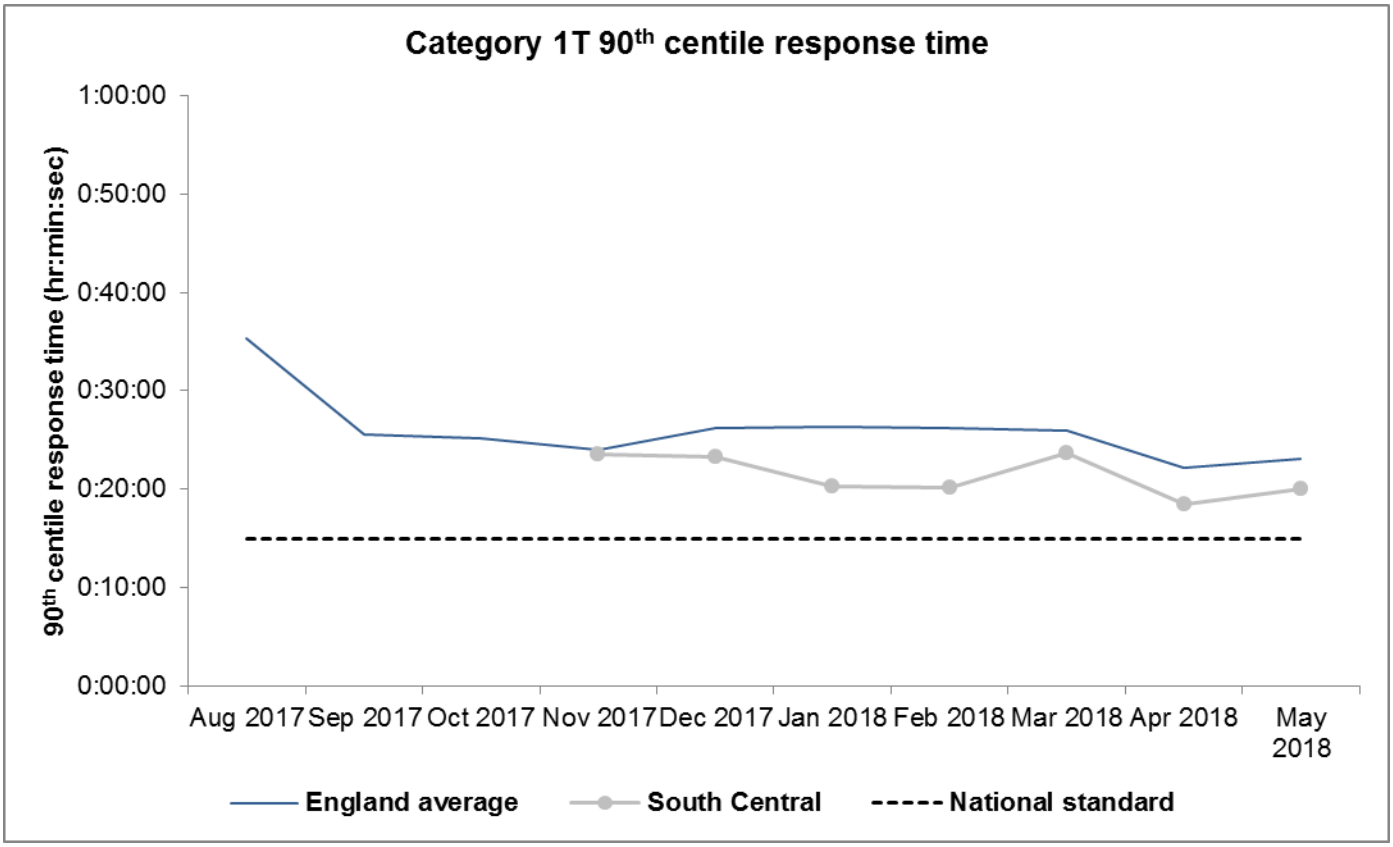
From November 2017 to May 2018 the 90th centile response time for category 1 calls to the trust ranged from 11.50 minutes to 14.27 minutes. The trust met the 15-minute national standard in each month and consistently performed better than the England average for all months in the period.

In the latest month, May 2018, the trust met the national standard and performed better than the England average. In the same month, eight trusts (73%) met the national standard.



From November 2017 to May 2018 the mean response times for category 1 calls with transport at the trust ranged from 9.59 minutes to 12.29 minutes. The trust did not meet the seven-minute national standard in any months, but consistently performed better than the England average for all months in the period.

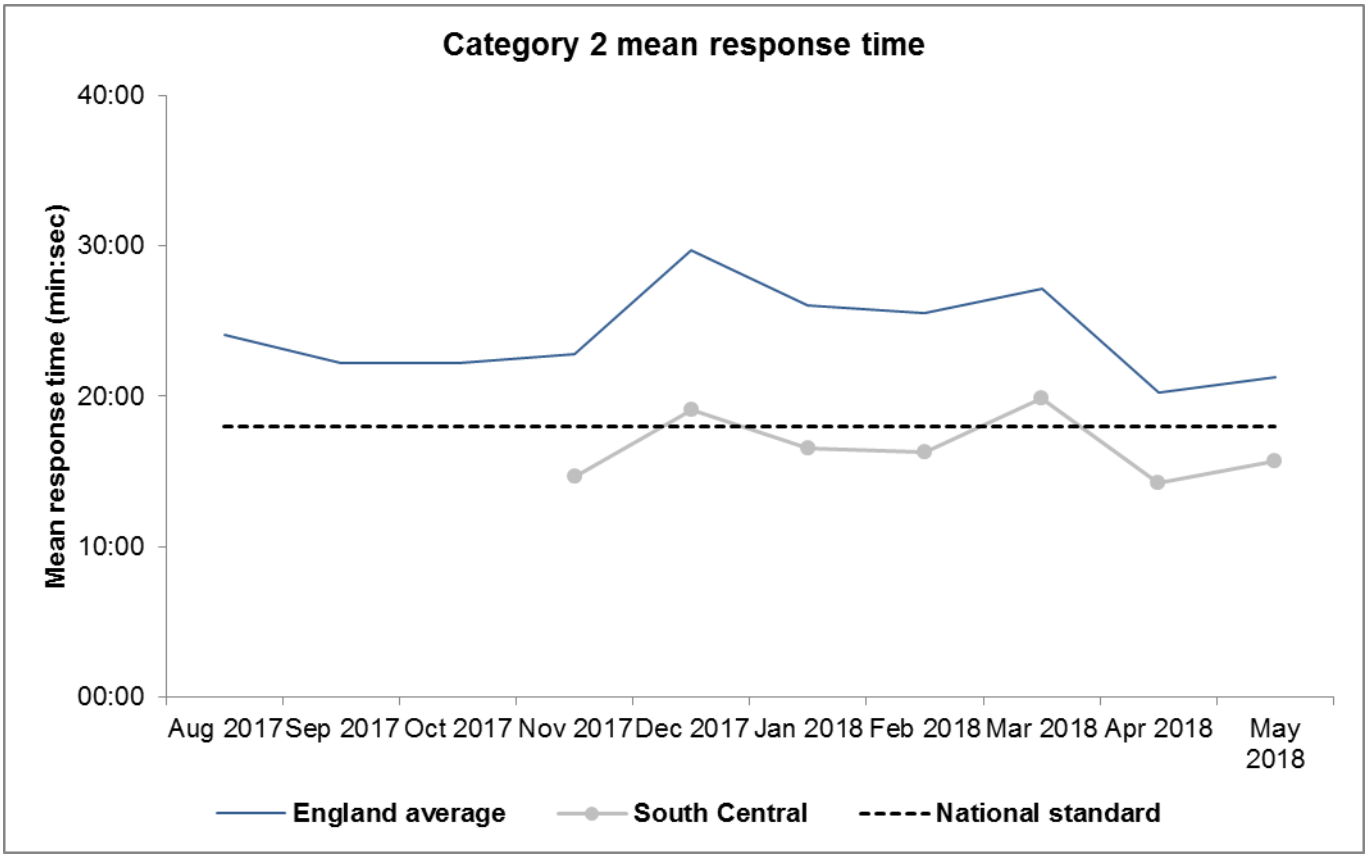
In the latest period, May 2018, no trusts met the national standard, but South Central Ambulance service performed better than the England average.



From November 2017 to May 2018 the 90th centile response times for category 1 calls with transport at the trust ranged from 18.31 minutes to 23.38 minutes. The trust did not meet the 15-minute national standard in any months, but consistently performed better than the England average for all months in the period.

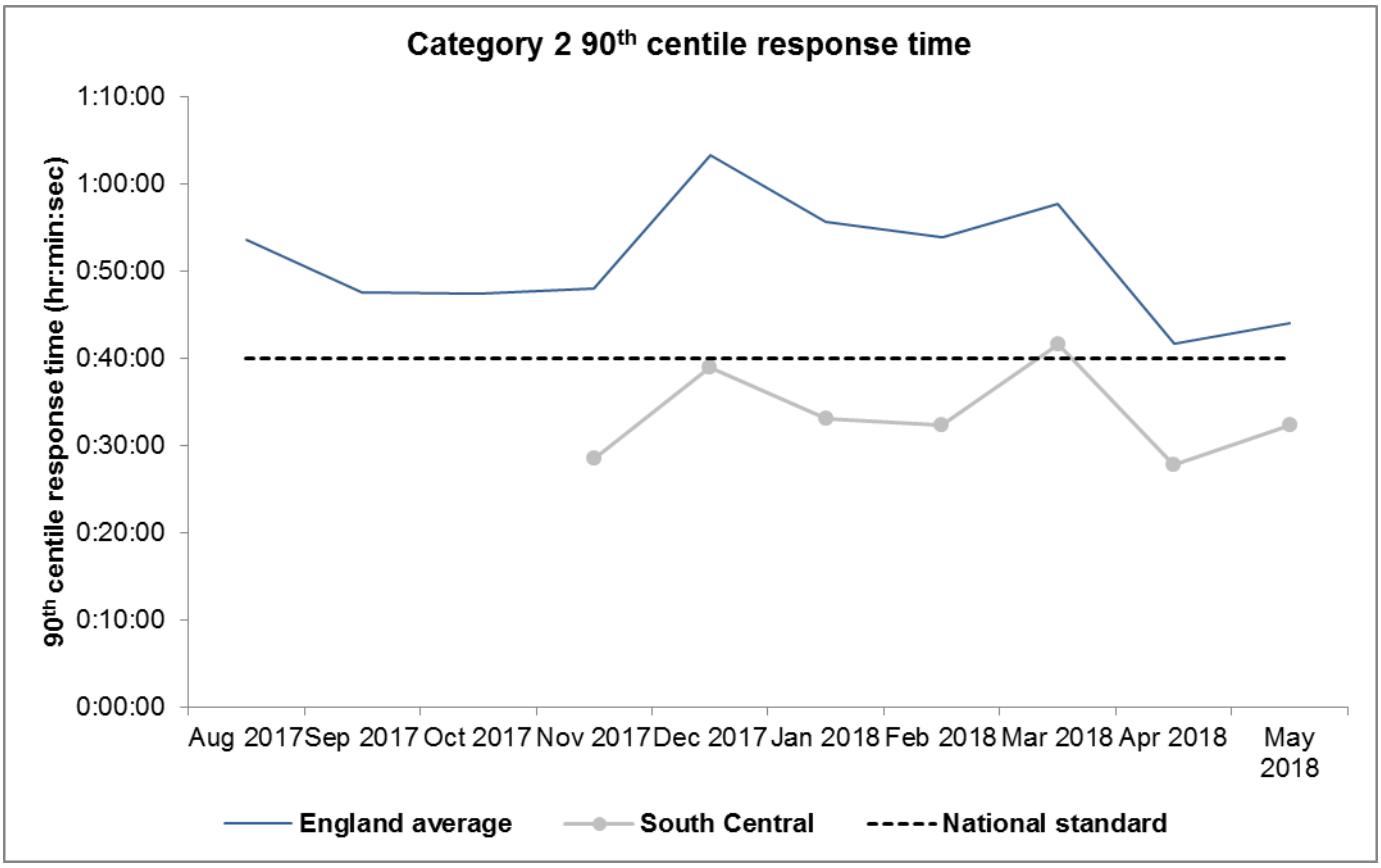
In the latest period, May 2018, the trust did not meet the national standard but performed better than the England average. In the same month, two trusts (18%) met the national standard.

Category 2 calls:



From November 2017 to May 2018 the mean response time for category 2 calls to the trust ranged from 14.13 minutes to 19.50 minutes. The trust met the 18-minute national standard five times and consistently performed better than the England average for all months in the period.

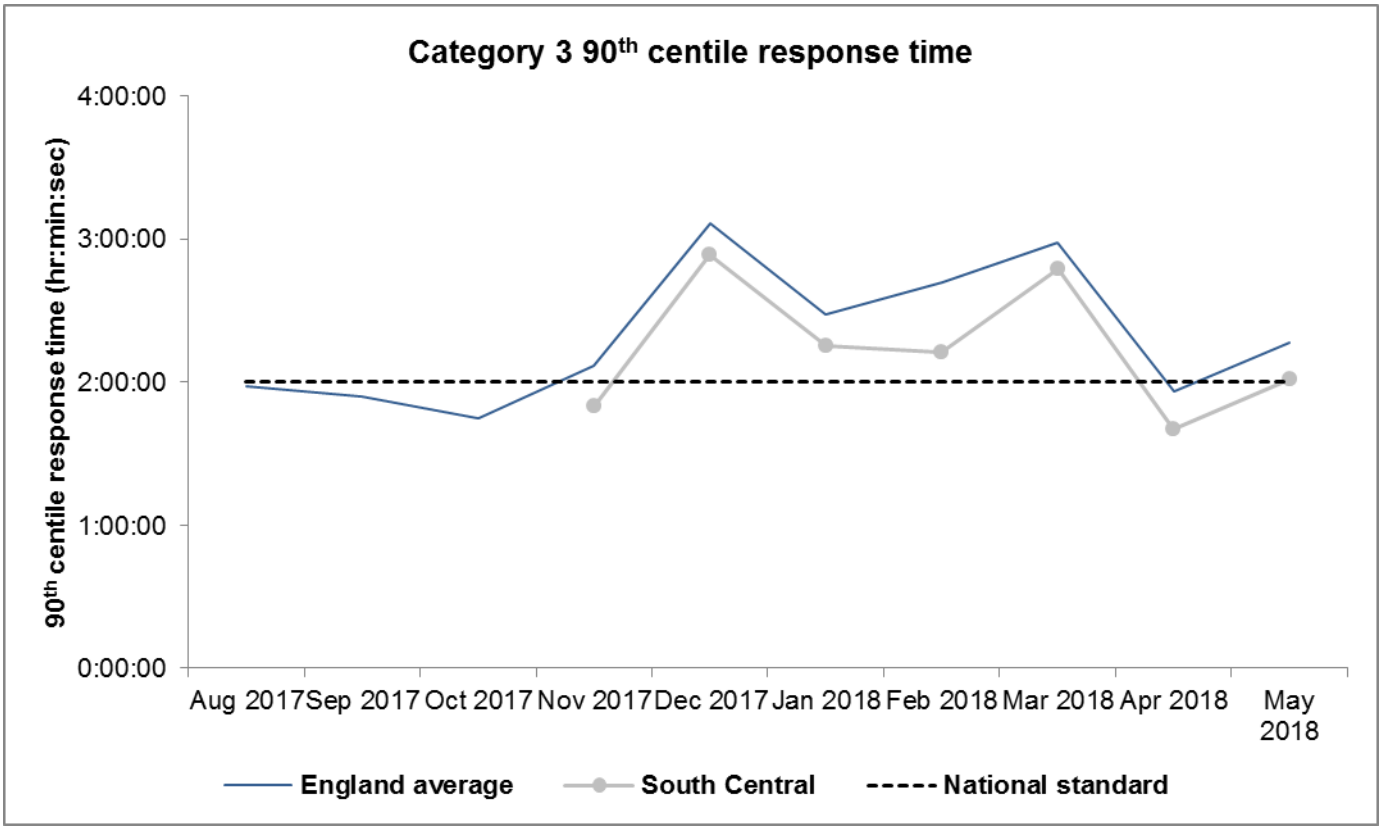
In the latest period, May 2018, the trust met the national standard and performed better than the England average. In the same month, five trusts (45%) met the national standard.



From November 2017 to May 2018 the 90th centile response times for category 2 calls to the trust ranged from 27.46 minutes to 41.36 minutes. The trust met the 40-minute national standard in all months during the period aside from March 2018 (41.36 minutes) and consistently performed better than the England average for all months in the period.

In the latest period, May 2018, the trust met the national standard and performed better than the England average. In the same month, six trusts (55%) met the national standard.

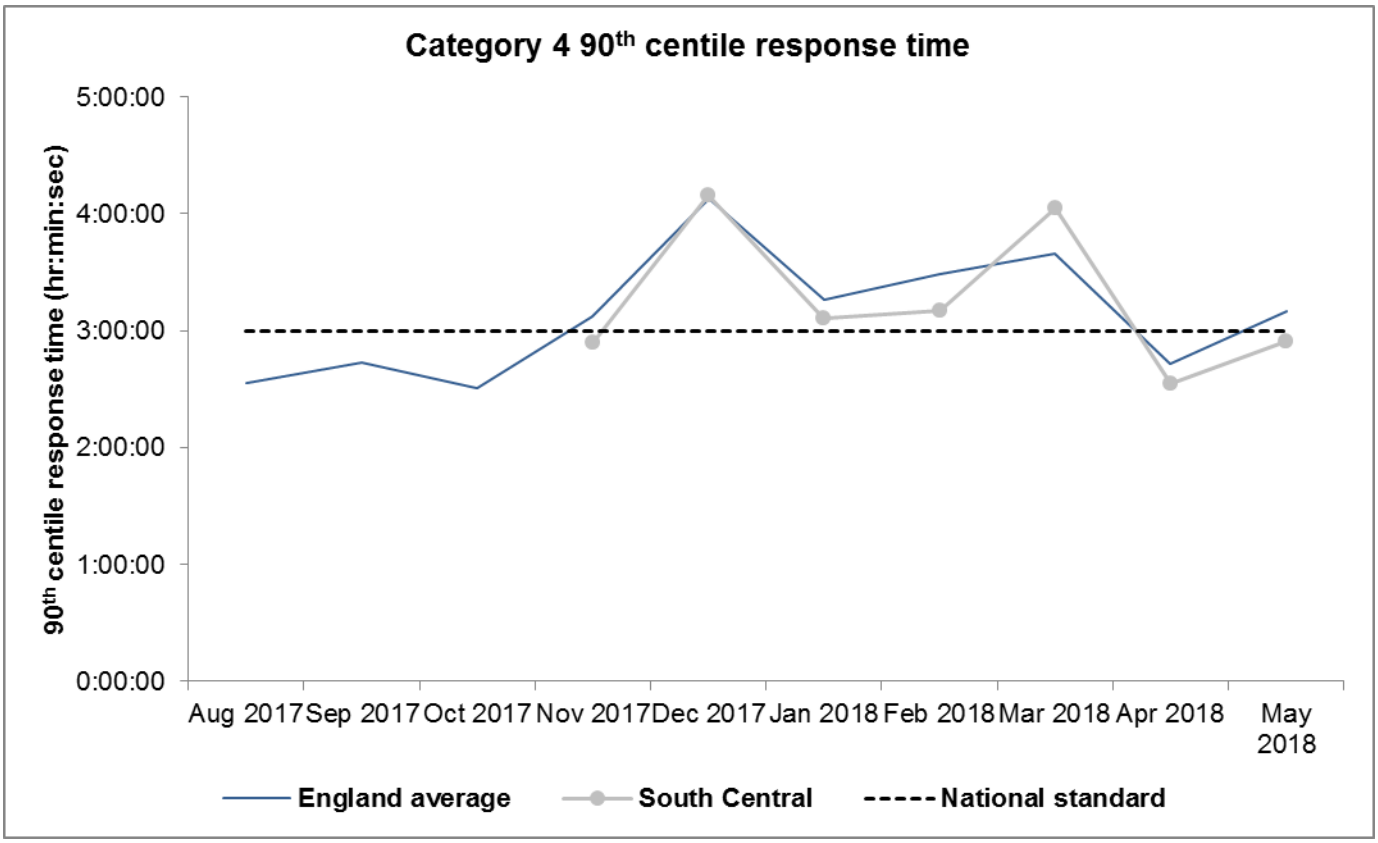
Category 3 calls (hours:minutes:seconds):



From November 2017 to May 2018 the 90th centile response times for category 3 calls to the trust ranged between 1:40:8 and 2:53:18. The trust met the two-hour national standard twice in November 2017 and April 2018, and consistently performed better than the England average for all months in the period.

In the latest period, May 2018, the trust did not meet the national standard but performed better than the England average. In the same month, three trusts (27%) met the national standard.

Category 4 calls:



From November 2017 to May 2018, the 90th centile response times for category 4 calls to the trust ranged from 2 hours 33 minutes and 4 seconds to 4 hours 9 minutes and 38 seconds. The trust met the three-hour national standard three times in November 2017, April and May 2018, and performed better than the England average in five of the seven months in the period.

In the latest period, May 2018, the trust met the national standard and performed better than the England average. In the same month, five trusts (45%) met the national standard.

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

Staff told us about government targets on the length of time they should spend with a patient. Staff said they often worked beyond these times to achieve the best outcome for their patient, and some felt pressured to convey the patient to hospital so not to breech the target.

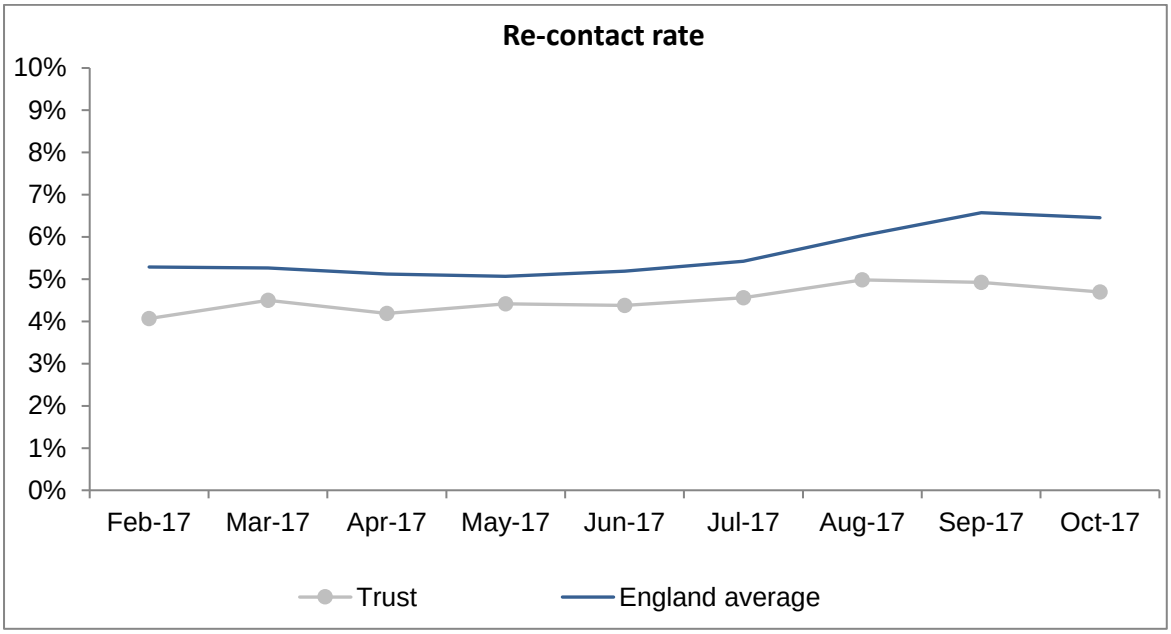
Staff who normally drive rapid response vehicles (RRV) rotated every 12 weeks onto ambulances to ensure they were confident in driving ambulances due to the reduction of RRV vehicles as part of the ARP.

Patient outcomes

The service monitored the effectiveness of care and treatment and used the findings to improve them.

Re-contact rate

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

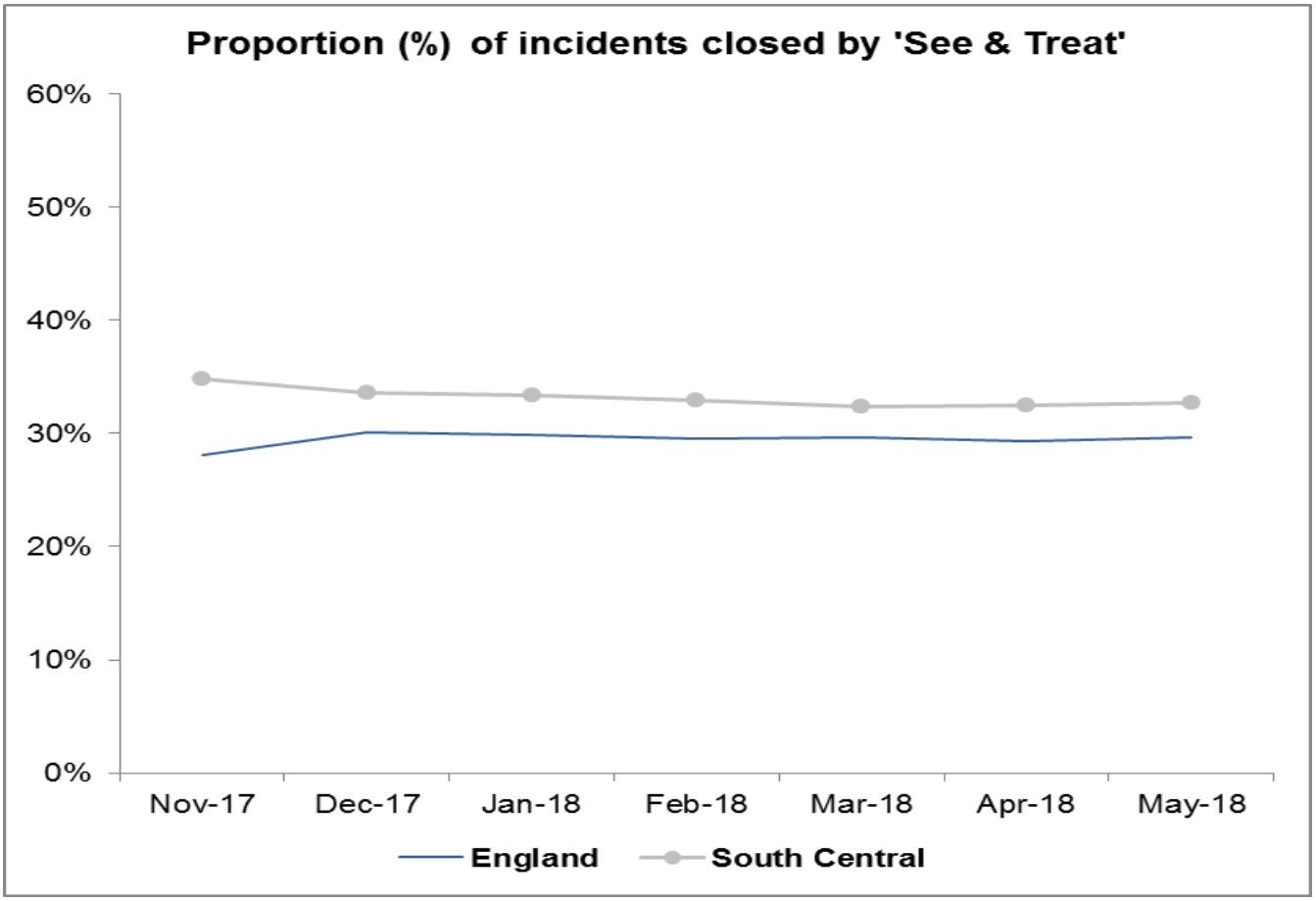


From February 2017 to October 2017 the proportion of patients treated and discharged at the scene who re-contacted within 24 hours was consistently better than the England average. Trust performance was consistent, varying between 4.1% and 5.0%.

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

See and treat

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



From November 2017 to May 2018 the trust consistently managed a higher proportion of face-to-face calls without the need for transport compared to the England average. Trust performance ranged from 32.3% to 34.8% compared to the England average range of 28.0% to 30.1%.

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

The trust as with all trusts in England have a bedding in period to achieve these new targets. The trust recognised the lack of resources during a service review and processes were in place to improve the targets. However, the trust believed the current results from the ARP performance showed pleasing results.

Senior staff said they were comfortable with staff spending additional time with their patients in see and treat cases. The trust sought to increase the number of patients where crews offered treatment at home therefore limiting the number of hospital admissions.

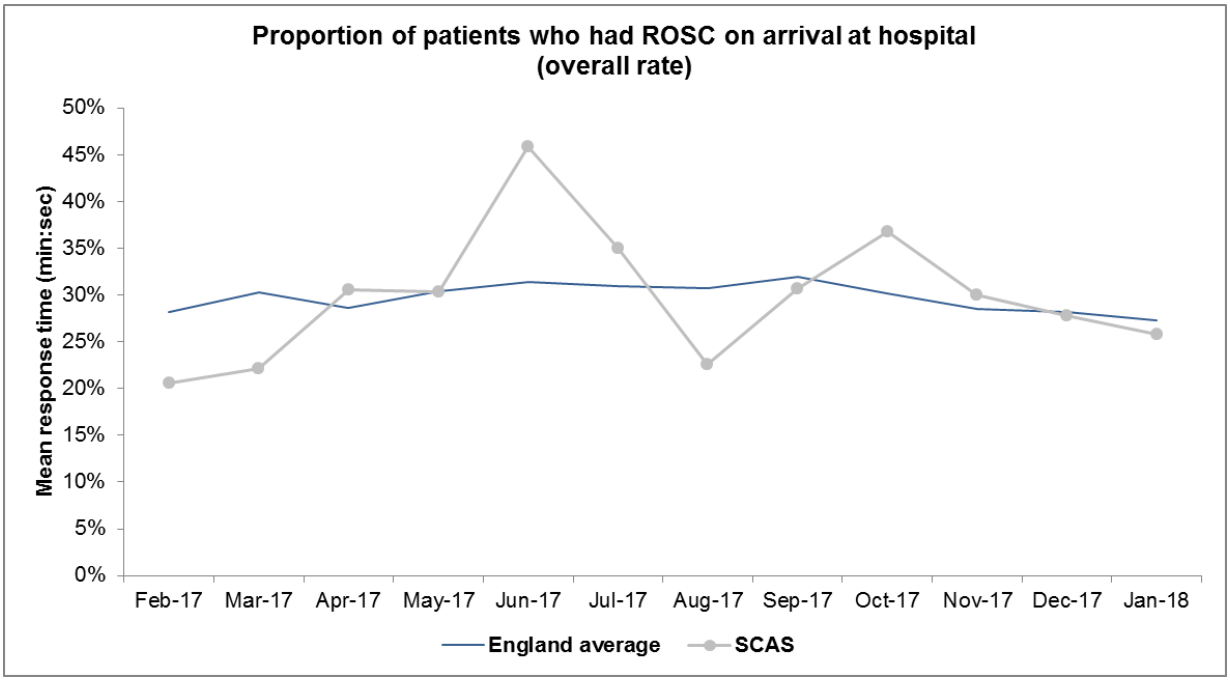
Ambulance Quality Indicator Clinical Outcomes (AmbCO)

Return of spontaneous circulation (ROSC)

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

ROSC Overall

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

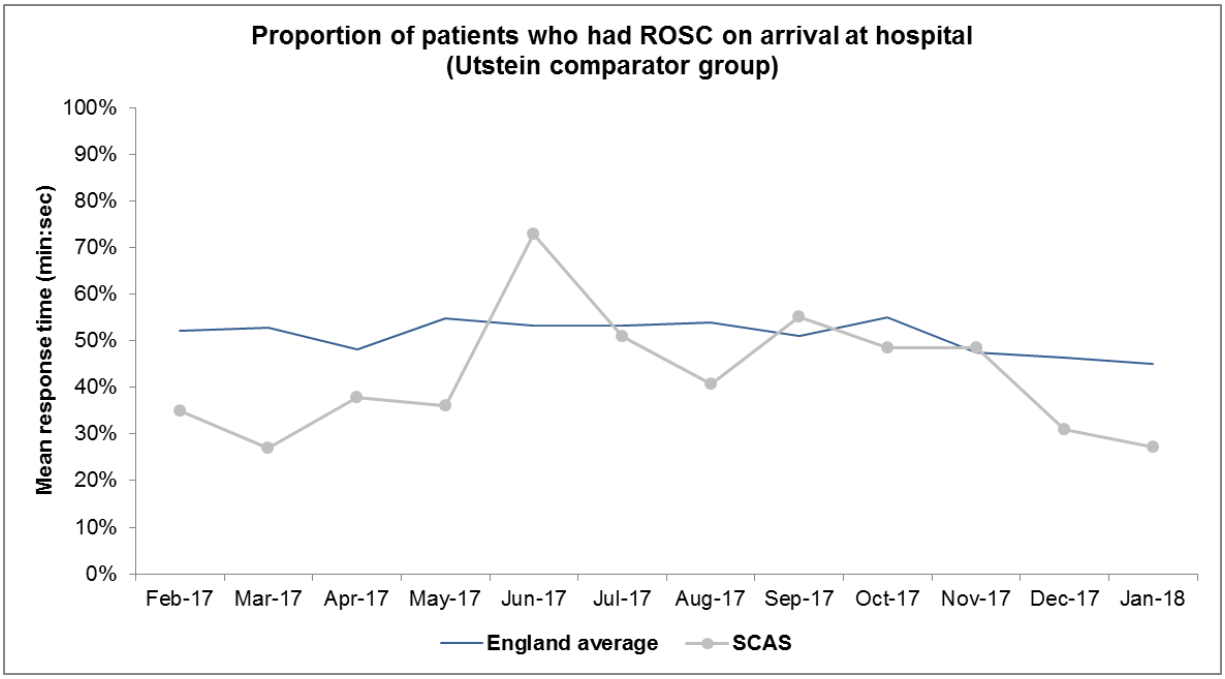


From February 2017 to January 2018 the trust's overall proportion of patients who had return of spontaneous circulation (ROSC) fluctuated, ranging from 20.6% to 45.9%.

For five months in the period the trust performed better than average with a higher proportion of patients having ROSC than the England average for April, June, July, October and November 2017. Five months in the period (February, March, August, September 2017 and January 2018) saw a lower proportion of patients having ROSC than the England average. June 2017 saw the highest proportion of patients with 45.9% having ROSC compared to the England average of 31.4%.

ROSC Utstein comparator group

The rate for the 'Utstein comparator group' provides a more comparable and specific measure of the management of cardiac arrests for the subset of patients where timely and effective emergency care can particularly improve survival. For example, 999 calls where the arrest was not witnessed, and the patient may have gone into arrest several hours before the 999 calls are included in the figures for all patients but are excluded from the Utstein comparator group figure.



From February 2017 to January 2018 the trust's proportion of patients from the Utstein comparator group who had return of spontaneous circulation (ROSC) was worse than the England average in 10 of the 12 months.

Trust performance ranged from 27.0% to 73.0% compared with 45.1% to 55.1% for the England average. June 2017 saw the highest proportion of patients with 73.0% having ROSC compared to the England average of 53.4%.

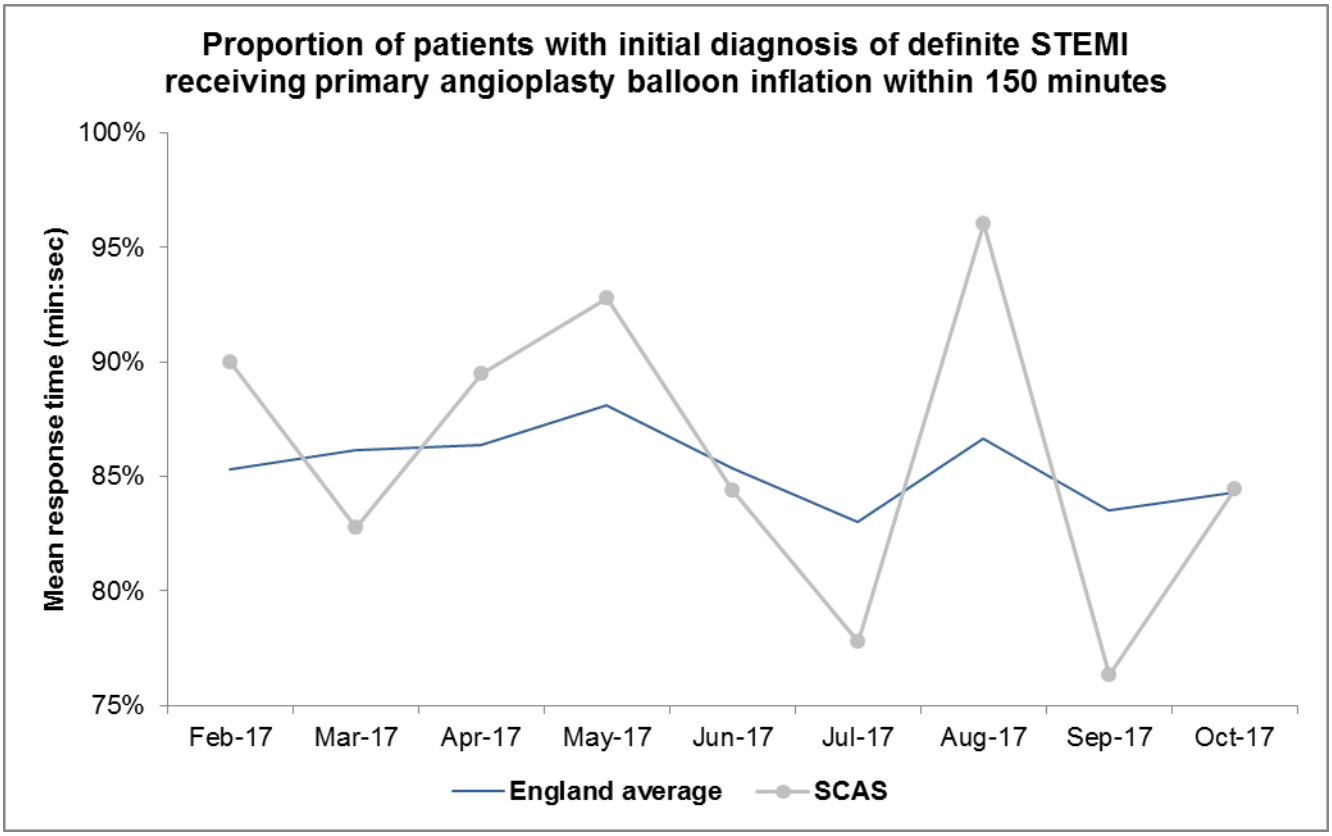
(*Source: NHS England – Ambulance Quality Indicators – Clinical outcomes)*

Outcome from acute ST-elevation myocardial infarction

The causation of heart attacks, or ST-elevation myocardial infarction (STEMI), is by a prolonged period of blocked blood supply. It is therefore vital crews use clinical interventions such as thrombolytic ("clot-busting") treatment or primary percutaneous coronary interventions to restore blood flow quickly. In addition to these primary treatments, however, patients with STEMI need to be managed in the correct way, including the administration of an appropriate care bundle; that is, a package of clinical interventions that are known to benefit the health outcomes of patients. For example, Crews should administer pain relief medicines to help alleviate their ongoing discomfort.

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

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



From February 2017 to October 2017 the trust's proportion of patients with an initial diagnosis of definite STEMI who received primary angioplasty balloon inflation within 150 minutes ranged from 76.3% to 96.0% and has been better than the England average for four months in the period (February, April, May and August 2017). Performance was below the England average in March, June, July and September 2017.

Outcome for patients admitted to hospital with an initial diagnosis of definite myocardial infarction (November 2017 to January 2018)

From November 2017 the metric above was superseded by two new metrics relating to patients in the Myocardial Ischaemia National Audit Project (MINAP) admitted to hospital with an initial diagnosis of definite myocardial infarction. The new metrics measure, for this patient group, the mean and 90th centile time from call to help until catheter insertion for angiography.

Both metrics exclude patients:

- Under 20 years of age or with age not recorded;
- Where the time is not available, or not realistic (call to angiography times less than zero or more than 1,000 minutes);
- Already in hospital, repatriated after coronary intervention, self-presenters, inter-hospital transfers, and any other or unknown admission methods;
- With cardiac arrest before arrival at hospital.

Shown in the tables below are the trust's results for these two-new metrics for November 2017 to January 2018 together with the England performance for comparison.

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

Month	South Central mean	England mean
November 2017	1:53	2:12
December 2017	2:03	2:18
January 2018	2:07	2:12

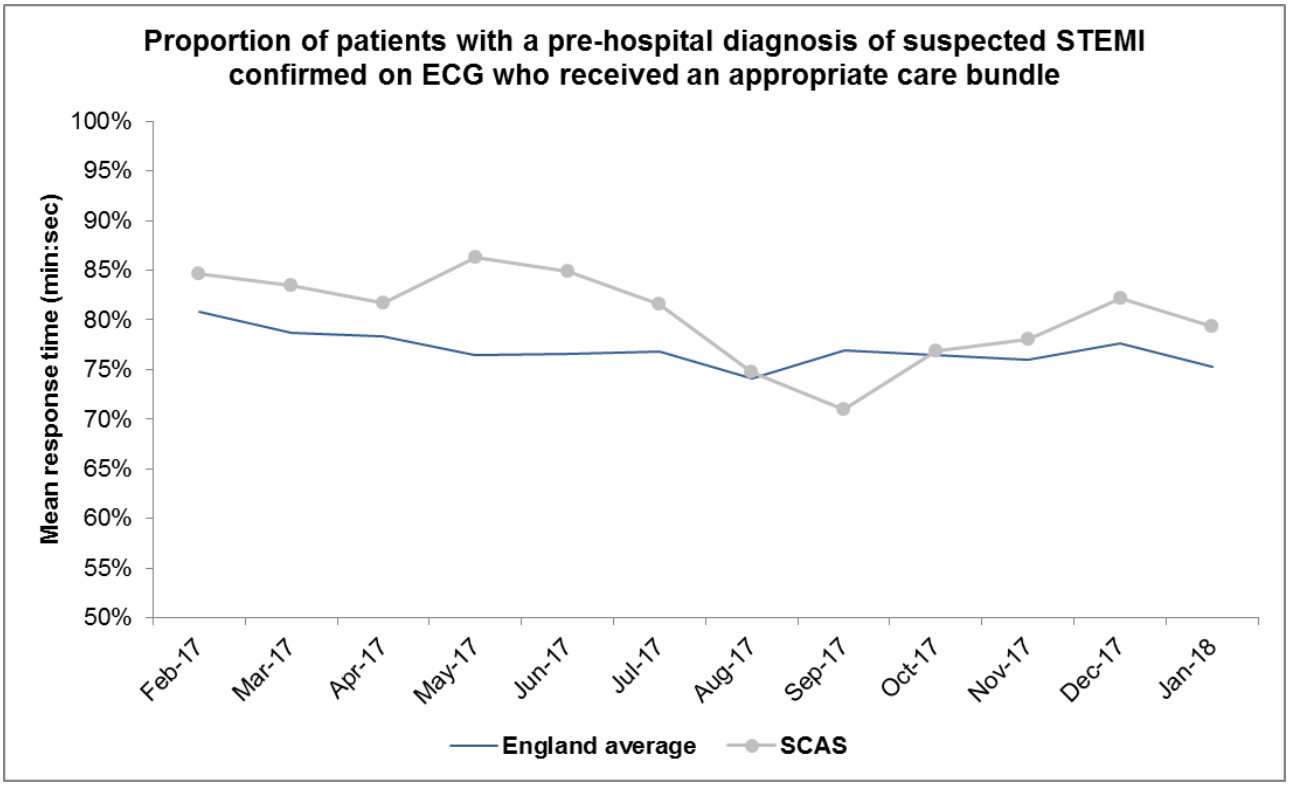
The trust mean was better than the England mean in all three months.

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

Month	South Central 90th centile	England 90th centile
November 2017	2:26	2:58
December 2017	2:52	3:07
January 2018	2:47	3:00

The trust's 90th centile performance was better than the England average in all three months.

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

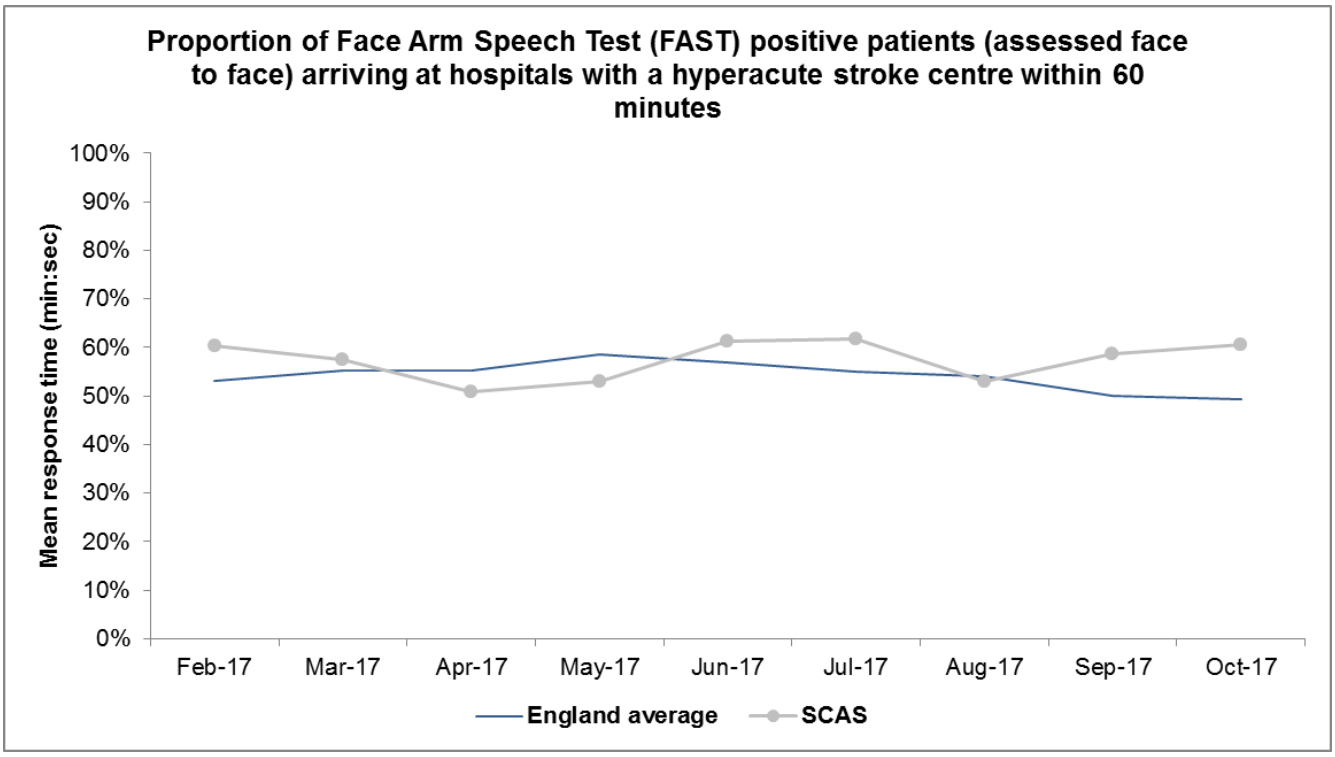


From November 2017 to January 2018 the trust's proportion of patients with a pre-hospital diagnosis of suspected STEMI confirmed on ECG who received an appropriate care bundle has been better than the England average for all months in the period except September 2017. Ranging from 70.9% to 86.3% compared to the England average of 74.2% to 80.8%.

(Source: NHS England – Ambulance Quality Indicators – Clinical outcomes)

Outcome from stroke

As set out in the NICE national quality standard, the health outcomes of patients can be improved by recognising the symptoms of a stroke or transient ischaemic attack (TIA), making a diagnosis quickly, and early transport of a patient to a stroke centre capable of conducting further definitive care including brain scans and thrombolysis.
Proportion of Face Arm Speech Test (FAST) positive patients (assessed face to face) arriving at hospitals with a hyper acute stroke centre within 60 minutes (February to October 2017)



From February 2017 to October 2017 the trust's proportion of Face Arm Speech Test (FAST) positive patients assessed face to face that arrived at hospitals with a hyper acute stroke centre within 60 minutes was better than the England average with the exceptions of three months in the period (April, May and August 2017) when the trust percentage was lower than the England average. The trust percentage ranged from 51.0% to 61.6% compared to the average of 49.3% to 58.6%.

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

From November 2017 the metric above was replaced by three new metrics relating to time from call for help to hospital arrival for patients that were FAST-positive and/or had a provisional diagnosis of stroke. Both patient groups are included in the new metric, because acute trusts can

record equivalent clinical episodes under either of these two categories. If patients are found to have had a transient ischemic attack (TIA) and their symptoms resolve whilst with the ambulance crew they can be excluded.
The three-new metrics, all measured as mean median and 90th centile, are:

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

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

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

Metric	South Central	England
Mean	1:09	1:13
Median	1:02	1:06
90th centile	1:40	1:49

For November 2017 the trust's mean, median and 90th centile waiting times from call to help to hospital arrival were better than the England averages for these three metrics.

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

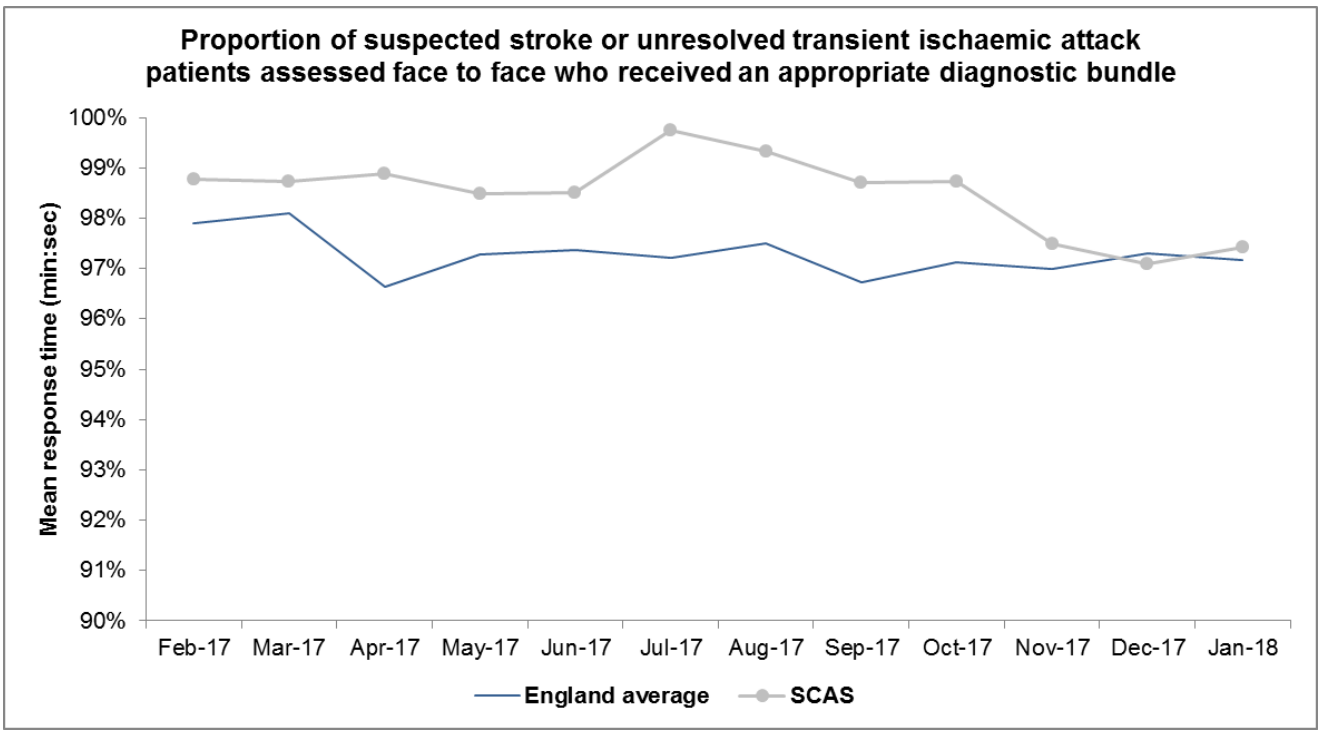
Metric	South Central	England
Mean	4:43	3:03
Median	0:56	0:44
90th centile	4:08	3:58

For November 2017 the trust's mean, median and 90th centile waiting times from door to scan were worse than the England averages for these three metrics.

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

Metric	South Central	England
Mean	0:50	0:54
Median	0:44	0:46
90th centile	1:30	1:33

For November 2017 the trust's mean, median and 90th centile waiting times from door to thrombolysis were better than the England averages for these three metrics. Proportion of suspected stroke or unresolved transient ischaemic attack patients assessed face to face who received an appropriate diagnostic bundle



From February 2017 to January 2018 the trust's proportion of suspected stroke or unresolved transient ischaemic attack patients assessed face to face who received an appropriate care bundle was consistently better than the England average, ranging from 97.1% to 99.7% compared to the England average of 96.6% to 98.1%. December 2017 was the only month where the trust's performance was like the England average.

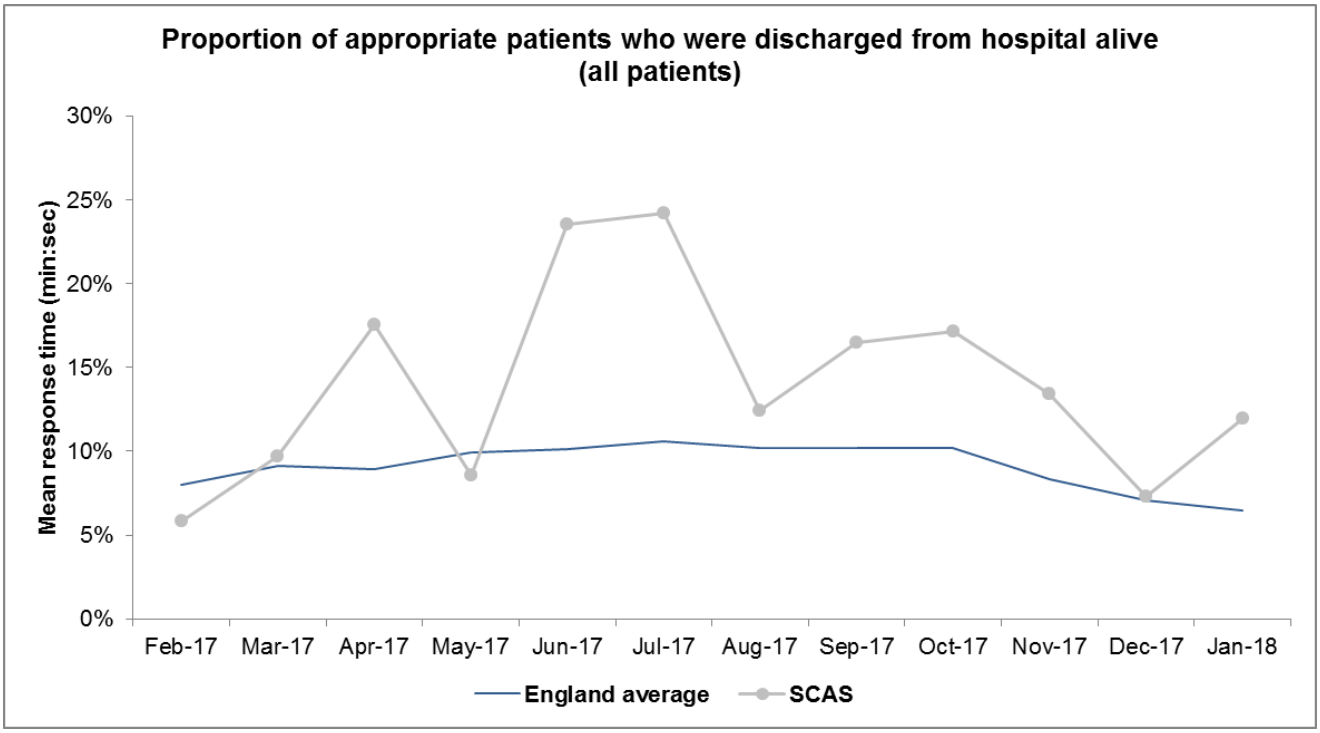
(Source: NHS England – Ambulance Quality Indicators – Clinical outcomes)

Survival to discharge following cardiac arrest

The presence of a paramedic (or doctor) significantly improves response to, and outcome from, a cardiac arrest, as the paramedic or doctor on scene can begin Advanced Life Support (ALS). By including both out of hospital and in-hospital periods of care, this measure reflects the effectiveness of the whole acute healthcare system in managing out of hospital cardiac arrest, reflecting the care delivered by both ambulance services and acute trusts.

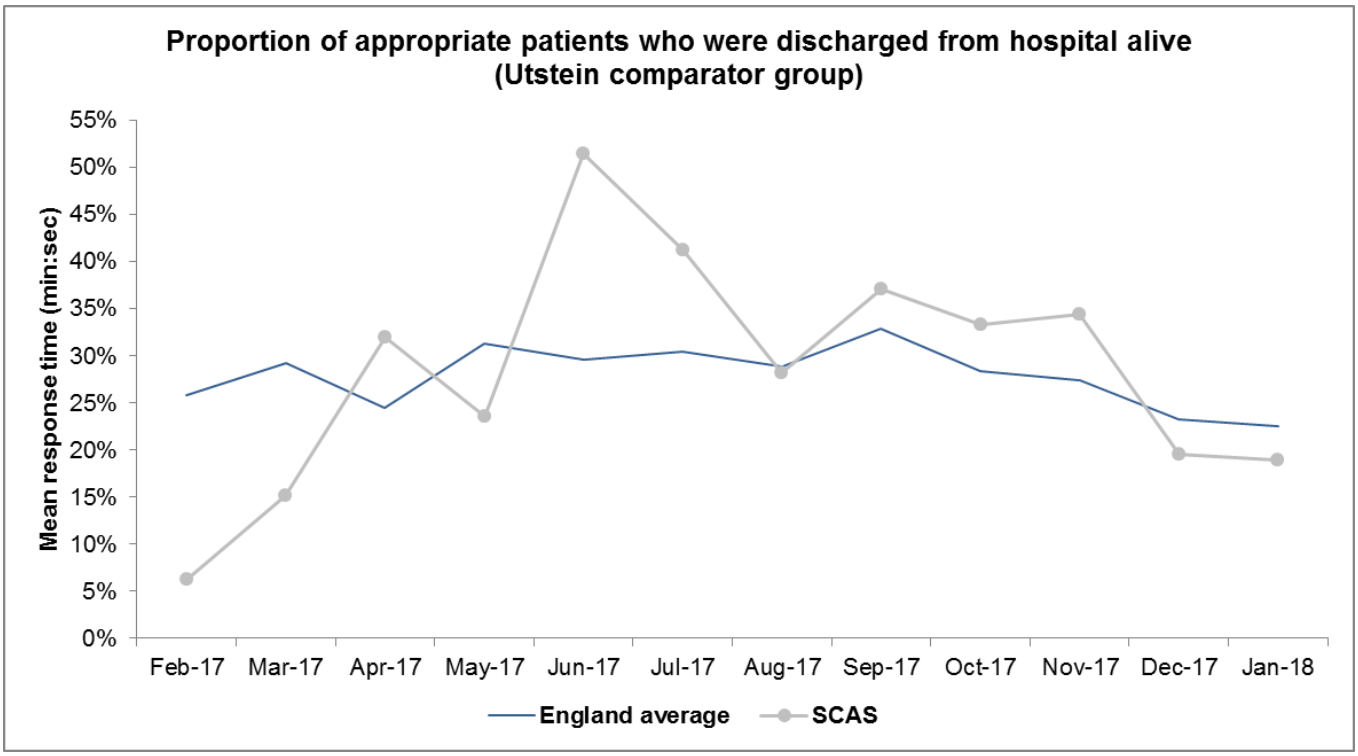
Survival to discharge is calculated for two patient groups; the overall group, and the Utstein comparator group.

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



From February 2017 to January 2018 the trust's proportion of patients who had resuscitation and were discharged from hospital alive fluctuated, ranging from 5.8% in February 2017 to 24.2% in July 2017. This was generally better than the England average proportion of patients however trust performance was below the England average in February and May 2017.

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



From February 2017 to January 2018 the trust's proportion of patients from the Utstein comparator group who had resuscitation and were discharged from hospital alive ranged from 6.3% in February 2017 to 51.4% in June 2017. This was better than the England average performance for seven months in the period, but below the England average in five months. The England average ranged from 22.5% to 32.8%.

(Source: NHS England – Ambulance Quality Indicators – Clinical outcomes)

Some staff stated they felt care was target driven and not patient need led. However, all stated they focused on patient need and providing the patient with the most appropriate care pathway to meet their needs.

Staff took time to seek the true mechanics of patient injury to ensure the care provided would result in the best patient outcome. During the inspection we observed a crew review closed circuit television (CCTV) of a work place incident to help identify the cause of an injury. This allowed the crew to provide the most appropriate care and therefore increasing the chances of a positive outcome for the patient's health and wellbeing.

The trust used specialist paramedics (SP) to try and limit hospital admissions. The hub based at Reading reviewed all calls to identify if it would be appropriate for deployment of a SP rather than a paramedic crew. Specialist practitioners could do catheter and wound care amongst other skills which reduced the patients need for conveyance to hospital.

Staff spoke positively about the use of specialist practitioners stating referrals were an easy, straight forward process. They said SP's were approachable and liaised with them providing best advice to enable the patient to remain at home. This reduced unnecessary ED admission which resulted in less delays for treatment for more seriously ill patients.

Competent staff

The service made sure staff were competent for their roles.

Appraisal rates

The trust set a target of 95% for appraisal completion.

From April 2017 to March 2018 the trust reported 91% of all staff in emergency and urgent care had received an appraisal. Although this does not meet the trust target it shows an improvement on the previous year (April 2016 to March 2017) where 82% of staff had received an appraisal.

(Source: Trust Provider Information Request – Appraisals)

Across the service staff receive yearly face to face training which goes through all the basics again plus e-learning updates (for example on drug policy). All staff we spoke with reported they had a yearly appraisal which was beneficial and aided in the identification of further development each staff member required.

The vehicle mechanics had their work regularly assessed and used the same appraisal system as the trust's staff.

The trust had a director of education, two education leads and a paramedic educational lead, all

were medical consultants who ran and oversee the education programme.

Clinical mentors worked with newly qualified paramedics for ten shifts before starting as a paramedic. All staff were rostered to have clinical supervision on shift with a mentor. Some staff told us the frequency was yearly and others told us four times a year. However, all staff we spoke with had clinical supervision either formally or as part of their development or informally by working with the clinical mentor in their team.

Part of the team leader's role involved observing staff competency. Team leaders would go with staff and monitor their work, offering support if required. Staff received four shifts a year working with their clinical mentor and staff confirmed this was happening and found it beneficial for their reflective practice.

Most staff spoke positively about their induction and said they could seek further extensions to their initial training if they did not feel confident in their ability. One member of staff told us individually tailored time could be available to meet their needs and the trust fully supported staff through the process.

SPs had undertaken a degree or level seven course and had trained in wound management and were able to suture. The SPs delivered training to staff and supported the clinical mentors and team leaders to develop training skills.

To ensure maintenance of SPs skills they undertook rotational work in different area's/locations? which included the first aid unit at Chipping Norton and the clinical hub at Reading.

At any time, the trust could be supporting 450 students at different stages on different courses including medical student placements. This year it was the first year of seeing BSc students complete their third year and this academic year (2018-2019) 120 paramedic students were entering their third year.

The trust received student feedback in the past regarding issues where they had been unhappy with their shift schedules however, following an introduction of a separate student scheduler issues were now almost resolved

All staff reported team training days were valuable. These were organised by team leaders, with agendas and content designed around the training needs of the staff at that time. All staff had protected time for team training days (two hours every week which was accrued into a whole day). Examples of team training were wellbeing sessions and end of life care.

There was a Helicopter Emergency Medical Service (HEMS) development pathway where staff can progress from a HEMS paramedic to an advanced paramedic. A consultant paramedic designed the advanced paramedic programme. There was also a pathway to consultant paramedic.

The HEMS team had base training days every other month. The findings from governance meetings dictated the training. Recent training included post-partum haemorrhage, paediatrics and a refresher regarding infusion pumps. The HEMS team reported there was a culture of never resting on their laurels and staff were regularly getting kit out and running through how to use it. We observed part of the morning checklist which included what training they will have for the day.

All nine HEMS paramedics had enrolled on a post graduate diploma in advanced clinical practice. Scenarios were recreated to be as real as possible in the trust's immersive training suite and the training suite was also used as part of the assessment process.

To ensure HEMS staff remain competent, their skills were audited using the HEMS base, this is a database that records interventions staff have undertaken and can then identify if someone has not done a specific intervention for a specified amount of time and required a refresher in this skill.

The HEMS team staff maintained their skills by rotating through roles on the ground, helicopter and on the dispatch desk. This ensured staff were skilled, trained and knowledgeable of all elements of the service.

Members of staff were chemical, biological, radiological, nuclear, and explosives (CBRNE) trained and had considered joining the intervention team. The Hazardous Area Response Team (HART) team train staff and there were yearly updates – both theory and competency practical skills / radio skills and practice in suits doing dexterity exercise for example.

All front-line staff in urgent and emergency care services completed training about resilience and major incidents. Staff we spoke with at resource centres had a good understanding about the role of the HART and HEMS team and were confident in requesting their support when required.

The trust employed trained paramedics from abroad and placed them on a reduced length paramedic training programme. Some staff felt the extra supervision required was not good for moral and staff expressed they would like to see some flexibility as overseas staff were very experienced. 50% of international, (four out of eight) paramedics had left due to the workload, paperwork and supervised hours needed for the fast track process.

To increase the skills of the crews the trust had recently introduced crew training days at which they presented specific interventions or cases, an example was a Rapid Sequence Intubation (RSI) walk through which staff gave positive feedback about.

Staff said, "Great training opportunities such as additional level six modules internally available for paramedics, great continuous professional development (CPD) building portfolio".

Independent ambulance crews who were undertaking sub-contracted front-line response work had to complete the trust's induction course as well as the trusts mandatory training before they could commence frontline work.

The trust had a robust system in place to manage poor staff practice. Staff could speak with team leaders and identify if they felt a member of staff required additional clinical practice. Following this acknowledgement, a clinical mentor would work with the identified member of staff. The clinical mentor would identify if the issue raised was due to lack of training or the staff member failing to carry out their role.

When managers identified performance issues with staff, they would complete assessment forms which highlighted areas for improvement. The manager and the individual would create an action plan which clarified how the individual would meet their development needs.

The trust supported staff members through this process and meetings held with the staff member could include their clinical mentor, team leader, union representative (if requested), human resources and the education team to ensure the trust provided support to improve individual's performance.

Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients.

Throughout the trust we observed effective handovers between the crews and ED staff. Handovers observed were clear, concise, contained relevant information relating to the patient's medical history, current medical presentation and if do not resuscitate (DNA) orders were in place. Staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. We received positive feedback from staff at various ED units regarding the trusts staff's knowledge, behaviour and integrity.

Staff (consultants, receptionist and nurses) at all ED's told us the ambulance service was 'brilliant' and they had 'nothing but respect' for their colleagues and likewise the trusts staff felt that staff at local NHS trusts were doing 'everything that they possibly could'.

A further ED consultant told us, "We are privileged to work with SCAS as an ambulance service". When asked they stated this was due to the recruitment, training and calibre of staff employed, they continued, "We really are so lucky to work with them".

Staff across the service told us they had a good working relationship with staff at their local cardiac care units and stroke units. Staff could speak with the specialist medical teams which resulted in crews directing patients to the correct medical ward to meet the patient's needs.

Staff reported to feel comfortable in contacting GPs for updates about patient's conditions if they so wished. This attributed to crews agreeing with both the patient and GP regarding their safety to be left at home pending a GP visit.

The trust had an 'Accident and Emergency Delivery Board' in each of the seven nodal areas to support ideas for the development of improved clinical pathways for example, developing a clinical navigator role. Staff told us this was working well, we spoke with a senior sister in one ED department who said the trust met bi-weekly with hospital staff to discuss issues around capacity and to establish practice to improve flow and access of patients through the ED.

Some emergency medical units across the region would accept direct referrals from the crews following the crews liaising with the GP regarding the correct place of treatment for the patient. Again, this reduced the pressure on local ED's and provided a better outcome for patients.

Staff reported a Clinical Validation line was available to the clinical support desk which included medical and surgical registrar's, and maternity and gynaecology registrars who were contactable for further advice.

Following a serious incident involving a delayed transfer of a pregnant patient between hospitals the trust has worked with a local NHS trust to develop joint guidance between the ED and maternity department to form collaborative working groups. The impact had been no further

incidents of this nature. In addition, the trust facilitated a national conference on improving ambulances services and paramedics response to maternity care.

The mental health lead within the trust liaised with mental health lead within the police around section 136 issues. There was a mental health nurse employed by an external trust who sat on the control desk and could advise the best placement for patients known to the service.

Although staff received training in the Mental Capacity Act (MCA) they told us there was little or no support once they had completed the assessment. The perception of some staff was that the police expected the ambulance staff to use the MCA instead of the police using Section 136.

Staff across the trust worked with the fire service co-responders if the fire service are closer to the scene and the police on a regular basis.

We saw evidence of the arrangement of multidisciplinary education where training sessions with Macmillan nurses, police, and other specialties took place. Clinical mentors also provided shadowing opportunities for students external to the trust.

One clinical operations manager was the trust's urgent and emergency representative on the 'Gaining entry group' that worked with the fire service trained in 'break-ins' and could assist crews in gaining access to patients when crews were unable to gain entry to properties. The police were also part of this group as they provided the 'boarding-up' service to damaged properties if required.

The trust gave staff the opportunity to attend yearly HEMS study days and received training about the Joint Emergency Services Interoperability Principles (JESIP) principles, which included multiagency working and structured processes for conveying information about major incidents.

Hampshire and Isle of Wight air ambulance served the population of the Isle of Wight. The Isle of Wight had its own ambulance service, but relied on the Hampshire and Isle of Wight Air ambulance service to provide rapid transfer of patients to the mainland for time critical treatment.

Health promotion

The service effectively promoted and empowered service users to manage their own health, care and wellbeing to maximise their independence.

Staff told us specialist practitioners offered detailed health promotion advice to patients regarding quitting smoking and health eating for example as part of their role when treating patients at home.

Staff managed frequent callers to the trust who may not require emergency and urgent care. Staff who were unable to work frontline shifts due to pregnancy or physical injury, for example, worked in the emergency operations centre to identify frequent callers. They would create and update a frequent caller list and liaise with the individual to understand why they made regular calls. Following discussion with the caller staff would liaise with other services to seek the most appropriate support, such as the mental health crisis teams for example, to reduce or stop their reliance on the urgent and emergency services.

The trust and local clinical commissioning groups were looking at improved management of "high intensity users" (10+ per year). The trust's data had been cross referenced with local NHS trusts data. From this the trust identified many patients who were frequent fallers and worked with social services to make these patients homes safer by providing hand rails to minimise the risk of falls.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005 but some staff felt they would benefit from more training.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004.

Some staff told us that although they received training in the Mental Capacity Act (MCA), they had very little training in mental health beyond their mandatory training. There was no further training to manage patients that presented with complex mental health conditions who were in a crisis and staff stated they did not feel adequately equipped to deal with users that suffered from poor mental health. However, the trust informed us all staff had access to additional e-learning and podcasts.

Staff we spoke with showed a full understanding of the processes of consent and could provide examples of where they had required to progress with treatment without gaining the individuals consent, for example when the individual had been unconscious. Staff also carried mental capacity act booklets which provided advice on how to determine if a patient had capacity to consent to their care.

Staff said they would explain all available options to patients to ensure they had consent explaining the possible outcomes if they were not to refuse treatment. However, staff acknowledged the right of a patient with capacity to make an unwise decision and refuse treatment.

The HEMS team were aware consent was a key part of the checklist they should follow should a patient require sedation, and had to explain to the patient what will happen and what the risks are. Staff told us they rarely had a patient who lacked capacity but if they did they would follow the JRCALC and MCA checklist. They would subsequently assess capacity and act in a patient's best interest.

Staff reported if the patient was unconscious, they would enquire after a 'Living Will,' Power of Attorney or a Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) form and if these were not available they would act in the patient's best interest. Crews would use would use the mini mental checklist on the EPR system if they felt a patient was confused and if the patient did not have capacity, staff would act in the patient's best interest.

One member of staff had accessed a module on mental health through 'the skills network'. A team leader reported laminated pathways were available for crews to refer to on their vehicles, for mental health patients under different sections of the Mental Health Act.

Some staff felt they would benefit from more specific mental health training and felt the Maybo course (a conflict management training course) did not meet their needs and training on how to get away from a threatening situation would be more beneficial with awareness of where they stood legally in these situations.

Is the service caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Compassionate care

Staff cared for patients with a great deal of compassion.

Friends and Family test performance

The trust scored similar to the England average for recommending the trust as a place to receive care with regards to it's see and treat activity in January and March 2017 and received a slightly lower score in February 2017. Data prior to January 2017 was not available for see and treat friends and family test. The response rate for these three months was similar to the England average

Month	South Central percentage recommend	England average percentage recommend
January 2017	91%	92%
February 2017	86%	91%

(Source: NHS England Friends and Family Test)

In the friends and family test, see and treat, from March 2017 to February 2018 the trust recorded no eligible responses for 10 of the 12 months in the period. Data was only available for January and February 2018.

The trust reported the reason for not recording eligible responses for 10 of the 12 months was due to poor patient response to questionnaires. The trust provided us with additional information which showed since January 2018 improvements had been made in the collection of the data.

We observed staff maintained the patient's dignity and respect during episodes of care. For example, this included in the back of the ambulance with the doors shut and in the patient's home. Staff spoke respectfully to patients, asking for, and then using their preferred choice of name.

Staff remained calm respectful towards patients and their family members. During the inspection staff dealt with a family member who was outwardly displaying frustrations about health matters. Staff remained calm, listened to their concerns whilst providing care to their family member.

We observed cards and letters from patients which detailed:

"A big thank you to all for such a splendid service"

"I would like to thank the three people who rushed my husband to the JR. Thanks to all of you my husband is now recovering from meningitis"

"I would like to pass on my gratitude and thanks to the two paramedics. Their speed, professionalism and reassurance to my wife and myself was excellent. Everything from the time they arrived and introduced themselves was explained calmly and clearly. I shall always be eternally grateful to the two paramedics who started the process of saving my life"

Staff showed concern for patients which included patients discharged from their care without the need for transfer to the emergency department (ED). During the inspection staff expressed concern about how a patient was going to reach an out of hours GP surgery. Staff reassured the patient and did not leave them until someone was available to return the patient home safely.

Crews were observed by the inspection team as being 'very caring' acknowledging service users' issues and concerns, being firm but polite and aware of the situations they were in and the

inherent risks of leaving the patient at home without treatment. On more than one occasion crews negotiated with patients that it would be in their best interest to go into hospital.

We saw an example of very good compassionate care where staff took additional action to relieve a patient's physical distress during their transfer to the ED. A member of staff recognised a patient experienced peaks in pain whilst moving. They identified an alternative route to the ED which would limit the amount of speed bumps the ambulance would travel. This limited the amount of movement the patient experienced and therefore minimised the amount of pain they felt.

A paramedic spoke sensitively about managing the expectations of patient families/carers especially where there is a life or death incident and followed the ethos of 'treat the patient, treat the family'.

Emotional support

Staff provided emotional support to all patients and their families to minimise their distress.

Staff offered emotional support to patients suffering from extreme emotional stress. During the inspection a patient was exhibiting signs of extreme distress, staff offered continual reassurance to try to help them calm down. When the patient made steps to leave staff encouraged them to return so they could seek the medical treatment they needed.

We observed a member of staff comfort a visibly upset patient in the ED by getting down to their level, holding the patients hand, and asking if there was anyone the patient would like to contact for support.

During the inspection staff continually reassured patients, before, during and after their treatment and transfer to the ED. We saw staff engaging with patients and reassuring them they would receive treatment to manage their condition and distress. Once settled within the ED, ambulance staff sought family and friends to provide companionship to the patients to help support their emotional wellbeing.

Staff showed empathy for patients treated and transferred to the ED and ensured they had items with them they might require for any period of treatment. This included items such as the patients phone, phone chargers and purses. During the inspection staff asked patients if there was anything else they thought they would need if they were to stay in hospital and offered to find this for them.

During the inspection we observed a crew treat a patient who had a child. Staff identified the patient was not happy to leave the child with another relative so decided in the best interest of the child and parent's emotional wellbeing, to transfer both. Staff engaged the child in conversation to minimise any distress about being in an unfamiliar environment and we saw the parent assured by having their child with them.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

We observed staff interact with patients and relatives in a positive way and used humour, where appropriate, to make patients and relatives feel more relaxed.

Many relatives we spoke with across the trust reported they had been well informed about the care their loved one was receiving.

We observed staff across the trust in the emergency departments explain to patients where they were going to take them. This kept the patient and the family informed regarding the next steps for their treatment.

One group of relatives gave very positive feedback “the call taker was excellent and the patient was rapidly seen by a crew, the pain needs were met and they were transported in a slow and careful manner”.

We observed staff provide the patient’s friends and family with clear information about the care they were to receive and the reasons for this. Staff encouraged patient’s relatives to help pack a small bag for the patient to ensure they had what they needed for any potential hospital stay. This helped inform the patient’s friends and family members regarding the plan for the patient’s treatment.

Staff were respectful of patient’s views and did not push patients for information they were unwilling to provide. During the inspection a patient did not wish to inform staff about previous falls they had suffered, despite physical injury signs being present. Staff spoke with the patient’s family members and identified the patient was independent and would not disclose their level of illness, or injury to any parties. Staff respected the patient did not want to share this information but raised their concerns with the ED staff regarding not having a full history available and described what they had seen and heard.

We observed crews give patients a choice of options available for care and treatment. Staff listened to the patient’s preferences and helped them to decide what care and treatment most suited them.

Is the service responsive?

By responsive, we mean that services are organised so that they meet people’s needs

Service delivery to meet the needs of local people

The trust planned and provided services in a way that met the needs of local people.

There were many different specialist clinical services designed to meet the needs of the local population. For example, the emergency and community first responder schemes to respond to life threatening emergencies in rural areas where ambulances might take longer to get to a patient.

The trust had a specialist practitioner led “First Aid Unit” (FAU) in Oxfordshire and Reading. The FAU is open during evenings and weekends and supports residents of a rural community to access minor injury and illness services without having to travel to an Emergency Department. Figures provided by the trust showed an attendance of 2676 patients from April 2017 – March 2018 of which 2143 patients were seen and treated and discharged home.

The trust had implemented a clinical validation line to support safe discharge decision making by newly qualified paramedics as well as a clinical support desk that supports clinicians with decision making to safely discharge patients at home with an appropriate plan of care in place.

Across most accident and emergency departments the trust had worked with local NHS trusts to create a better flow for patients especially if they had to wait in corridors. For example, one trust has a purpose built ‘rapid bay’ area. Crews bring patients in through an L shaped corridor which provides more privacy for patients if there is a queue as it is further away from the door.

The trust was planning to increase the numbers of staff and ambulance resource in line with forecasting for the expected growth in population of Milton Keynes due to the building of new homes.

The Helicopter Emergency Medical Service (HEMS) team (Thames Valley) each morning held a helicopter briefing checklist which included weather checks. They worked out detailed plans which included who will sit where on the helicopter and what role they will each have. This saved time in the event of a call out because they each know exactly what they were doing. They worked closely with Thames Valley Air ambulance covering each other's area and working shifts to support each other. Hampshire and the Isle of Wight Air Ambulance (HIOWAA) do two weeks of 7 am – 7 pm and then two weeks of 9 am – 5 pm and 5 pm – 2 am. Thames Valley do the opposite weeks so when HIOWAA are on a 7 am – 7 pm, Thames Valley are on 9 am – 5 pm and 5 pm – 2 am. The team who are on 7 am – 7 pm also cover the dispatch desk.

Air ambulance services could respond to a call within their region within 15 minutes, ensuring patients could receive effective emergency care and attend to a life-threatening situation.

The HEMS team had clear guidance of which patients they could accept but some staff reported they were receiving unnecessary call outs to patients who did not require their expertise. The HEMS team fed back this information via incident reporting mechanisms.

The trust had worked closely with NHS England on an accelerated clinical triage process looking at low acuity/low risk call types identified early in the call taking process and referred directly through to clinicians on the clinical support desk in the call centre. A clinician assessed these calls rather than the patient "telling their story" twice. These low acuity calls have a higher chance of referral to the correct area of the NHS to receive onward treatment if required, with the trusts hope of improving hear and treat levels.

Meeting people's individual needs

The service took account of patient's individual needs.

Crews referred patients to the most appropriate medical or care provider. During the inspection we saw a member of staff contact an out of hours GP service as the patient did not require immediate emergency medical care. This allowed the crew to provide initial assessment, treatment and provide advice for the patient on the right course of action to take.

For patients whose first language was not English the trust used a translation service via a telephone system. Some staff reported they may have to rely on the patient's relatives on occasions but were aware this wasn't best practice. We also observed prompt cards to facilitate communication in pictures for use with patients with learning disabilities or speech disorders. This indicated the trust complied in most part with the Accessible Information Standard.

Staff discussed with us how they would meet the needs of patients whose religion would require treatment by male or female only staff.

The trust's ambulances were accessible for people with wheel chairs and for walking, bariatric, stretcher, and wheelchair patients via tail lift or ramp. Depending on mobility of the patient, staff used many ways to ensure the patients safe entry onto the vehicle, for example through assisted walking, carry chair, wheelchair, or stretcher.

Additional equipment was available on the ambulances to support patients with additional needs such as children for example. Ambulances contained a child harness system which was placed over the top of a stretcher to ensure children were securely seated during their treatment and

transfer. A seat within the rear of the ambulances contained a rotating panel which presented a further child harness system.

The trust had a flagging system on the EPR to identify patients with specific needs, for example learning disabilities. This enabled staff to prepare and deliver an appropriate patient response plan to ensure staff could meet individual needs.

Newly qualified paramedics were required to complete a dementia module as part of their training. This ensured paramedics could understand the issues faced by a patient living with dementia.

There was a new frailty service in the Hampshire and Reading areas. The service in Hampshire was staffed by experienced ambulance technicians, and the service in Reading by Specialist Practitioner Paramedics (including an occupational therapist) to keep patients (particularly those who frequently fall) out of hospital.

Staff received training in conflict management to disengagement training and staff used the training to help them deal with violent or aggressive patients. Some staff we spoke with felt it wasn't appropriate for their role.

The trust had a mental health lead who actively engaged with the local mental health trust, other professionals to review any challenges related to service delivery.

The trusts chair of LGBT group, has been working nationally on a task and finish group to produce care guidance for staff regarding transgender patients. The trust has supported the chair to undertake this work.

Access and flow

Five major pathways including myocardial infarctions (heart attacks), strokes, trauma, vascular and maternity were available for staff to follow with the view to reduce admissions into Emergency Departments (ED) and to ensure patients arrived at the appropriate setting.

The trust developed the specialist paramedics role, (in other areas known as emergency care practitioners (ECPs) which examined admission avoidance by liaising with GPs to check what is 'normal' for patients so crews did not have to take them to hospital.

Staff reported the geographical areas of the teams had been designed around patient flow and where they were most needed.

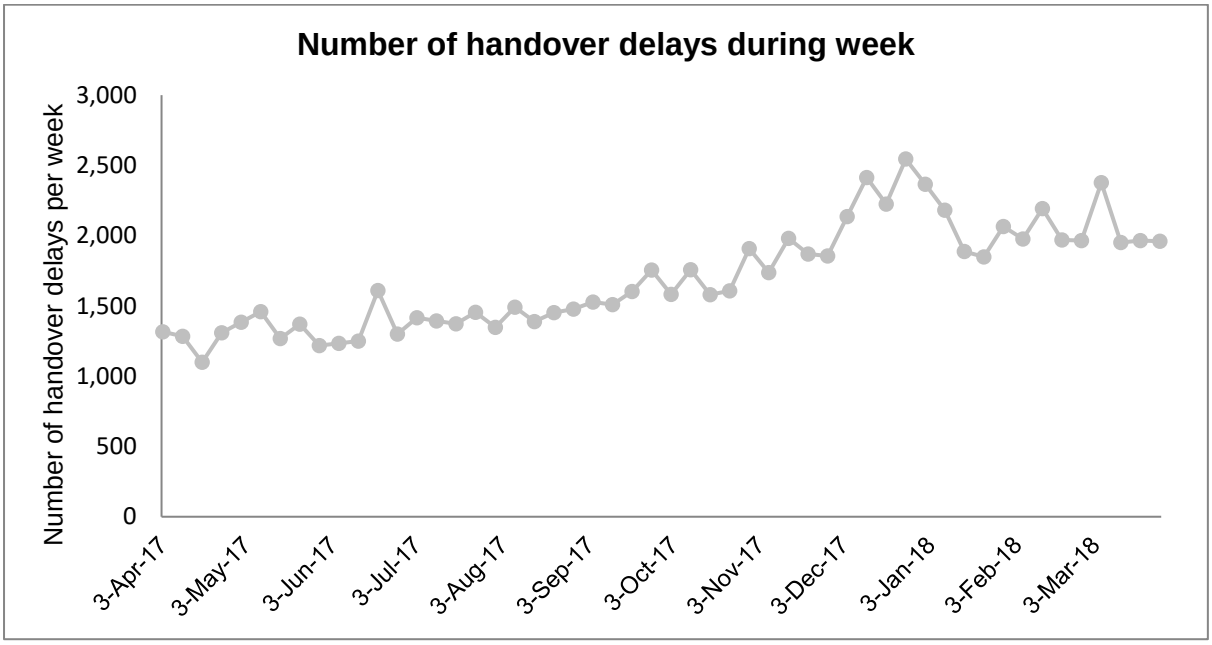
Handover delays

Handover start time is defined as the time of arrival of the ambulance at the Emergency Department (ED), with the end time defined as the time of handover of the patient to the care of ED staff. Best practice is 15 minutes but handover time is a contextual measure to indicate time lost from waiting to handover patients at emergency departments, and is not a measure of performance.

Staff experienced excessive hand-over times at some acute hospitals, which impacted the trust's resources and reduced the ability to meet the service demand. The trust was working with local NHS trusts to resolve this issue.

From April 2017 to March 2018 the trust reported 88,206 delayed handovers with average time of delays ranging from 6.53 minutes in April 2017 to 27.20 minutes in December 2017.

Out of the 52-week period there were eight weeks where an average delay of over 15 minutes was reported. All eight weeks were within the winter period (December 2017 to March 2018).



(Source: Trust Provider Information Request – Handover delays)

The trust liaised with local NHS trusts to try to reduce delays from handover times in the accident and emergency department. Bronze response staff would attend the local ED if there was a backlog of patients and would relieve the ambulance crew and care for the patients (with a limit of one clinician to three patients) whilst they awaited triage. This enabled the control desk to release ambulance crews to respond to emergency calls.

An example we observed was one ambulance was waiting to handover to the triage nurse and we observed senior hospital and ambulance staff to work together to assess the patients and improve flow. In another setting we observed a paramedic mentor acting as hospital ambulance liaison officer (HALO) whilst waiting to unload the vehicle, but not all local NHS trusts had a HALO in place. We observed good teamwork on many occasions when an ‘alert’ came in and anybody who was ‘spare’ stopped to help get the patient into the resuscitation area without delay.

The trust was developing new models of care to improve access and flow whereby a band 6 paramedic could refer appropriate adult patients directly to a senior registrar or on-call medical registrar.

During the inspection in the Oxfordshire area there were 36 crew members who required ambulances with only 24 able to access a vehicle and get out on the road. This resulted in some crews stood down waiting for an available vehicle to commence work. This did not assure us vehicle demand was always met. However, the trust was aware of this issue and told us new ambulance vehicles were on order.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

Summary of complaints

From April 2017 to March 2018 South Central Ambulance trust received 104 complaints relating to emergency and urgent care services (23% of all complaints received).

Values and behaviours of staff was the subject with the most complaints, accounting for 38% of all complaints about emergency and urgent care services.

Of the 104 complaints about emergency and urgent care, 13 were still open at the time the trust submitted their RPIR. Of the closed complaints the trust took an average of 44 working days to complete, which is not in line with their complaints policy which states complaints should be closed within 25 days (unless an extended timescale has been agreed). We were informed by the trust where they were unable to provide a response within 25 days an extension would be agreed the complainant.

Shown below is a breakdown of complaints by subject is:

Subject	**Number of complaints**
Values & Behaviours	39
Other	37
Transport	15
Communications	8
Patient care including Nutrition & Hydration	3
Communications	2
Total	**104**

(Source: Trust Provider Information Request – complaints)

The trust policy and own target was to acknowledge complaints within three working days of receipt and to investigate and respond to complaints within 25 working days. However, data supplied by the trust showed it failed to meet this target between April 2017 to March 2018.

Staff discussed a robust process for dealing with customer complaints however, were not aware of any complaints paperwork or leaflets they could hand to patients. We saw no information regarding complaints on vehicles. Staff reported they would direct patients who wished to complain to their patient advice and liaison service (PALS). All staff we spoke with reported they rarely had patients who wished to complain.

The trust's patient experience team managed complaints received by members of the public. Team leaders were delegated responsibility for investigating complaints with oversight from the clinical mentor and senior managerial staff.

The trust board had oversight of complaints and the director of nursing and clinical quality group informed the board of specific issues. Patient stories were regular agenda items for the board and included complaints or serious incidents enabling the trust board to hear the patient voice.

The trust had an area on its website where with contact information was available for the public who wished to make a complaint.

Staff told us resolutions focused upon what the patient wanted or needed which included a formal response by letter or telephone or an acknowledgement their concerns, such as ambulance parking for example.

Senior staff discussed where they had taken proactive measures to resolve a long-standing complaint. This had involved acting over and above the trust's complaints policy to reach a satisfactory conclusion for the complainant's wellbeing. When the trust felt they were no longer able to reach a conclusion which met the complainant's needs they voluntarily referred them to the public health ombudsman. This would enable the complainant to have their complaint reviewed by an independent body. This demonstrated the trust's openness to being transparent with their dealings with the public.

Team leaders shared compliments and positive feedback with individual teams across the service and displayed in their resource centres. Some teams as part of their wellbeing initiative had a display board of 'Honks' which was where staff could place positive feedback regarding their colleagues.

The trust shared learning from complaints through the various newsletters and email alerts such as 'hot News' and SCAScade. As well as face to face learning within team days.

Is the service well-led?

Leadership

Managers at all levels had the right skills and abilities to run the service and provide high quality sustainable care.

Leadership began at board level with executive and non-executive directors feeding in to director of operations then down to assistant directors to head of operations and then down to clinical operation managers who oversaw the operational team leaders.

Across the service staff reported their director of operations was visible, met with the clinical operations managers weekly and emailed a weekly newsletter on Fridays. We were told 'senior executives come around at any time including weekends and bank holidays' and most staff reported the executive team to be visible and approachable.

The specialist paramedics currently had team leaders that are band six. This was currently under review as specialist paramedics are band sevens. It was therefore inappropriate for a band six to be appraising a band seven practitioner.

The team leaders reported their clinical operation managers offered good support and reported they had access to leadership courses.

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

Staff told us their immediate leadership in the form of team leaders had the capacity, capability and experience to lead effectively. Staff at Wexham told us this was because their heads of operation had been a front-line member of staff before their promotion and understood the pressures current front-line staff encountered.

Staff at all levels of the organisation understood their roles and responsibilities and what to escalate to a more senior person, however staff on the ground felt disconnected from the higher

level of management, including the senior leadership team (executive board). They said they felt well connected with team leaders and the clinical operations managers, but less so with staff more senior of this. This meant they were unaware of decision making at a more senior level, and felt decisions were 'top-down'.

Due to the large geography covered by the Stoke Mandeville resource centre, managers could not visit stations frequently. This meant staff did not always see them. They reported the executive team occasionally drop in, and described them as approachable and will listen. The executive team were making it a requirement that the non-executive team members carried out regular resource centre visits to meet the staff and hear concerns from the ground.

Vision and strategy

The service had a vision for what it wanted to achieve and were actively working towards achieving the vision.

The trust had a five year forward view strategy which includes working on a project to reduce admissions to accident and emergency. Across the trust we saw copies of the five-year plan displayed on the staff notice boards.

Progress against the delivery of the strategy and local plans was monitored and reviewed at trust board level. Performance and progress was reported within the trust's integrated performance report (IPR), which was presented to the board of directors at each board meeting alongside the board assurance framework (BAF). The minutes for these meetings were detailed and used data from all areas of the service to evaluate performance and drive improvements. However, there were some concerns the BAF did not provide assurance against the mitigation of the risks incorporated in the IPR

The trust was working with various clinical commissioning groups (CCG) across the service to deliver the right care at the right time. For example, the trust worked with a local CCG to form maternity collaborative working groups.

Many of the staff we spoke with knew the trust vision:

"towards Excellence – saving lives and enabling you to get the care you need"

and the core values of:

• teamwork – delivering high performance through an inclusive, and collaborative approach which values diversity.

• Innovation – continuous improvement through empowerment of our people.

• professionalism – setting high standards and delivering what we promise.

• caring – for our patients and each other.

However, few front-line staff we spoke with knew the trust's strategy. All staff we spoke with stated patient care and safety as being at the forefront of their job

The vision underpinned the trust's recruitment process and recruited staff against the values of the trust. Staff told us the trust had introduced values based interviewing to ensure potential staff could demonstrate personal attributes identified as important to the needs of the trust.

The trust was planning to build a tri-service' hub in Milton Keynes with the police and fire service. The head of operations told us about these plans and staff were also aware. It was anticipated this would improve the multidisciplinary working and communications.

Staff told us they perceived the Chief Executive as 'visionary' and the service was growing incrementally.

We observed the trust embedded its vision, values and strategy in corporate information received by staff as well as embedded in the appraisal system which was values based.

Within the trust's IPR document the trust had an implementation plan for the new ARP standards and monitored their progress against this plan. The board discussed the progress monthly to maintain focus on their progress.

The trust had an implementation plan for the new ambulance response programme (ARP) standards and had switched over to the new monitoring system in November 2017. Progress against this plan was monitored daily through trust-wide operational calls and reports to the National Ambulance Advisory Council (NAAC).

Culture

The trust's strategy, vision and values underpinned a culture which was patient centred.

Staff felt positive and proud about working for the trust and their team.

All staff we spoke with had the opportunity to discuss their learning and career development needs at appraisal, which ensured managers were aware of development gaps and career progression needs of their staff.

Most crew we spoke with received positive feedback from patients and one member of staff had received a letter of thank you from the head of operations regarding their excellent patient care. However, all staff we spoke with told us they were not reporting compliments on the reporting system due to time constraints. This meant verbal compliments were not officially recorded.

The trust had health and wellbeing champions at every resource centre, there was a notice board at every resource centre and a card with access to health and wellbeing numbers given to staff at induction (contact details for: Optum, Occupational health, TRiM, pensions / payroll and MIND charity).

Staff reported a very positive, very nurturing team and management who want to develop them. Most teams had positive relationships, worked well together and addressed any internal conflict appropriately.

Staff told us there was openness and honesty between all staff levels and between the trust and the public. Staff told us senior staff understood the pressure they experienced in their job role.

During our observations at ambulance stations and at local hospital emergency and urgent care departments we observed all crews were committed to ensuring patients received a good quality service and we noted staff behaviours and conduct reflected the values of the organisation.

Managers told us they addressed poor staff performance where needed involving the human resources department.

One member of staff told us the HEMS team were working on a wellbeing app to support staff. A paramedic we spoke with told us they only attend the most severe incidents and they had required extra counselling and support in the past which they had received.

Across all resource centres there was a well-being team and champions. One clinical operations manager expressed they would like an extra step of being able to offer staff direct referrals to physiotherapy sessions following lifting injuries for example.

Part of the HEMS team is transferring to an independent provider in the coming months, the trust has supported the staff during this change and staff will be transferred on the same pay and conditions. The trust offered staff alternative roles within the trust if they did not wish to transfer. The trust has arranged individual and group meetings, and human resources were responsive to any emails sent with queries and were available if staff wished to speak to them.

The trust had appointed a Freedom to Speak Up Guardian (a national role that all trusts require) who provides them with sufficient resources and support to help staff to raise concerns. However, most staff we spoke with were not aware the trust had a freedom to speak up guardian and were not aware of their purpose. However, staff reported they were happy to approach their team leader or head of operations with any concerns they may have.

A current review of the rota system was underway and the trust were using an external research company to do a Fitbit trial on sleep and fatigue. Phase one was complete and included 50 staff and phase two is underway with another 50 staff. The research is trialling in a mix of urban and rural areas with a range of staff volunteers. Recommendations from the research will come out in August 2018. Target date for completion of the new rotas is April 2019. Staff we spoke with on the trial were very positive about the trust involving staff in the rota implementation.

Governance

The service used a systemic approach to continually improve the quality of its services and safeguard high standards of care.

The trust had an effective governance framework to support good quality care. The service held regular senior management team meetings, which monitored progress on achieving strategic aims, and reported to the trust board. Sub committees of the board included the quality and safety committee, audit committee and governance. An executive director chaired the quality and safety committee and the board sub-committee. All meetings featured agenda's and follow up actions.

The HEMS team across the service have internal clinical governance meeting every month and alternate months are joint with both HEMS teams. These are the forums for discussing incidents and sharing learning.

The HEMS team held monthly mortality and morbidity meetings to discuss and review all jobs they had attended. These were open governance meetings that any member of the trust could attend and sometimes crews who had been at the job attended as the trust believed it was an excellent learning forum and promoted a 'no blame' culture with everyone's views valued.

All levels of governance and management functioned effectively. Team leaders attended level one meetings where team leaders discussed operation performance, risks, complaints and compliments and governance issues and fed up to level two meetings which the director of operations attended. The director of operations focused on operational performance which fed up to level three meetings, chaired by the chief operating officer and fed back into the board. Dissemination of Information went back through the meetings so team leads could share relevant information with frontline staff.

We reviewed two sets of clinical governance quarterly reports which covered areas such as incidents, compliments and complaints, safeguarding, NICE guidelines, medications and duty of candour. Both quarterly reports showed actions identified and actions subsequently taken.

We observed papers for board meetings and other committees were of a reasonable standard and contained appropriate information

Across the service, every morning there were bronze 9 am and gold 10 am video conference calls. On the gold call the director of operations, two senior managers from the emergency operations centre and the urgent and emergency care duty officers (silver rota), fleet director, scheduling, head of business intelligence called in to highlight any concerns. We observed a discussion with solutions provided around vehicle availability during one of the calls.

A CCP who had been involved in an incident led debriefs. Staff reported feedback was productive in facilitating learning and assisting in supporting staff. Trauma Risk Management (TRiM) was also available to support staff following particularly difficult incidents, staff told us they valued this service.

Teams delivered training at regular governance days, such as new interventions, learning from audits etc. Managers used meetings to share essential information such as learning from incidents and complaints and to act as needed.

HEMS staff reported there were a range of audits taking place, but staff could not detail any changes of practice due to the outcome of the audits or if they received feedback. We saw evidence of a wide range of audits internal and external including long waits, infection control, end of life and ambulance clinical quality indicators (various).

The trust subcontract work to other providers for example independent ambulance providers who received trust policies and protocols and were emailed updates of risks and alerts in the same way as trust staff were alerted.

Although incident reporting was centralised via an electronic system, the trust had an incident review panel that were responsible for grading the incidents and undertaking investigations. This gave them an overview of themes and trends locally and individual staff members received feedback when and where it was appropriate.

The trust employed a community first responder manager who oversaw the governance of community first responders (CFRs are volunteers who give their own time to respond to emergency calls made in their own community). All community first responders were required to attend on-going professional development and refresher training and the CFR manager monitored and maintained their training records.

Management of risk, issues and performance

The service had effective systems for identifying risks, planning to eliminate or reduce them and coping with both the expected and unexpected.

Senior staff had oversight and managed risks appropriately. Data supplied by the trust prior to inspection included a copy of the organisational risk register. The trust rated risks by cause and effect, with an inherent risk score, identified existing controls, a residual risk score, and action required. Risks identified included recruitment of staff, risk of not achieving cost improvement plans and poor patient turnarounds at ED from delayed handovers amongst others.

The trust had systems in place to identify learning from incidents, complaints and safeguarding alerts and make improvements. Frontline staff reported Incidents on the online reporting system. The clinical governance leads and risk department monitored the reporting system daily to ensure incidents of concern were immediately actioned and escalated to senior managers accordingly. Risk themes and harm levels were aggregated and reported into the patient safety group and upwards into the quality and safety group and board.

We reviewed the trust's quality report for March 2018, which demonstrated the trust monitored its safety performance over time, and compared this with national averages. The trust used the safety data to produce actions and improve performance in any areas of weakness.

The trust's quality report and quality dashboard consisted of a wide range of quality and safety indicators, which provided the board with an understanding of the trust's safety position.

Staff had access to the risk register either at a team or division level and could effectively escalate concerns as needed. We observed Health and Safety group minutes displayed on noticeboards including evidence discussion took place regarding two Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDORs) and the learning that came from the discussions.

Arrangements were in place for identifying, recording and managing risks, issues and mitigating actions. Recorded risks were aligned with what staff said were on their 'worry list'.

Upon review of three risk registers and team meeting records, it was clear the service reviewed their risk registers regularly and updated any outstanding actions.

Across the service risk was managed day to day with a gold call at 10 am each morning. Managers told us there can be problems with low numbers of available vehicles due to servicing and repairs and the stock availability at times. The bronze and gold daily calls mitigated the risk were identification of low ambulance availability was reported and enabled reallocation of ambulances depending on demand.

Due to the implementation of the ARP which included a move away from using RRV's the trust was addressing the risk of low vehicle availability by remodelling rosters and additional ambulances which were on order. Where cost improvements were taking place, we did not see evidence this was compromising patient care.

One clinical operations manager explained how they met team leaders three times in a twelve-week period and worked through an electronic dash board with them to discuss the importance of performance indicators. This enabled team leaders to share the performance information with their teams so staff were kept up to date regarding the trust's performance.

There was a long waits meeting held every month to review when patients had waited for an ambulance outside of the trust target. This sought to identify a reason for this and could include if there was a coding issue when the call was first made, or if it had been identified as a low priority call on a day when the trust had been busy.

We saw there were plans in place for emergencies and other unexpected or expected events. For example, adverse weather, a flu outbreak or a disruption to business continuity. The trust had a business continuity plan in place which staff could access.

All staff we spoke with had had some form of major incident training. A team leader reported they received extra incident training to other frontline staff. The staff had undertaken major incident training for airports and had participated in a 'table-top exercise' the day before a local festival in which they work closely with the local council. The Basingstoke crews had attended Urban Search and Rescue (USAR) building collapse and a gas explosion training and felt major incident training had been very helpful. In these situations, they would use Major incident, Exact location, Type of incident, Hazards, Access, Number of casualties and Emergency services (METHANE) reporting framework (an established reporting framework which provides a common structure for providers to share major incident information).

Staff across the service reported there were many opportunities to take part in major incident planning events with the fire and police services. In the event of a major incident senior staff would allocate staff a role and staff reported they were confident in their ability to fulfil any given position.

The trust took account of potential risks taken when planning services, for example seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities. This was evident in their winter plan, major incident plan and when planning staffing rotas to meet the needs of the service.

Information management

The service collected, managed and used information to support its activities.

We found that managers understood performance targets including quality, operations, and finances. Quality and sustainability were prominent items on agendas in trust board meetings and staff meetings.

The trust was aware of its performance by using KPIs and other metrics. This data fed into a board assurance framework and the board reviewed this information for assurance and improvement monthly.

Team managers had access to a range of information to support them with their management role. This included information on the performance of the service, staffing and patient care. Senior staff said there was an easy online dashboard system, updated every hour, which enabled them to see staff performance against identified performance measure. This information is electronically collated and a tracker report produced every month for team leaders to be aware of.

Leaders used meeting agendas to address quality and sustainability sufficiently at all levels across the trust. Staff said they had access to all necessary information.

The trust was monitoring staff handover delays at accident and emergency departments. This helped to inform the trust of processes that could be changed because of delays, for example one accident and emergency worked with the trust to redesign the waiting areas for patients away from public thoroughfares to protect their privacy.

Engagement

The service engaged well with staff and partner organisations to plan and manage services.

The teams and divisions had access to feedback from patients, carers and staff and were using this to make improvements.

We observed staff notice boards contained up to date relevant information for staff across the trust.

We saw a project management board for the rota change project. There had been three weeks of listening events involving all resource centres across the trust with a focus on health and wellbeing when talking about changing shift lengths. There had also been an online survey sent to staff to gather feedback. Thoughts provided included moving away from 12-hour shifts. Managers asked staff to provide evidence of personal experiences of 12-hour shifts, and a fatigue study was underway by an external research company. Trade unions had also been involved in the project.

The HEMS teams try to follow up patients and give them opportunities to contact the charity and visit the air base. They do engagement events with other organisations, schools, fetes, shows and speaking engagements.

Communication systems such as the intranet and newsletters were utilised to ensure staff, patients and carers had access to up to date information about the work of the trust and the services they used. However, some staff across the Oxfordshire region reported information technology issues due to limited or slow internet access, causing potential loss of work hours.

The trust had a dedicated employee assistance programme, which staff could contact confidentially for any support, for example, occupational health, to aid them in their recovery following illness or an injury.

Further support mechanisms were in place for staff, the trust had a programme for all staff to access counselling called trauma risk management (TRiM). In all ambulance stations, managers displayed details regarding the blue light support programme available to all staff within the emergency services and offered by MIND the mental health charity. Staff told us that they knew how to access the service.

The trust used an online anonymous survey company to seek staff feedback. The trust also used face to face engagement methods to liaise with staff. The trust used an external company to devise the value based behaviours, who had been to the trust and liaised with staff at all levels of the organisation to ensure they reflected what staff felt were important.

Within the past year the trust has been one of 33 employers to receive an Armed Forces Covenant Gold Employer Recognition Scheme award. This is a Ministry of Defence prestigious badge of honour, awarded in recognition work done to support the Armed Forces community, particularly to support veterans with developing second careers.

The trust has also developed 'job well done' cards which staff receive to recognise a positive contribution to the work of the trust, and the trust management team introduced AMBI staff awards for ‘Customer Service Person of the Year’ and staff were complimentary about this scheme.

Learning, continuous improvement and innovation

The trust was committed to improving the service by learning from when things went well and when they went wrong, promoting training, research and innovation.

The trust encouraged staff to suggest ideas which they felt would improve their efficiency or improve their working practices. The trust ran a ‘Bright Ideas’ scheme which encouraged staff to think about what they needed to work more efficiently. A member of staff, through the bright idea’s scheme developed the trauma app and the clinical pathways app which is now available across the trust. Other implemented ideas included click on torches for uniforms and work was ongoing at the time of the inspection on a sealed cannulation pouches. These would contain all relevant items such as swabs and a clean and dirty tray.

A new hub was being developed in Milton Keynes for police, fire and ambulance which will increase multidisciplinary team working and joint training. The trust plan to move to the hub in Summer 2019.

The HEMS teams do bike safety education within schools and have won an award for school engagement.

A station in Hampshire is known as ‘the innovation station’ and fire service and paramedics have visited from Duisburg in Germany (twinned with Portsmouth) to benchmark against their own service.

There was a new frailty service in the New Forest and Reading The service in Hampshire was staffed by experienced ambulance technicians, and the service in Reading by Specialist Practitioner Paramedics (including an occupational therapist) to keep patients (particularly those who frequently fall) out of hospital.

This was in response to the local population having high numbers of elderly and frail people. This role had been very successful .

The trust has recently rolled out an 'alternative transport' scheme. This utilised private hire vehicles to transport low acuity patients to hospital or relevant places for treatment.

Emergency operations centre

Facts and data about this service

South Central Ambulance Service NHS Foundation Trust (SCAS) is part of the National Health Service (NHS). It was established on 1 July 2006 following the merger of four ambulance trusts in the counties of Berkshire, Buckinghamshire, Hampshire and Oxfordshire. This area has a residential population of over four million, covering an area of approximately 3,554 square miles from Milton Keynes in the North to Portsmouth and Southampton in the South, and from Slough in the East to Newbury in the West.

On 1 March 2012, SCAS became a foundation trust.

They provide the ‘999’ service and handle around 500,000 emergency and urgent calls each year. There are around 1,700 operational staff working from 30 sites with 280 vehicles.

SCAS operates its control services from the EOC Southern House in Otterbourne, Hampshire and the EOC Northern House in Bicester, Oxfordshire.

During the inspection, we spoke with 27 members of staff including clinical advisors, four managers, one director, ten emergency call taker staff and five dispatch staff.

Is the service safe?

Mandatory training

Emergency call takers (ECTs) new to the role completed an assessment day and a 4 week training course, which included 3 assessments. If successful, a mentor was then allocated to provide one to one training with an emergency call taker for 18 shifts, at the end of this period assessments were completed and more training provided if required. We were informed that after periods of long term sickness, mandatory shifts with a mentor were completed until the emergency call taker felt confident.

The senior emergency call takers (SECT) received notification from duty managers regarding staff within their team that needed to complete mandatory training through e-learning. This meant they could monitor staff compliance with training. Senior staff told us staff could access their electronic personal record to view mandatory training and we observed staff accessing their own records. This meant that staff were aware what training they needed to complete and the timescale for completing this.

The trust used NHS Pathways, an assessment system to triage calls received in the Emergency Operations Centre (EOC). This facilitated the management of emergency and urgent ambulance

calls and allowed a range of dispositions to be assigned from a single assessment by non-clinical emergency call takers. Emergency call takers sought clinical advice from the clinical support desk as necessary. The pathways license provided regular updates and staff told us that they received two update training dates per year. This meant that they were up to date with changes and were aware of new updates to medical advice, a recent example given was for chemical attack.

Some staff informed us that allowing time for mandatory training within the rota was not always possible, however the trust had agreed to overtime payments for staff to complete training.

The trust set a target of 85% compliance for the completion of mandatory training for all modules except information governance, for which a 95% target is set.

The trust had changed their reporting methods over the last three years to reflect the improvements that have been made, it should be noted that the compliance figures below include both 999 and 111 staff (the trust have not provided the NHS 111 service staff data as separate figures).

A breakdown of compliance for mandatory courses for the year to date, April 2018 to 9 May 2018 for all staff in the emergency operations centre (999 and 111) is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/ No)
Equality and Diversity	596	616	97%	85%	Yes
Dementia Awareness (inc Privacy & Dignity standards)	577	615	94%	85%	Yes
Infection Prevention (Level 1)	576	614	94%	85%	Yes
Conflict Resolution	568	607	94%	85%	Yes
Health and Safety (Slips, Trips and Falls)	573	615	93%	85%	Yes
Fire Safety 1 year	524	615	85%	85%	Yes
Information Governance	575	613	94%	95%	No
Moving and Handling	505	613	82%	85%	No
Resuscitation	326	470	69%	85%	No

Overall, for the current year to date, all staff in the emergency operations centre had met the trust targets for mandatory training in six of the nine modules.

(Source: Trust Provider Information Request – Mandatory training)

Following our inspection, the trust has provided us with more up to date information and as of July 2018 the trust target was met for all mandatory training modules.

Safeguarding

There were clearly defined systems, processes and standard operating procedures to keep people safe and safeguarded from abuse. Staff understood their roles and responsibilities in relation to safeguarding adults and children.

We observed call takers requesting paperwork to initiate safeguarding alerts. There was an automatic alert process for safeguarding to local authorities.

The trust set a target of 95% for the completion of the safeguarding modules adults and children level 1, and 85% for the safeguarding modules adults and children level 2.

A breakdown of safeguarding training compliance rates by module for all staff in the emergency operations centre (999 and 111) is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Safeguarding Children (Level 1)	600	614	98%	95%	Yes
Safeguarding Adults (Level 1)	599	614	98%	95%	Yes
Safeguarding Children (Level 2)	562	601	93%	85%	Yes
Safeguarding Adults (Level 2)	551	600	92%	85%	Yes

Overall, for the current year to date, all staff in the emergency operations centre have met the trust targets for safeguarding training in all four modules.

(Source: Trust Provider Information Request – Mandatory training)

Cleanliness, infection control and hygiene

The EOC at Northern House was visibly clean and well maintained. We observed desks were clean and tidy.

The EOC at Southern House had tired decoration and heavily stained carpets. The bins were heavily marked and not visibly clean, although they were emptied daily. However, we were informed the area was cleaned before the early shift commenced each morning. Staff were allowed food snacks at their desks, if it did not require using cutlery, and we observed that desks were clean and tidy. Staff informed us that the toilets were not always left in a satisfactory state and were often out of order. The kitchen nearest the staff working area was lacking in attention; such as the seats were worn out with peeling fabric.

The service had processes for identifying patients who were at risk of infection or who presented an infection control risk to those delivering care to them. We observed emergency call takers asking callers whether they knew of any known infections or contagious diseases affecting the patient. Staff recorded this information on the patient's electronic record. The information was then visible to dispatch and ambulance response crews, this allowed them to take the necessary precautions.

Environment and equipment

Both EOC premises were secure and all areas accessed via card entry systems.

The trust used a mobile data system with Integrated Computer Aided Dispatch (ICAD), privacy regulation and Airwave. This provided operational crews with dispatch data, satellite navigation and response statuses.

The EOC at Northern House was spacious and could comfortably accommodate the equipment and staff. Dispatchers were located between the emergency call takers and the clinical service desk which meant that they could communicate easily and seek support. Auditors were at the other end of the room enabling the auditors with a Pathways license to access the call handlers' desks to answer calls during times of high demand.

EOC staff at Southern House informed us their work environment was crowded and noisy. There was no proven impact on patient care, although the noise and layout meant the call handlers and dispatchers were unable to interact easily with each other. There was a plan on display of the

reconfiguration of the layout at Southern House EOC, with completion due before the end of 2018. Staff were aware of the future layout and had been included in the consultation and planning process.

Desktop equipment in both EOCs included computers and multiple monitor screens. Staff were able to access a desk with IT equipment; including computer, monitors, headset and telephone in working order.

Staff told us they had the equipment they needed to carry out their roles. Following occupational health assessments, some staff were provided with equipment that had been adapted for their individual needs, such as lumbar supports. Staff were afforded comfort breaks for disabilities, such as back pain.

The EOC at Northern House and Southern House had an office allocated in the event of a Major Incident. We did not review the room as part of the EOC.

In the event of equipment and software failure, there were systems and processes to ensure the service could continue to operate. Staff we spoke with had not experienced any software failures. If the computer system failed, call takers would still receive information and use paper forms. The forms contained the necessary information required for each call. Staff received training on the paper format when they first joined.

Assessing and responding to patient risk

EOC staff used the NHS pathways clinical tool to guide with assessing and triaging patients. Emergency call takers triaged patients and reached a categorisation disposition based on the information provided using the pathways guidance. All the emergency call takers we observed actively requested scene information that could pose a risk to staff. For example, how to enter the property and the presence of dogs. Call takers ensured this information was recorded and available for the responding ambulance crew.

The trust had procedures in place to manage changes in demand at both sites. The two sites worked as one virtual EOC. Each emergency call was directed to the next available emergency call taker across both centres to facilitate timely response.
The pathways system allowed emergency call takers to give bystanders advice on how to assist the patient before the ambulance crew arrived. We observed an emergency call taker giving advice to a caller on how to maintain the airway of a patient. They did this in a calm manner ensuring the caller understood.

Dispatchers either phoned or messaged the responding crews to inform them of patient risks. We observed that a dispatcher kept close contact with a responding crew to an incident where the patient required restraint and police assistance. Dispatchers could dispatch specialist resources when it was considered to be in the interest of the patient, such as the air ambulance. We observed a dispatcher arrange for the dispatch of the air ambulance to avoid delay. This meant that the most appropriate crew and vehicle was dispatched to meet the patient's needs.

All calls in the category of accelerated clinical triage required the caller to speak to a member of staff on the clinical support desk. This call would either be transferred, if a clinician was free, or referred to the list for a health professional to call the patient back. The emergency call takers also transferred calls when three or more of the callers' answers were 'unsure' to the pathways guided questions. Emergency call takers were confident that they could transfer complex cases to the clinical staff if needed, or to seek advice from them. We observed calls being transferred to a clinician and others where the caller was advised that a clinician would call them back.

The clinical support desks at both EOCs were staffed by qualified nurses and paramedics who were able to provide appropriate clinical support and advice. At Northern House welfare calls, for example those relating to category two calls such as patients who may have suffered a stroke, were made by the clinician. We were told by staff that these patients would receive a welfare call at 30 minutes to assess their breathing, and then a call every 20 minutes thereafter. A category three call was usually responded to within 120 minutes, and in some instances those patients may be treated by ambulance staff in their own home and not transferred to hospital. These calls would receive a welfare call at 90 minutes, and then every hour thereafter from the clinician. A category four call, patients that required support but not urgently, would receive a welfare call at 150 minutes. These time lines reflected those described in EOC directive from July 2018. We observed a clinician who had spoken to a family of a young person assessed as category two, request that the dispatch team responded to the young person as quickly as possible as they were unwell. This approach demonstrated that while patients waited for an ambulance crew, they continued to be monitored and the response escalated as appropriate.

At Southern House, we were told by staff that during periods of high demand an emergency call taker was permitted to make a welfare call to a patient. If the patient's condition had not changed, the call taker documented in the event chronology that the welfare check had been completed. If during the welfare call the patient's condition had worsened, the call would either be transferred to a clinician or placed into the clinician queue to call the patient back.

Northern and Southern House clinicians completed welfare calls based on geographical location. The clinicians felt this provided some patient continuity as local agreements, resources and systems in the North, were less known to the clinicians in the South and vice versa. The arrangement of calls being returned by the clinician in the caller's geographical location meant there was a risk of delay at busy times. At the time of inspection, we saw that patients' welfare were not delayed. Information provided by the trust demonstrated the documentation of a welfare call taking place was included in the call audit process. We were told if this had not been completed this would be discussed further with the individual.

Unforeseen delays were record at the EOC, for example ambulance crew's hospital handover delays. We noted that the day prior to our inspection, there were 12 ambulances waiting to handover at one emergency department which had an impact on ambulance availability. The trust had a range of actions in place to mitigate this risk, this included the new accountable care system which assessed the situation on the site of the emergency department. Other unforeseen delays we observed was when an ambulance on route to a patient had broken down, the next available ambulance was dispatched to the patient but did result in a delay. All time delays were logged and reported back to ambulance operation managers which we were told were assessed daily.

The details of staff on duty were displayed in the EOC and updated daily. This information included the roles and names of key staff such as: M1 Gold, a duty director, Silver 1, Silver 2, TAC 1, TAC 2 and the Medical Incident Advisor. There was a trust wide business continuity plan including a major incident response plan, which all staff we spoke to were aware of. This included the actions taken in the event of either EOC not being operational when calls would automatically be directed to the other EOC as an interim measure.

The EOC could dispatch specialist resources in the event of a major incident, such as the Hazardous Area Response Team (HART) and Helicopter Emergency Medical Service. HART was a specialised team of medical personnel who attended serious and dangerous incidents. This ensured the most appropriate staff, vehicles and equipment were available on scene.

Staffing

The trust used Resource Escalation Action Plan (REAP) for forecasting performance and service delivery influenced by seasonal, weather changes or disruption to staffing levels. The trust assessed staffing levels associated with anticipated changes in demand, such as the World Cup and Royal Ascot and provided additional staff during these peak times.

We were told the last EOC workforce review was undertaken four years ago. The trust informed us that workforce review was ongoing. The trust informed us they had a robust integrated workforce plan (IWP) in place with reports going directly to the workforce development board. This was in line with demand and budget and incorporated a detailed training and education plan. We were told this was reviewed on a monthly basis. The trust considered the EOC workforce review had been superseded by the IWP.

During our inspection we reviewed staffing levels for the 26 July 2018 and found the rota was compliant with planned staffing levels. These included;

- Planned staffing levels for the clinical support desk were compliant for 23 out of 24 hours, at 19.00hrs they were one member of staff short.

- Senior emergency call takers had met or exceeded, by a maximum of two members of staff, the number of staff required for 23 out of 24 hours. However, at 23.00hrs they were under the forecast by two members of staff.

- Dispatchers at Northern House, did not meet the required staffing levels between 6.00 to 18.00hrs by one member of staff.

- Dispatch assistants at Northern House exceeded the requirement number by one member of staff between 10.00 and 17.00hrs, met the requirement during 07.00 to 23.00hrs, but were under the forecast by up to three members of staff between 00.01 and 06.00hrs.

- Dispatchers in Southern House, met or exceeded the requirement numbers for 24 hours.

- Dispatch assistants in Southern House exceeded the forecast between 07.00 and 18.00hrs, but were below the forecast by at least one member of staff during the hours of 00.01 to 06.00hrs and 19.00 to 23.00hrs.

However;

- Planned staffing levels for emergency call takers were met according to their rota line. However, staffing levels did not meet the forecast requirement for 21 hours out of 24 hours. For example, between 18.00 to 21.00hrs the forecast requirement was for 25 emergency call takers, however the EOC had between 17 and 18 emergency call takers during those hours.

We were told by staff there were delays in completing rotas in advance. For example, we discussed the plan for the 6 August 2018 where the rota was not yet completed. The scheduling department explained that it was often the case that these rotas were unable to be completed in advance due to staffing level availability. The trust used a heat map to show staff allocation requirements, this used a colour coded system of green, amber and red. Red demonstrated a significant requirement for staff. An example we observed on the heat map was for Saturday 27 July 2018, where the emergency call takers were rated as red with minus 15 to 20 shifts not filled. The scheduling department had systems in place and worked five weeks in advance to try and increase the number of emergency call takers, either by utilising other trained staff or offering overtime shifts. Trainee call takers were under a separate section within the rota and trainers would only be used for call handling in cases of high demand.

The scheduling team were responsible for scheduling shifts for emergency call takers, senior call takers, dispatchers and dispatch assistants in both EOCs. The shift pattern for emergency call takers consisted of 6 days on and 4 days off. Emergency dispatchers worked 12-hour shifts with an allocated break of 1 hour, this was a set rota that allowed enough time off between shifts. Dispatchers had the responsibility of overseeing the meal breaks for ambulance crews following a clear policy. The aim was to ensure all crews received their meal break within an allocated time period to avoid crews working for excessive periods of time without a break.

At the time of our inspection, the clinical support desk was trialing a self-roster pilot. The clinical team lead decided locally how many clinicians were required to manage the desk and would develop the rota accordingly without the support of the scheduling department. It was recognised that the trust found it difficult to recruit clinicians, to mitigate the risk of shortages of clinicians we were informed one member of the team had been employed on a long-term basis from an agency.

Absence monitoring was in place and was informed by the trust's absence management policy. The policy stated that any member of staff that had 4 periods of sickness in rolling 12 months or 13 working days absence, would be placed on three months absence monitoring.

There was recognition of the problems experienced in recruiting and retaining emergency call takers due to the high pressurised environment. Emergency call takers had a high turnover rate of 39.9%. Some emergency call takers had been promoted internally to assistant dispatcher, while others had left due to the pressure of work. We spoke with some staff who believed the role of dispatch assistant and dispatcher was a career progression from emergency call taker. It was hoped that the new pay deal for unsocial pay would attract some call handlers into the role, although exit interviews had been reviewed and salary had not always been in the top reasons for leaving. Following analysis of the staff survey results for EOC the trust had implemented changes to improve the working environment. These improvements included the kitchen at Northern House and the reconfiguration of Southern House, which was at the planning stage.

The trust reported their staffing numbers for the emergency operations centre as of March 2017 and March 2018.

As of March 2018, the trust reported an overall fill rate of 91.5% for all IWP* rota staff within the emergency operations centre, with 21.8 fewer WTE staff in post than the trust planned to provide safe and effective care.

This has deteriorated since the previous year (March 2017) where the trust reported an over-establishment of 79 more WTE staff in post and a fill rate of 156.5%

A breakdown of planned vs actual staffing levels by job role within the emergency operations centre is shown below:

Job Role	As of March 2017			As of March 2018		
	Planned staff WTE	**Actual staff WTE**	**Overall fill rate**	**Planned staff WTE**	**Actual staff WTE**	**Overall fill rate**
Clinical Staff	39.9	31.0	77.7%	44.1	33.6	76.1%
Dispatch Staff	99.9	80.0	80.1%	100.6	92.0	91.5%
Emergency Call Takers	104.1	107.8	103.6%	113.0	110.2	97.6%
Total IWP rota staff	**139.8**	**218.8**	**156.5%**	**257.6**	**235.8**	**91.5%**

All three groups of staff had less staff in post than planned in March 2018, with emergency call takers the group with the highest fill rate, however, they still reported less staff in post than the previous year where there was an over-establishment of 3.7 WTE.

Clinical staff in the emergency operations centre had the lowest staff fill rates in both 2017 and 2018, with March 2018 seeing a slight reduction reporting 76.1% compared to 77.7% the previous year.

* IWP – integrated workforce planning.

(Source: Trust Provider Information Request– Total staffing)

Vacancy rates

The emergency operations centre has an annual vacancy rate target of 3.0%.

From April 2017 to March 2018 the trust reported an annual vacancy rate of 11.7% for all staff working in the emergency operations centre which was worse than the trust target. The trust was increasing Southern House EOC staff numbers and transferring the vacancy from Northern House where it had been more difficult to recruit to. This would not impact negatively on the service as the EOCs were run as one virtual service with calls being directed to the next available call taker.

A breakdown by job role is shown below:

Job Role	Total vacancies (WTE)	Total number of staff establishment (WTE)	Annual vacancy rate
Clinical Staff	145.5	521.2	27.9%
Dispatch Staff	118.4	1,232.6	9.6%
Emergency Call Takers	98.5	1,336.4	7.4%
Total	**362.4**	**3,090.2**	**11.7%**

All three groups of staff had vacancy rates above the 3% target, with clinical staff in the emergency operations centre having the highest number of vacancies with an annual rate of 27.9%.

(Source: Trust Provider Information Request– Vacancy)

Turnover rates

The emergency operations centre has an annual turnover rate target of 25%.

From April 2017 to March 2018 the trust reported an annual turnover rate of 28.0% which was worse than the trust target.

A breakdown by job role is shown below:

Job Role	Total leavers (WTE)	Average number of staff establishment (WTE)	Annual turnover rate
Dispatch Staff	14.5	92.8	15.6%
Clinical Staff	8.0	31.3	25.6%
Emergency Call Takers	41.2	103.2	39.9%
Total	**63.7**	**227.3**	**28.0%**

Dispatch staff were the only group of staff in the emergency operations centre that had a turnover rate lower than the 25% target. Emergency call takers had the highest turnover rate with 39.9%.

(Source: Trust Provider Information Request– Turnover)

Sickness rates

The trust has an overall sickness rate target of 6%.

From April 2017 to March 2018 the trust reported an annual sickness rate of 5.6% for all staff working in the emergency operations centre which was better than the trust target.

A breakdown by job role is shown below:

Job Role	Total absence days	Total WTE days available	Annual sickness rate
EOC Non Clinical Staff	5,255.7	85,280.9	6.2%
EOC Clinical Staff	251.7	12,422.4	2.0%
Total	**5,507.5**	**97,703.3**	**5.6%**

Both clinical and non-clinical staff had sickness rates that were better than or in line with the trust target of 6%.

(Source: Trust Provider Information Request– Sickness)

Bank staff usage

The trust did provide data but unfortunately there were errors in their submission where the trust had copied figures over incorrectly, resulting in errors in certain fields. They have also only submitted the hours of work provided by temporary staff without also including the total hours available, so it has not been possible to analyse it. Therefore, we were unable to report on the % of bank staff used in the EOC.

(Source: Trust Provider Information Request – Bank and agency tab)
The EOC used bank staff as appropriate and were supported with training and development. The bank staff we spoke with were satisfied with the number of hours they worked and the support they received.

Records

The trust had an information management policy. Patient records were initiated at the beginning of a call and stored electronically on the NHS pathways system. Access to computers was password protected. Call handlers documented the caller's name and, in cases where this was not the patient, also confirmed the patient's details. After establishing the category of call and address to

attend, they confirmed the patients' date of birth, registered doctor's surgery and gender. There was the option of including 'special notes' to alert staff of safety risks and important information, such as key codes to access properties. Staff updated records as more information became available. Records were colour coded to indicate priority and response.

There was a year to date NHS pathways audit compliance report demonstrating oversight of the audits undertaken by month. Calls were recorded and monitored to ensure patient safety and the appropriateness if the information obtained by both call auditors and the clinical support desk. During March 2018, non-clinical staff within the EOC had 89% call audit compliance and 11% non-compliance. Clinical staff had 95% call audit compliance and 5% non-compliance. If a member of staff failed the call audit, they received training with an auditor. We were told all staff had one to ones to discuss performance including audit findings.

Medicines

Staff followed the NHS pathways protocol for advice and obtaining information from the patient or the caller.

We observed call handlers asking patients whether they were taking any medicines or pain control medication and provided advice accordingly. The information received and advice given was recorded in the patient's call record and shared with the clinical support desk and attending crew. This informed the care the patient received. Call takers were also able to obtain advice relating to medicines from the clinical support desk to ensure accurate information was provided to the caller.

Incidents

The service had a system in place to report and respond to incidents. Staff we spoke with felt comfortable raising incidents and reported these to managers through the electronic incident reporting system. Staff received feedback from incidents they had reported. However, we were not provided with any specific examples of when this had occurred or the changes made to working practices.

Emergency call takers informed us that there was an option for time out from call taking after a distressing call or serious incident. Staff said they received support and felt able to talk to colleagues or managers after difficult calls. Staff could access further support from occupational health or the Trauma Risk Management (TRiM) peer support system if required.

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From May 2017 to April 2018 the trust reported no incidents classified as never events for the emergency operations centre.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported five incidents in the emergency operations centre which met the reporting criteria set by NHS England from May 2017 to April 2018.

Four of the five incidents (80%) within the emergency operations centre relate to treatment delays. All four of these incidents resulted in the unexpected or potentially avoidable death of the patient.

The fifth incident related to the sub-optimal care of a deteriorating patient and also resulted in the unexpected or potentially avoidable death of the patient.

(Source: Strategic Executive Information System (STEIS))

Is the service effective?

Evidence-based care and treatment

Patient's care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and technologies. This was monitored to ensure consistency of practice.

The service used the recognised NHS pathways system to assess calls received by the EOC. Protocols were in place for the assessment and planning of care for paediatric patients, major trauma, obstetrics, cardiac arrest, hyper acute stroke and minor injuries. Staff provided care and treatment based on national guidance and evidence.

All calls were categorised in line with national guidance, for example category one calls were calls assessed as immediately life threatening. Pathways provided emergency call takers with questions based on the patient's urgent medical complaint or condition and offered prompts where required. Emergency call takers chose the most appropriate category for the call based on responses to the questions provided which was colour coded according to priority. We observed a call taker that used the pathways system to assist a caller experiencing chest pain. The call taker established that the patient had already used their prescribed medication for their heart condition which had not relieved the symptoms. The pain was very similar to a previous episode which had been diagnosed as a heart attack. The call taker ensured the caller had no allergies and ascertained whether aspirin was available. The call taker advised the caller to rest and let a relative retrieve the aspirin and clarified the dosage for the caller to take before the ambulance arrived.

The clinical support desk and the Helicopter Emergency Medical Service (HEMS) team could assist call takers. We observed a member of the HEMS team listen to a call and aided the call taker until they considered there was no longer a need for HEMS involvement. Call takers also felt confident in transferring calls to the clinical support desk if they felt they needed further clinical guidance. Staff on the clinical support desk had access to a directory of services and could guide patients to their nearest specialist or contact a specialist on their behalf. For example, a midwife could be arranged for women in the early stages of labour.

Staff also had access to registered mental health nurses (RGN) during twilight hours to seek advice on patients with mental health issues.

The trust employed dedicated auditing staff. The trust audited three to five calls per staff member per month as standard. If call handlers failed to meet 86% at regular audit then they would review the calls with an auditor to understand where and how they could improve.

Pain relief

Patient pain was taken seriously and responded to by the EOC. The call takers assessed pain using the pathways software and provided advice based on this guidance.

Response times

While there is no national target for call answering within five seconds, this information is captured as part of the Ambulance Quality Indicators (AQI). The national mean for call answering time was 13 seconds for July 2018 for this trust the mean was 12 seconds**.** During our inspection we documented the trust answered calls within 5 seconds between 75.5% and 90% over three days. On one of the days, the trust received a surge in calls relating to two significant incidents. The EOC had access to a performance dashboard and procedures in place to respond when performance dropped. We were informed that as demand increased, senior emergency call takers, trainers and dispatchers with a pathways license would assist. During levels of high demand, we were assured that front end messages were used to inform callers.

The trust introduced the new national Ambulance Response Programme in November 2017. The programme resulted in all measures of ambulance systems performance being changed to reflect the new ways of working being introduced. The trust's response data was available against the historical standards up to November 2017, and against the new ambulance response programme measures from this date onwards.

Ambulance clinical outcome measures remain unchanged.

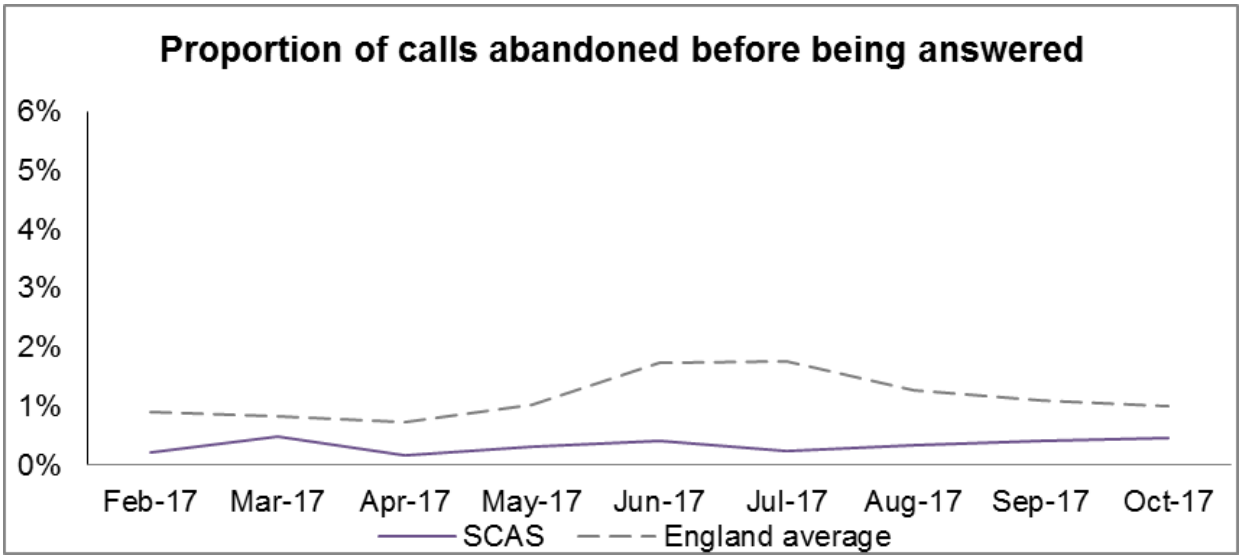
Ambulance systems (AmbSYS) indicators prior to NHS England Ambulance Response programme (ARP):

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

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

Call abandonment

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



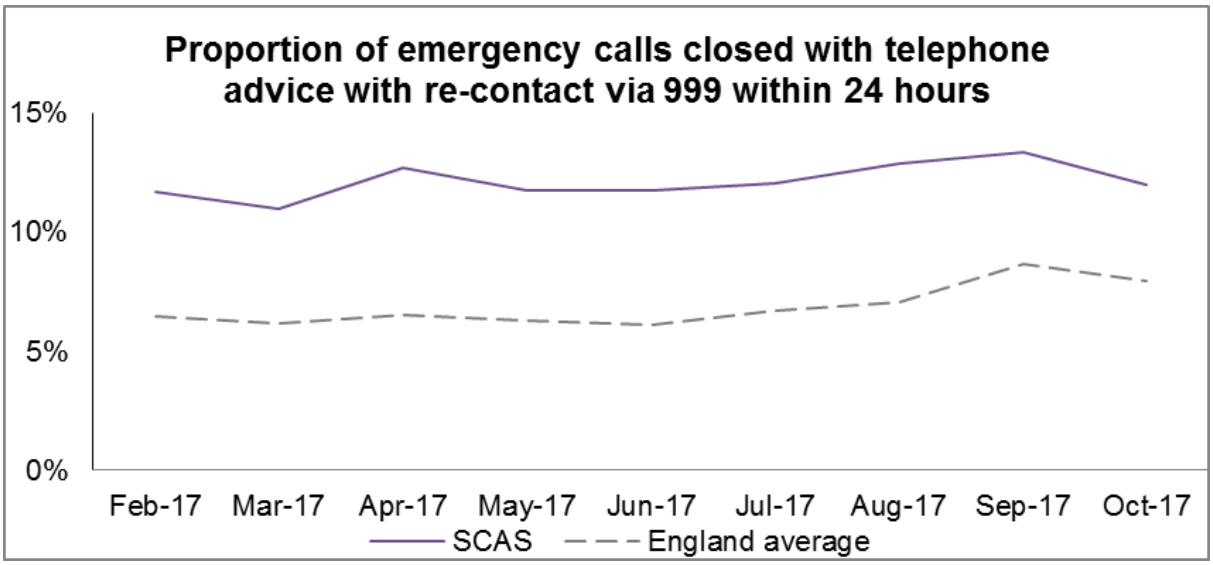
From February 2017 to October 2017 the trust consistently had a lower proportion of calls abandoned before being answered than the England average, ranging from 0.2% to 0.5% compared to the England average of 0.7% to 1.8%.

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

Patient outcomes

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

- Re-contact for different patient
- Patients transported after first attendance on scene

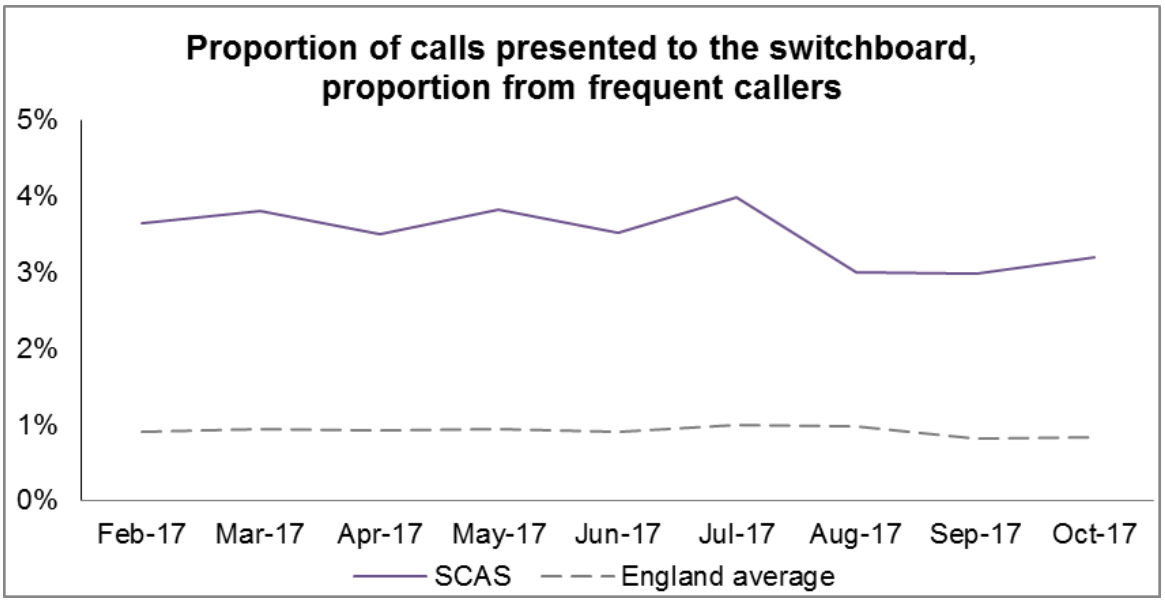


From February 2017 to October 2017 the trust had a consistently higher proportion of patients who re-contacted the service within 24 hours following closure with telephone advice than the England average. The proportion of re-contacts to the trust ranged from 11.0% to 13.4% compared to the England average of 6.1% to 8.6%.

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

We noted the clinical support desk in Northern House completed local self-audits in addition to the trust audit. For example, the clinician reviewed their own calls that had passed the call audit to evaluate whether anything could have been done differently to improve patient care. The clinician assessed whether improvements could have been made to active listening, skilled questioning, communication and how the clinician felt after the call. A reflective piece of writing with analysis, conclusion and action plan was completed as a result of this audit for use with future calls. There was a proposal from the clinical lead to build on this work further in the coming months by referencing clinical decision making within the reflective writing and presenting the findings to other staff to share best practice.

Frequent caller



From February 2017 to October 2017, the proportion of calls from patients for whom locally agreed frequent caller procedure is in place was higher than the England average.

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

The trust had frequent caller procedures in place and individual patient treatment plans for these callers. During the inspection we observed two instances where these callers were managed as per local protocol. For example, the emergency call taker informed the caller that a clinician would call them back and terminated the call. The call taker was then available and answered the next emergency call.

Competent staff

We were told staff were qualified, competent, had the skills they needed to carry out their roles effectively and in line with best practice. We asked for the revalidation data, the trust provided the nurse revalidation data, but not paramedics working in EOC. All emergency call takers we spoke with had training as required. The learning needs of staff were identified through appraisals, one to ones and as part of induction. To monitor compliance with call standards staff completed audit call assessments for all call takers. All staff we spoke with told us they had meaningful supervision in addition to a monthly one to one and annual appraisal with six-month review.

On employment all call takers received a training package to ensure they had the appropriate skills for their role. Staff that had been off work for a period of long term absence completed mandatory shifts with a mentor which ensured they had the skills and confidence to return to their role. Dispatchers and assistant dispatchers received an induction programme that included; ICAD dispatch functions, dispatch protocols, observations, radio communication, emergency services interoperability programme, situation reports, safeguarding, patient handover system, escalation

and REAP, major incidents, special incident desk and the capabilities of other resources such as Helicopter Emergency Medical Service (HEMS), British Association of Immediate Care (BASIC), Ambulance Intervention Team (AIT) and Hazardous Area Response Team (HART). Dispatchers received a competency review and sign off at 3, 6 and 12 months. Assistant dispatchers also undertook call handling to maintain their licence, in particular during times of high demand. The dispatch shift officer had developed a role specific training programme to include major incident and command training internally. Clinical support staff were registered nurses and paramedics, all were pathways trained. All calls were recorded and 1% of all calls were monitored for quality assurance purposes. Call audits resulted in a requirement for training in some instances. Early intervention was established, an action plan was implemented and staff produced reflective learning and feedback would be received.

Staff told us that they used the solo offline training system to practice pathways updates and any calls they felt needed to be practiced. This meant if staff were not familiar with the pathways updates, they were able to gain confidence prior to using in a live situation.

Staff were also provided with other learning opportunities to improve or increase their skills. There were posters advertising non-mandatory drop in events for staff to attend, such as audit training.

Individual teams within the EOC at Southern House had champions for key topics, including sepsis, safeguarding and difficult calls. Champions shared important information across the teams, which we were told enabled sharing of information more effectively.

Appraisal rates

The trust set a target of 95% for appraisal completion.

From April 2017 to March 2018 the trust reported 96% of all staff in the emergency operations centre had received an appraisal. This was a slight drop in appraisal rates from the previous year (98%), but still achieved the 95% target.

(Source: Trust Provider Information Request – Appraisals)

At Southern House we observed a manager, with 4 of their staff, conduct appraisals off site to allow for a dedicated and uninterrupted one-to-one meeting with a social element.

Multidisciplinary working

Each EOC provided coordinated safe care delivery. We observed internal EOC multidisciplinary team working between emergency call takers, dispatchers, clinical advisors, auditors and the scheduling team. These teams and services were involved in planning, assessing, and delivering people's care and treatment. Staff worked collaboratively within their respective EOC to understand and meet the range and complexity of people's needs. All staff worked together to meet the needs of patients. For example, when a GP practice called the EOC to arrange a transfer of a patient with end of life care needs, the emergency call taker was aware of a 4 hour wait and asked their team leader for advice, this was relayed to the GP practice. However, the layout at Southern House EOC meant call handlers and dispatchers were not situated near to each other which meant they could not easily interact, but there was a plan in place to reconfigure this.

There was evidence to demonstrate cohesive working between the clinical support desks at Southern House and Northern House. Every Wednesday between 13.00 and 15.00 alternating clinical support desks would use this time for training, whilst the other covered the calls. The clinical support desks had also trialled no geographical split between welfare calls, although they

felt this did not work due to the well-established relationships they had with the local surrounding services and knowledge of resources and availability.

The scheduling department communicated regularly with the Head of EOC, Northern House, Southern House, shift managers and administration staff. This meant the scheduling team were able to inform the EOCs of any staffing issues.

Dispatch shift officers were responsible for allocating and managing the Hazardous Area Response Team (HART) and the Air Ambulance. This meant resilience operations were integrated into the EOC and patient care was coordinated.

We found some evidence to demonstrate cohesive working between emergency call takers and dispatchers between Northern House and Southern House to discuss availability of ambulances and whether a patient address was close by to either dispatch location. Southern House senior emergency call takers were aware of the rotas for Northern House emergency call takers so they were able to support across both sites.

We observed effective team working between the EOC and external bodies. In peak demand neighbouring ambulance services worked across boundaries, this was also the approach taken to call handling when at busy periods, other trust's EOCs would take calls for the trust.

A mental health nurse was based at Northern House during 18.00 and 04.30 every night. Patients could be transferred, ambulance crews could phone for advice and the clinical support desk could ask for support and guidance. This ensured patients received appropriate care.

We observed the Helicopter Emergency Medical Service liaise with staff in the EOC and offer support to call handlers. The EOC had a separate health care professional line for requesting an ambulance. There were also links with the fire service, police, local hospitals and maternity services.

Labour Line was based at Southern House. The line was staffed by 2 midwives 24 hours a day, 7 days a week and they offered advice to women in labour. They supported emergency call takers and ambulance crews that required help when speaking with or conveying women in labour.

Special notes were used for patients, such as Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR). Special notes were also used to identify risks which were passed on to the ambulance crews to inform the care they provided.

Health promotion

Clinical EOC staff gave advice to patients in relation to accessing further health information or guidance when their condition did not meet the criteria for an ambulance to be dispatched. This ensured the patient received the most appropriate care for their needs.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

The EOC considered patient consent when sharing information, such as safeguarding. Staff informed us that they had training in the Mental Capacity Act 2005. The EOC did not confirm the number of staff who had completed this training and when.

Is the service caring?

Compassionate care

Staff consistently demonstrated kindness, respect and dignity during all interactions with patients and callers in some difficult and demanding circumstances. This included instances such as people experiencing mental health crisis, a road traffic collision and a caller that had discovered a deceased relative.

We observed staff listening to callers in distress, clarifying information where necessary, and arranging the appropriate care. They did this calmly and compassionately. Staff were supportive and reassuring when callers were upset or anxious. Staff were respectful and polite when callers showed challenging behaviour.

Emotional support

Staff supported patients, those close to them and callers in their emotional response to the medical emergency.

Staff comforted callers that were upset, confused, anxious and scared. We observed a call taker offer reassurance to a young person supporting their mother through labour. The call taker ensured the caller understood the actions that were required. Staff communicated clearly and were kind and respectful.

We observed staff show empathy for those in mental health crisis. A call taker ensured the caller in mental health crisis was aware how many miles away the ambulance crew were. The call taker reminded them to not be afraid to let them into their premises to help.

Understanding and involvement of patients and those close to them

Staff understood the importance of involving patients in their interactions. For example, we observed a caller that had phoned on behalf of their spouse. The call taker encouraged the patient to speak on the phone to discuss their medical emergency and care, as well as involving the spouse when suitable.

Staff recognised when patients needed additional support. We observed call takers ask healthcare professionals whether patients would be travelling with a companion. This ensured the correct vehicle type was requested. We observed a caller encouraged to stay on the line whilst the ambulance was on route, the emergency call taker offered regular updates on how far away the ambulance was to be supportive.

Is the service responsive?

Service delivery to meet the needs of local people

The EOC had three core sections; emergency call takers, dispatchers and clinical support that is operational 24-hours a day, every day of the year. Both sites operated as one virtual control room with emergency calls directed to the next available call taker across both EOCs. Both control rooms had linked standard operating procedures. Senior emergency call takers had the rota details for both centres to anticipate demand. Dispatchers and clinical support staff operated as

one service across two sites, except for welfare call back checks where Northern House and Southern House clinical support desks were geographically divided for this task.

The trust had a new smart phone application used to support the standard and enhanced response for community first responders. There were developments to implement for cardiac arrest response, due to commence in October 2018.

The EOC did not have a hear and treat survey recorded on their website, however they did have patient contact surveys. The published 'Member and Patient Survey' report, undertaken in June 2017, results showed that 60% of responders rated the advice given by a call taker as excellent, which was a 10% improvement on the previous year. The survey also reported on the caller's perception on how quickly their call was answered by the ambulance service. 72% thought the time to answer was excellent, and 21% thought the time to answer was good.

Meeting people's individual needs

EOC staff sought to meet people's individual needs. For example, they had access to a language translation service for callers that did not speak English as a first language. The EOC had access to the national relay service for the deaf or speech impaired.

The trust had a frequent caller database and individual patient care plans for callers with complex needs. We observed the frequent caller protocol being followed by an emergency call taker. The patient plan stated the caller received a phone call from the trust every 24 hours. We noted that this plan was being followed and the trust contacted the patient. This avoided the individual making numerous emergency calls that were not always appropriate.

We observed a call taker on the telephone to a child. We were informed that any caller under the age of 16 years would only be stood down by a clinician. We observed a call taker support a young caller on the phone right up until the ambulance crew arrived as they were considered to be in a vulnerable position.

The Mental Capacity Act 2005 policy was in date and included where deprivation of liberty safeguards were required. There were registered mental health nurses based at Northern House during 18.00 and 04.30 every night. This allowed callers to be transferred if required and for emergency call takers and clinicians to request advice during these times.

The service liaised with other services and providers regarding patient needs for transport. We observed a healthcare professional requested an ambulance to transport a patient on the end of life care pathway. The call taker ensured information regarding passengers, mode of transport to the vehicle and any other considerations were recorded and available for the ambulance crew. This ensured the patients comfort.

Access and flow

Calls into the EOC were monitored at all times. The performance of both EOCs was displayed on large screens in the EOC. Staff could see if calls were waiting, how many staff were on calls and how many staff were available. This allowed managers to identify and respond to a queue of calls. If demand increased all pathways trained staff would take calls and managers could invoke a 'no send' of ambulances to category 4 patients. The clinical support desk made an informed decision regarding patient transport once the clinical needs had been established and it was considered appropriate to organise alternative methods.

Dispatchers were able to view screens with the time ambulances were waiting at each emergency department across the trust. A record of performance and reasons for delays was produced.

The national expectation was for ambulance crew to handover to an emergency department in hospital within 15 minutes on arrival. The trust informed us that they had experienced delays at particular emergency departments within the region. During April 2017 and December 2017 delays in handover were reported up to 27 minutes and 20 seconds. We were informed of a recorded delay of a category 3 patient waiting for 109 minutes on the previous day to the inspection. The trust were aware at which hospitals ambulance crews were experiencing delays and liaised with the hospital trusts. Hospital Ambulance Liaison Officers (HALO) were sent to emergency departments when crews were experiencing delayed handovers to intervene and implement immediate cohorting and handover of patients, which meant ambulance crews did not have wait at emergency departments. This ensured resources were available to the dispatchers as crews were not waiting at hospitals for extended periods of time.

When a potential major incident was identified, we observed the service respond effectively and were able to focus resources on the incident. North Hampshire dispatch team in Southern House were given direct support by local managers to focus on the incident until it had been fully assessed, ensuring a timely and appropriate response to the situation.

We were informed that the staff on the clinical support desk could advise callers to arrange taxis for non-urgent patients. This allowed ambulance availability to front line emergencies.

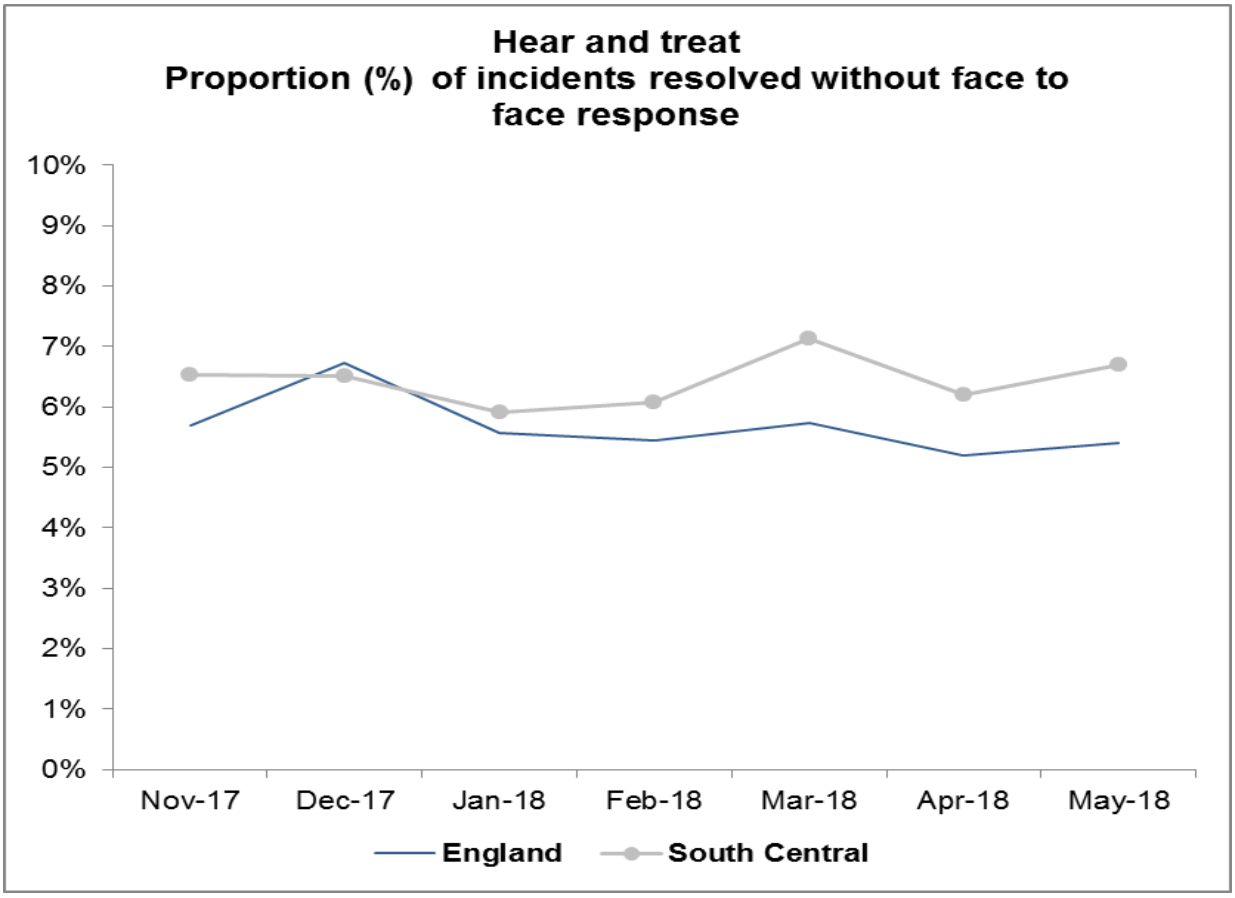
Ambulance systems indicators

The trust introduced the new Ambulance Response Programme (ARP) in November 2017 which included new performance timings and responses to reflect the new way of working.

Calls closed with telephone advice / hear and treat

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

Following the introduction of ARP this indicator had been amended and now related to all calls to the emergency operations centre that were resolved through telephone advice or by referring to another service and where an ambulance was not dispatched.



From November 2017 to May 2018 the trust resolved a higher proportion of incidents without a face to face response than the England average in six of the seven months in the period. Trust performance ranged from 5.9% to 7.1% compared to the England average range of 5.2% to 6.7%.

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

Time to answer call

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

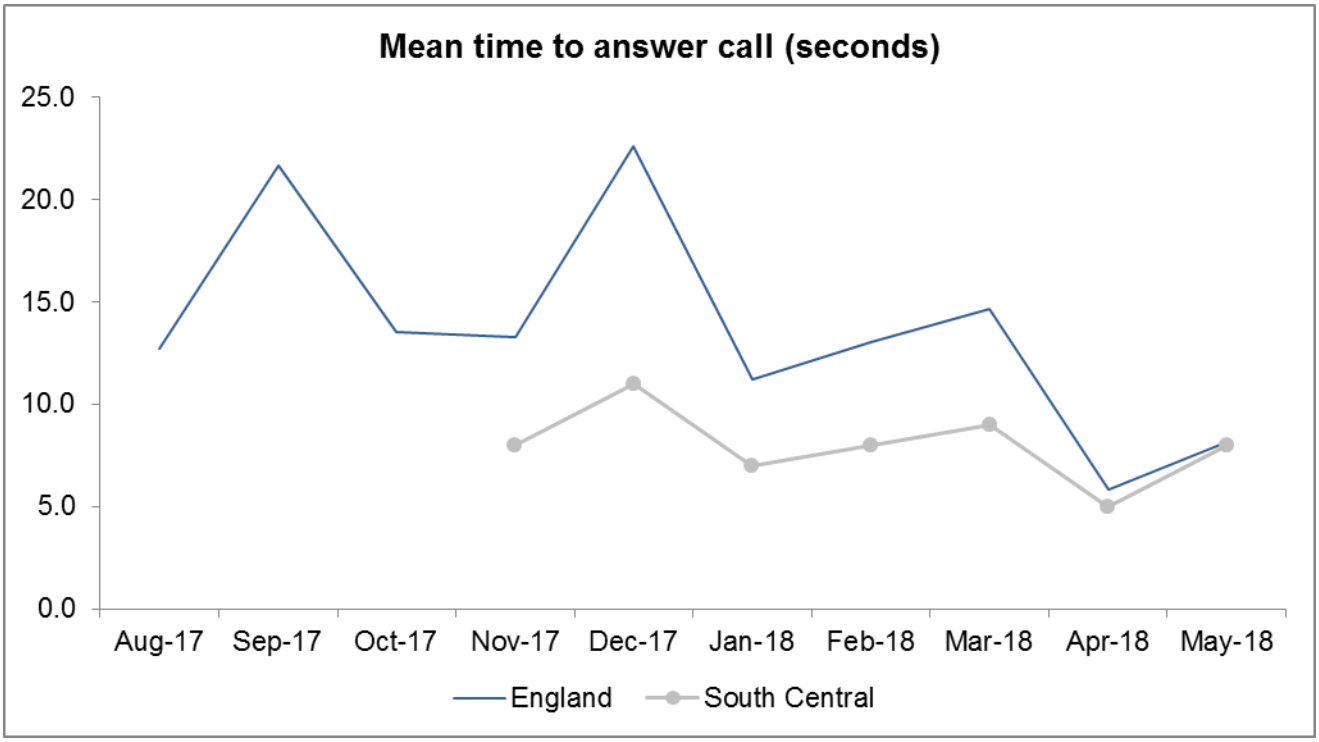
Prior to the ambulance response programme, time to answer calls (emergency and urgent) was previously measured by median, 95th percentile and 99th percentile.

As a result of the ambulance response programme this indicator now includes the mean average time.

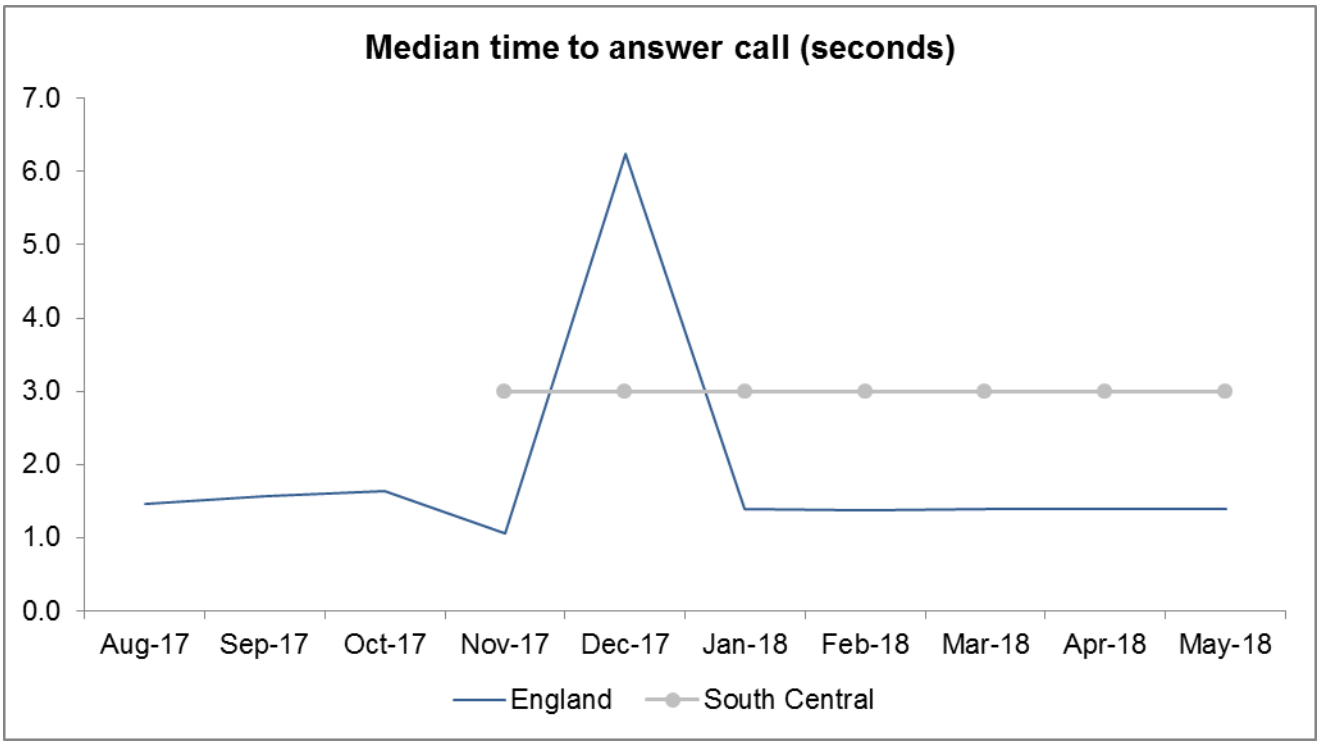
The three existing measures are unchanged.

The metrics measure time to call answering, measured by:

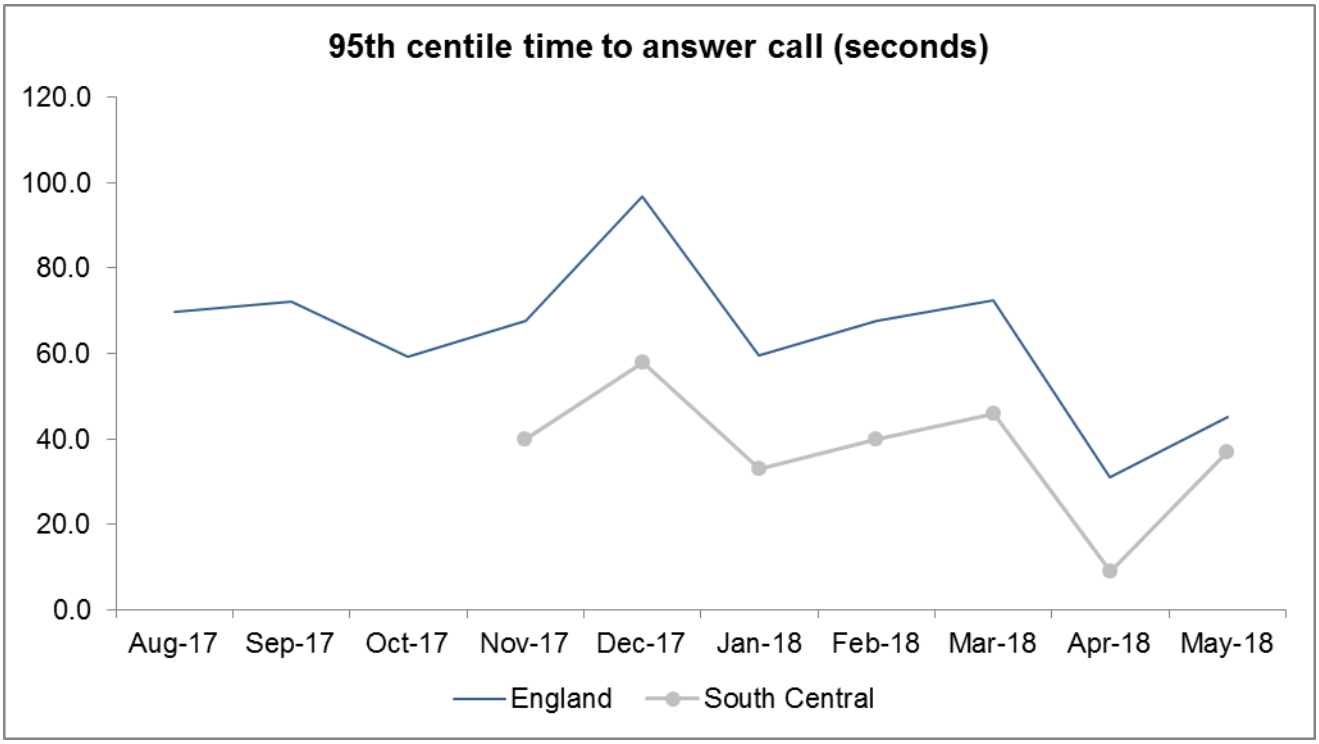
- Median time spent between call connect and call answer (i.e. the time below which 50% of calls were answered)
- Mean average time from call connect to call answer (i.e. total call answer time divided by calls answered)
- 95th percentile of times from call connect and call answer (i.e. the time within which 95% of calls were answered)
- 99th percentile of times from call connect and call answer (i.e. the time within which 99% of calls were answered)



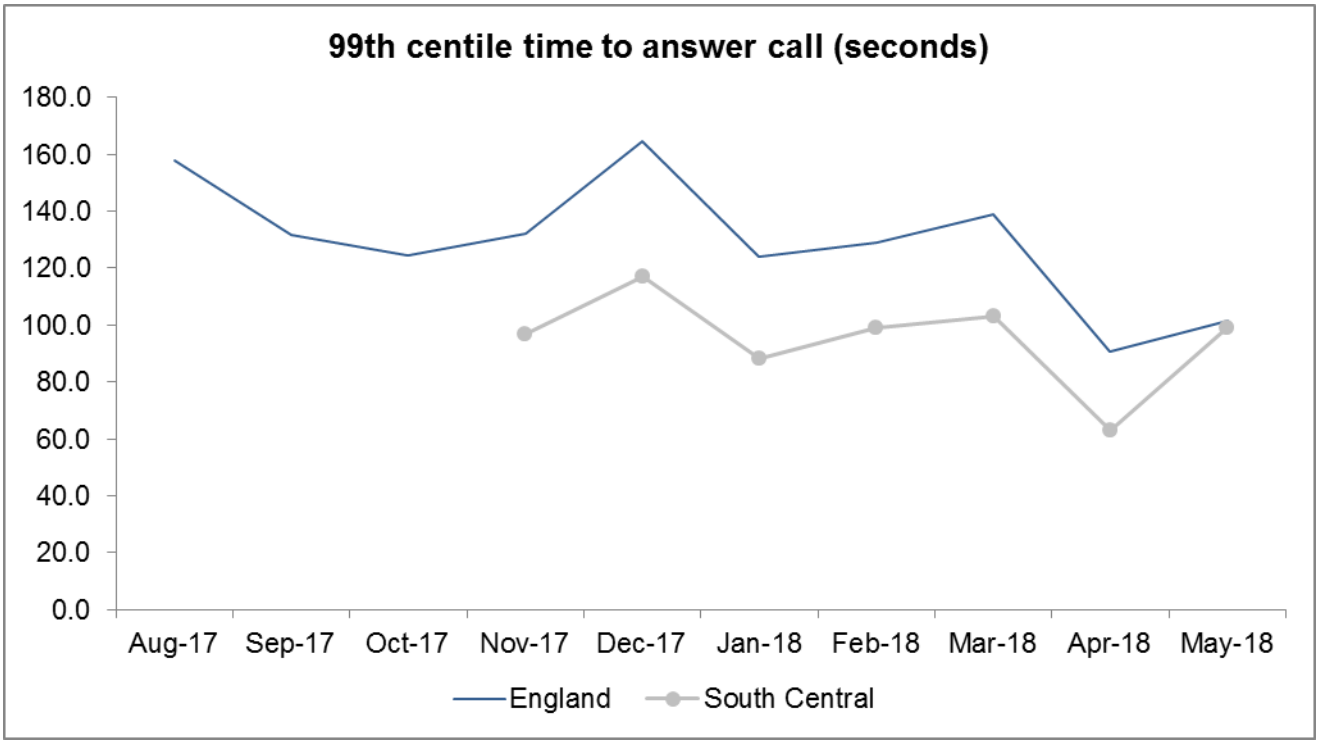
From November 2017 to May 2018 the trust's mean time to answer calls ranged from five seconds to 11 seconds and remained consistently lower than the England average, which ranged from six seconds to 23 seconds for the same period.



From November 2017 to May 2018 trust's median time to answer calls has remained stable at three seconds throughout the period, which was slightly higher than the England average of one second for each month in the same period, aside from December 2017 where the England median rose to six seconds.



From November 2017 to May 2018 the trust's 95th percentile time to answer calls ranged from nine seconds to 58 seconds. This was consistently lower than the England average, which ranged from 31 seconds to 97 seconds.



From November 2017 to May 2018 the trust's 99th percentile time to answer calls ranged from 63 seconds to 117 seconds. This was consistently lower than the England average, which ranged from 91 seconds to 165 seconds.

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

Learning from complaints and concerns

From April 2017 to March 2018 South Central Ambulance trust received 75 complaints relating to the emergency operations centre (17% of all complaints received).

Transport was the subject with the most complaints, accounting for 81% of all complaints about the emergency operations centre, the majority of the complaints about transport relate to delays in ambulances being dispatched or arriving on time.

Of the 75 complaints about the emergency operations centre, six were still open at the time the trust submitted their RPIR. Of the closed complaints the trust took an average of 31 working days to complete, which is not in line with their complaints policy which states complaints should be closed within 25 days (unless an extended timescale has been agreed). We were informed by the trust where they were unable to provide a response within 25 days an extension would be agreed the complainant.

A breakdown of complaints by subject is shown below:

Subject	**Total**
Transport	61
Values & Behaviours	7
Other	4
Communications	2
Delay/Non-Attendance	1
Total	**75**

(Source: Trust Provider Information Request – complaints)

The trust welcomed and encouraged the public to share their views and experience of using the service. There were links and guidance on how to feedback to the trust on their website.

The trust stated that although a formal complaint may have exceeded the target timeframe for a response, they felt assured that each complaint received a full investigation by a team leader. The process included a senior member review of responses along with the investigating officer as required. Every formal complaint investigation and response was reviewed and signed off by the Director of Service.

One of the complaint's themes was the delayed allocation of ambulances to patients. We were told that if SCAS were unable to provide a resource within the allocated time, the trust apologised to the complainant that they did not have available resources at the time and they upheld those complaints. The trust were engaged in system wide initiatives, such as Hospital Ambulance Liaison Officers (HALO), to reduce the impact of hospital handover delays had on patients waiting for an ambulance in the community.

The trust told us that staff attitude and communication issues reported had reduced. Actions were taken to deal with attitude and communication themed complaints. These were upheld or partly upheld and managed at local level and involved staff reflections and mentoring.

Is the service well-led?

Leadership

Leaders had the experience and capability to provide effective leadership with clearly defined roles and responsibilities. Leaders understood the challenges surrounding good quality care and risks to performance were addressed.

Leaders were visible in both EOCs. We observed that staff were clear about the leadership and managers demonstrated confidence and trust in their staff. Monthly one to one meetings allowed staff to discuss any problems or issues and managers addressed these concerns, including sickness rates.

Managers appreciated their staff and provided them with positive feedback regarding their performance and felt face to face recognition was important. Northern House displayed the EOC 'family tree' with the most senior person as the seed at the bottom of the tree, the managers and shift officers were displayed as the trunk and dispatchers and emergency call takers were the branches.

Staff were engaged with change in both EOCs. Staff we spoke with at Southern House had been included in the new floorplan design, which was due to be implemented at the end of the year.

Most staff we spoke with at both EOCs felt managers were approachable. Most staff said they felt confident to raise any concerns with them and therefore were supported in their work.

Vision and strategy

The trust vision, values and strategy were clear and driven by quality and sustainability. There were well defined objectives that were relevant and achievable.

Staff we spoke with were aware of the trusts vision and strategy. The EOC at Southern House was divided into teams of 8 staff, each with their own colour. Each team had their own clear values displayed which aligned to the trusts vision.

EOC management attended meetings bi-weekly and monthly at each of the EOCs. EOC level, and cross site meetings were attended quarterly. Managers were able to explain how their role, and the EOCs role, contributed to achieving the trust's strategy.

EOC staff were part of the Ambulance Response Programme (ARP) pilot for 18 months and assisted in shaping the ambulance service nationally.

The EOC were involved in delivering the trust strategy and attended regular meetings with the education lead and 111 services. Discussions had taken place regarding the opportunity for 111 call takers and emergency call takers to trial as joint call takers in Northern House.

All staff we observed and spoke with demonstrated a commitment to teamworking and high level of professionalism to provide a safe, caring and high-quality service for service users.

Culture

Most staff felt respected, supported and valued. There were processes to promote staff positive well-being including healthy eating. Staff health and well-being was measured via staff survey and the results instigated changes which were implemented throughout both EOCs.
Most staff we spoke with were positive about the trust's culture. Support for staff was available from colleagues, team leaders, managers, occupational health and outside agencies. Staff were aware that they could have time out after distressing calls and that support would be available to them. We found that staff were given cards with helpful telephone numbers at induction; these included details for an employee assistance programme, occupational health, TRiM and MIND charity. Extra counselling was available to staff, their manager referred them to either occupational health, experienced in emergency services, or a TRiM practitioner. If necessary, mental health assessment would then be arranged through HR and further counselling provided.

The trust had signed a pledge with MIND charity and received advice and guidance from them. Recently, the trust had requested MIND to initiate a mental health resilience training programme with an emphasis on EOC staff initially.

Staff at both EOCs felt connected to teams within their own EOC, were dedicated to patient care and were supportive of each other.

Northern House displayed a 'pride wall' and had a staff working group that met monthly to discuss staff survey results. There were 'employee of the month' and 'person of the year' awards. Southern House was undergoing a reconfiguration to improve team working further between call takers and dispatchers. Staff had been consulted with on this and felt included as a result. However, we found that there were less call takers at Northern House and Southern House provided the additional cover needed as a result on a regular basis to meet the needs of patients.

Governance

There was a trust governance structure. There were some governance procedures in place, however these were not fully established.

Internal audit had a positive impact on quality governance. For example, the quality assurance team audited all emergency calls and monitored operational performance against national requirements.

The EOCs had shared standard operating procedures to ensure a consistent approach. There were a range of policies and procedures in place for staff to follow to meet the trust's expectations and purpose. These included safeguarding, consent, mental capacity, clinical pathway audits and clinical records policy. A head of department call took place across the two sites daily to discuss EOC performance. Managers held a monthly management meeting within their own EOC and a cross site meeting quarterly. Senior EOC management meetings took place on a bi-weekly basis. Managers maintained oversight of Category One jobs, incidents and staffing levels. Integrated workforce planning meetings took place monthly.

Complaints were monitored and investigations completed, however the responses to patients were not always timely. The main theme resulting from the complaints related to delays, the trust held a long wait review group which used the Ambulance Response Programme (ARP) definition for reviewing long waits. Patient harm remained low across all categories of calls. The trust engaged in system wide initiatives to reduce the impact of hospital handover delays.

Management of risk, issues and performance

The organisation had the processes to manage current and future performance. The EOC maintained a risk register. The register included a risk relating to the inability to recruit and retain experienced staff. The actions taken to mitigate this risk included the ongoing work with the

recruitment team to improve staff retention rates in EOC. It was recognised in January 2018 that clinical service desk staff in Southern House were leaving and at Northern House, staff vacancies meant it was not always possible to meet the planned staffing levels. The risk register detailed that a watching brief was required since the implementation of the Ambulance Response Programme (ARP). The EOCs at both sites were recorded as a major exporter of staff to other areas of the trust, for example to field operations and NHS 111.

In the event of equipment and software failure, there were systems and processes to ensure the service could continue to operate with the use of paper forms. The forms contained all the necessary information required for each call. Staff were confident in transferring to this paper system if necessary.

The trust used Resource Escalation Action Plan (REAP) for forecasting performance and service delivery, influenced by seasonal, weather changes or disruption to staffing levels. This meant staffing levels could be increased during times of expected high demand.

The trust had an incident management procedure in place which established impact from low, moderate, significant, severe and critical. This plan stated at what level these incidents would be managed, for example by a local manager, senior manager, Silver Commander, Gold Commander, Tactical Advisor, Executive Director or Trust Incident Management Group. There was an incident response plan that covered single site events through to complex multi sited scenarios. The EOC had action cards that related to roles in the event of a major incident. Staff we spoke with knew the procedure for a major incident and what would be expected of them.

There was a major incident policy in accordance with national guidance. EOC Staff received resilience and major incident training during their induction training and through their team training sessions. Policy was followed when EOC Northern House had experienced a major incident in relation to the collapse of a building in 2016.

We were provided with a copy of the EOC risk register dated April 2018, this included risks impacting on the EOC that leaders had discussed. The risk register was shared with staff at a local level and safe practices were applied, for example call audit, clinical audit, reflective learning, lessons learned bulletins and the potential for revision of standard operating procedures.

The EOC risk register included a risk relating to the lack of a dedicated EOC clinical governance lead in March 2018 and the impact this had. For example, that duty of candour may not be assessed for serious incidents. This trust told us this was mitigated by experienced clinical governance leads from urgent and emergency care and the 111 service, looking at incidents and attending the EOC governance meetings.

From the public board meeting minutes of 29 March 2018 the risk, assurance and compliance committee had identified the top three risks in order to provide additional focus. These were in relation to the handover delays experienced at some hospitals, the impact of the new ARP process meant that the risk had developed from implementation to the delivery of the operating practices. Thirdly, the delivering of statutory and mandatory training compliance with the trust's targets.

Information management

There were arrangements for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. IT systems were used effectively to monitor emergency calls and patient care.

Staff easily accessed protocols, policies and emails required for their roles through the local restricted network.

The NHS Pathways system was used by emergency call takers to make dispositions on emergency medical requirement and the need for appropriate assistance. The system allowed call takers to ask systemised questions to callers and provided call takers with prompts and instructions to aid in advice given. Staff working at EOC had visibility of where ambulance vehicles were located. This allowed dispatchers to make informed decisions relating to vehicle response and for call takers to advise callers how far away an ambulance was from them.

'Special alert' notes to ambulance crew staff were held on some patients record and if no further entry to the record had been made after one year, the information was removed in line with data protection.

FEngagement

The service proactively engaged with staff, ensured that their voices were heard and acted upon to shape culture. This was done through staff surveys, one to ones and health and wellbeing roadshows.

Staff received recognition for hard work in the form of 'staff of the month'. Staff we spoke to felt there were plenty of opportunities for career progression and they felt they were supported with training.

EOC participated in the staff survey and the results informed changes within the EOCs in 'you said, we did' approach. Staff working groups were devised and met once per month to discuss a range of categories and implement changes within the EOC. Staff provided an example where once a month they could pay £1 to dress in civilian clothing which would go towards supporting the SCAS charity. Staff informed us that in September 2018, there would be a week of celebrating the EOC.

Scheduling had also implemented changes as a result of the staff survey. This included staff being able to download an application to use on their smart devices to book their leave. This meant they received an instant reply as to whether this had been approved or not.

We were told by the Health and Wellbeing lead that EOC staff were provided with yoga and stretches they could do at their desk from the trust.

The relationship between EOC and frontline staff was recognised as important. EOC staff were given the opportunity to complete third manning shifts with frontline crews, and frontline crews were able to sit with emergency call takers in the EOC. This arrangement increased staff knowledge of each other's roles.

The trust used their newsletter to offer national and seasonal advice to staff. Roadshows were also used, approximately four times a year, to visit frontline and EOC staff to offer advice, health promotion, awareness and to improve team working.

Healthy eating was something the trust took seriously. Vending machine companies were contacted regarding supplies and informed that if they did not comply with 80% healthy eating choices (less than 250 kcals) and 20% of drinks containing 5gs sugar per 100ml, they would remove the contract. The trust had consulted with staff regarding preferred options and feedback had shown a preference for breakfast options. As a result, the trust was picking items such as raisons, snack bars, boxes of cereal and porridge.

Learning, continuous improvement and innovation

The EOC used standardised improvement tools and methods, such as audit and self-reflection. Staff working in the clinical support desk advised us that they completed peer reviews, listened to each other's calls and used check sheets to provide feedback to colleagues on their performance.

It was recognised by the trust that it was difficult to recruit clinicians and an example was given of GP services paying Band 7 rate of pay with no unsociable hours. The clinical support desk and scheduling informed us that a trial was being arranged post summer, to attach six frontline qualified military paramedics to the clinical support desk within EOC. The trust would train these personnel in Pathways but they were effectively paid by the Ministry of Defence as they would be undertaking a placement. This would mean more clinical staff available at EOC.

The Child Protection Information Sharing project (CPIS) was in progress, which was in conjunction with NHS Digital for all ambulance trusts. SCAS was part of the national project group assisting in the processes required before national rollout. The trust were keen to support a project that would benefit vulnerable children.