Isle of Wight NHS Trust

Ambulance Service

Quality Report

St Marys Hospital
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This report describes our judgement of the quality of care at this provider. It is based on a combination of what we found when we inspected, other information know to CQC and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this ambulance location	Inadequate
Emergency and urgent care services	**Inadequate**
Patient transport services (PTS)	**Requires improvement**
Emergency operations centre	**Requires improvement**

Summary of findings

Letter from the Chief Inspector of Hospitals

The ambulance service is an integral part of Isle of Wight NHS Trust. . The ambulance station and headquarters are based at St Mary's Hospital, in Newport. The service responds to 999 calls, 24 hours a day, 365 days a year. The trust also provides a Patient Transport Service (PTS) which provides transport 7 days a week for service users in cases of medical need for outpatient appointments, admissions, discharge and transfer.

The Isle of Wight covers 147 square miles. There is a fluctuating population throughout the year with a resident population of approximately 140 000, swelling to upwards of 230 000 throughout the summer months and during island based events.

The ambulance service employ around 145 people including approximately 52 paramedics, 29 emergency vehicle operatives (emergency care assistants), 11 PTS staff 12 clinical advisors and 36 dispatch staff /call centre staff. They have at their disposal, 10 emergency ambulances, 10 rapid response vehicles (RRVs) and three co-responder vehicles.

Between April 2016 and September 2016 the PTS provided 4677 journeys, an average of 780 journeys per month. For the year 2015/16 the ambulance service took 24597 calls.

We carried out an unannounced comprehensive inspection of the ambulance service including the emergency control centre, the urgent and emergency care service and the patient transport service on 22-24 November 2016

We rated the ambulance service provided from St Mary's Hospital part of the Isle of Wight NHS trust as Inadequate overall.

- Although staff knew how to report incidents the trust could not be assured that all front line staff were reporting all incidents and learning was cascaded. There was a mixed understanding of the principle of the duty of candour.
- The ambulance station was not secure. The mobile data terminal used to provide staff with patient information and navigation was unreliable. Confidential information, medicines and cleaning products were not always securely stored in the urgent and emergency care service.
- On the front line, emergency and urgent staffing levels meant shifts operated at minimum levels. On the EOC staff worked flexible to maintain a safe service although they were not consistently staffed to the planned levels. Staffing levels for the PTS service were well managed
- Mandatory training was not always completed to the level expected by the trust and and not all staff had received an annual appraisal. However, all permanent staff in the PTS had received an appraisal in the previous 12 months. There were a comprehensive induction programmes in place for staff. Not all staff with professional registered had an individual learning plan in place to support their development. There was no formal system for ensuring those Community First Responders registering for duty were competent in their role. Call handlers had not had training in the Mental Capacity Act (2005), or learning disability, or dementia awareness. Front line staff had not had specific training on supporting patients experiencing a mental health crisis and had not completed the required refresher training on resilience in the event of a major incident.
- For patients, for whom English was not their first language or who were not able to communicate verbally, there were no communication aids on the ambulances. Staff had access to language line and the SMS system in the control centre to help with communication with all patients.
- There was no clear vison or strategy for the service. The governance framework used to monitor the quality and risks of the service was not effective. The risk register did not reflect all of the current risks of the service.
- Delays in handover at the emergency department and the service running at minimum capacity meant people could not always access the service in a timely way. The trust response times were consistently below the expected target and patient outcomes where not as expected for patients suffering a heart attack. The proportion of emergency calls

Summary of findings

resolved by telephone advice was lower than expected and calls abandoned before being answered was consistently higher than expected. However, the trust consistently had the shortest waiting times of any trust in England for call answering. The proportion of patients who re-contacted the service following discharge of care, by telephone within 24 hours was lower than the England average.

- The trust had processes in place to respond to feedback from patients and members of the public. Complaints were investigated with a written response to the complainant. However, complaints were not always responded to in the agreed period of 25 days.
- Morale was low amongst ambulance staff. While they spoke highly of the support they were given from their direct line managers and were proud of the strong sense of team work, they felt there was insufficient knowledge and experience amongst the senior managers within the clinical business unit to effectively manage the service. A number of managers were in interim roles and staff felt this impacted on their ability to be effective.
- In general, vehicles were clean with deep cleans taking place. Infection control policies with in the patient transport services were not consistently adhered to particularly concerning hand hygiene.
- The service co-ordinated effectively with other emergency and community healthcare services. The multi-agency hub was used to co-ordinate care with other agencies when patients were discharged at the scene.
- Staff treated people with dignity, respect and kindness during all interactions. They were compassionate and kind and showed empathy when caring for patients.
- The PTS service was able to meet the individual needs of patients and was accessible to patients who met the eligibility criteria set by commissioners. There was good use of risk assessments to reduce the risks to patients and staff.

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

Importantly, the trust must ensure:

- All ambulance staff are provided with training on Duty of Candour regulation and this is adhered to
- The ambulance station door is repaired to ensure the station is secure.
- Vehicles are kept locked and secure at all times
- There are sufficient numbers of suitable qualified and competent staff, and managers, to provide a safe, effective and responsive ambulance service.
- Cleaning products are securely stored in line with the Control of Substances Hazardous to Health (COSHH) requirements.
- Risks across the ambulance services are identified, assessed and managed appropriately. Risk registers are current, with a responsible person allocated to monitor completion of each action.
- A review and action to ensure the ambulance service and trust are meeting all national requirements in relation to emergency preparedness, resilience and response.
- Patient records are stored securely at all times.
- Improved response times and performance on key performance indicators and national targets for urgent and emergency ambulance service.
- Staff observe good hand hygiene practice and this is audited.
- The quality and performance of the patient transport service is monitored, including the national KPI for arrival and collection time of patients attending for dialysis.
- Staff are able to report incidents and learning is shared and implemented.
- All staff have an appraisal and individual learning plans.

In addition the trust should:

- Complete a review of the storage of medical gases at the ambulance station and ensure all gas bottles are stored securely and in line with national guidance.
- Regularly changes the codes for medicines cupboards on vehicles

Summary of findings

- Ensure the practice in patient transport services and trust medicines policy are aligned.
- Review the system provided on the mobile data terminal to ensure it is reliable and fit for purpose.
- Review the provision of equipment for the safe transportation and care of children.
- Provide adequate staff training in mental health and dementia awareness, which is updated at regular intervals to ensure that mental health knowledge is current.
- Ensure a multi-lingual phrase book is stored on all vehicles at all times to support patients to receive safe care and treatment.
- Consider providing a communication aid to support patients who are unable to communicate verbally.
- Implement actions in response to the investigation reports and improve the ambulance service culture.
- Implement a formal system for ensuring those Community First Responders registering for duty are competent in their role.
- Provide training for all staff in Mental Capacity Act (2005).
- Ensure timely response to complaints.
- Monitor staff are up to date and compliance with mandatory training is monitored.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Emergency and urgent care services	Inadequate 	The ambulance station was not secure. The trust could not be assured that staff were reporting all accidents and incidents and learning was cascaded. Front line staff did not have an understanding of the duty of candour. The mobile data terminal used to provide staff with patient information and navigation was unreliable. Confidential information, medicines and cleaning products were not always securely stored. Staffing levels meant shifts operated at minimum staffing levels, which made it difficult to support the transfer of patients to the mainland. Compliance with mandatory training was below the trust target level of 80% and not all staff had received an annual appraisal. Staff had not completed specific training on supporting patients experiencing a mental health crisis. For patients, for whom English was not their first language or who were not able to communicate verbally there were no communication aids on the ambulances. The governance framework used to monitor the quality and risks of the service was not effective. The risk register did not reflect all of the current risks of the service. Delays in handover at the emergency department and the service running at minimum capacity meant people could not always access the service in a timely way. The trust response times were consistently below the expected target and patient outcomes where not as expected for patients suffering a heart attack. The trust did not monitor if they has responded to complainants within the agreed timeframe as part of the quality monitoring of the service. Morale was low amongst ambulance staff. While they had confidence in their immediate managers they felt there was insufficient knowledge and experience

Summary of findings

amongst the senior managers within the clinical business unit to effectively manage the service. There were no team meetings and memos and emails were the main route for communication

Staff followed infection prevention and control procedures to reduce the risk of the spread of infection. Vehicles were clean and tidy and staff kept ambulance well stocked.

Staff provided care to patients in line with national guidance. The service had processes in place for staff to get additional clinical advice, if needed, and completed audits to monitor staff adherence to national clinical guidelines.

The service had a comprehensive induction programme in place for staff. Staff had an individual learning plan in place to support their development.

There was good multidisciplinary team working between ambulance crews and other emergency teams. The multi-agency hub was used effectively to co-ordinate care with other agencies when patients were discharged at the scene. The proportion of patients who had suffered stroke who followed the correct initial patient's pathway was good.

Staff asked patients for consent before starting observations or treatment and completed mental capacity assessments when patients were unable to provide consent.

Ambulance staff took the individual needs of people accessing the service into account when providing care and treatment. Frontline staff were focused on giving good quality care to patients.

The trust had processes in place to respond to feedback from patients and members of the public. Managers investigated complaints and provided a written response to the complainant.

Staff provided compassionate to patients and their families care. They were kind and showed empathy when caring for patients.

Summary of findings

Patient transport services (PTS)

Requires improvement

The service was able to meet the individual needs of patients and was accessible to patients who met the eligibility criteria set by commissioners. There was good use of risk assessments to reduce the risks to patients and staff.

Team leaders demonstrated strong leadership and used their skills and experience to improve the service.

There were systems in place to manage anticipated resource and capacity risks with a flexible workforce. A new late shift had been agreed to extend the operating hours of the service and facilitate discharge from the emergency department.

Staff were caring and compassionate in their interactions with patients and made an effort to develop supportive relationships with patients, particularly regular users of the PTS.

Staff reported incidents, received feedback and learning was shared across the service. However, staff were not familiar with their responsibilities under the Duty of Candour regulation.

Staff were positive about the induction process and the support they received from their team leaders. All permanent staff had received an appraisal in the previous 12 months.

Policies relating to the PTS were past their review date. There was no regular monitoring of the quality and performance of the PTS through, for example, setting of key performance indicators (KPI) including the national KPI for arrival and collection time of patients attending for dialysis.

No audits of the service had been carried out, including infection control audits to ensure compliance with policies and procedures.

Although staff said they had undertaken mandatory training, the trust did not provide data to confirm uptake of all the mandatory training.

Radio reception and connectivity in some areas of the island was poor which meant staff used their own mobile phones to contact dispatch or use satellite navigation systems.

Summary of findings

Limited feedback on patients' experience was obtained for the service and patient information on complaints was not readily accessible.

Emergency operations centre

Requires improvement

There was no assurance all staff members had received an annual appraisal, with learning plans developed as part of this process. There was no formal system for ensuring those Community First Responders registering for duty were competent in their role. Call handlers had not had training in the Mental Capacity Act (2005) or learning disability or dementia awareness.

The proportion of emergency calls resolved by telephone advice was lower than expected and calls abandoned before being answered was consistently higher than expected.

Staffing levels in the EOC consistently did not meet the planned levels. Although staff worked flexibly to manage the potential risk.

Staff they felt there was insufficient knowledge and experience amongst the senior managers within the clinical business unit to effectively manage the service. They also raised concern about the number of managers in interim roles and their ability to make decisions.

There was no clear vision or strategy for the service. The number of meetings and the complexity of the reporting structure made it difficult to clearly see how oversight of the quality and risk of the service were maintained. The risk register was not reflective all of the current risks.

There was no formal process for engaging with patients.

Staff were aware of how to report incidents and learning from incidents was displayed for staff to read, however most staff where not able to describe any learning from incidents.

Staff were aware of how to give safe advice on self-medication.

Staff had a good understanding of how to recognise and report safeguarding.

Summary of findings

The EOC had plans and back up arrangements to ensure service continuity in the event of a business continuity incident.

The service co-ordinated effectively with other emergency and community healthcare services.

The service used the accredited NHS pathways system to triage calls and provide clinical advice.

The trust consistently had the shortest waiting times of any trust in England for call answering. The proportion of patients who re-contacted the service following discharge of care, by telephone within 24 hours was lower than the England average.

Staff treated people with dignity, respect and kindness during all interactions.

The service made reasonable adjustments and took action to remove barriers to enable people to access the service easily.

Staff in the EOC spoke highly of the support they were given from their direct line managers and were proud of the strong sense of team work.

Ambulance Service

Detailed findings

Services we looked at
Emergency and urgent care; Patient transport services (PTS); Emergency operations centre (EOC);

Detailed findings

Contents

Background to Ambulance Service

The ambulance service is an integral part of Isle of Wight NHS Trust. . The ambulance station and headquarters are based at St Mary's Hospital, in Newport. The service responds to 999 calls, 24 hours a day, 365 days a year. The trust also provides a Patient Transport Service (PTS), which provides transport seven days a week for service users in cases of medical need for outpatient appointments, admissions, discharge and transfer.

The IOW is 147 square miles in size. There is the fluctuating population throughout the year with a resident population of approximately 140000, swelling to upwards of 230000 throughout the summer months and during island based events.

The ambulance service employ around 145 people including approximately 52 paramedics, 29 emergency vehicle operatives (emergency care assistants), 11 PTS staff 12 clinical advisors and 36 dispatch staff /call centre staff.

Between April 2016 and September 2016 the PTS provided 4677 journeys, an average of 780 journeys per month. For the year 2015/16 the ambulance service took 24597 calls.

We carried out an unannounced comprehensive inspection of the ambulance service including the emergency control centre, the urgent and emergency care service and the patient transport service. We visited 22-24 November 2016.

Our inspection team

Our inspection team was led by:

Head of Hospital Inspections: Joyce Frederick , Care Quality Commission

The team included a CQC inspection manager, two inspectors and one assistant inspector and three specialists a paramedic, call centre (NHS111) shift manager and an ambulance service manager.

How we carried out this inspection

Before visiting, we reviewed a range of information we held about the hospital and carried out an unannounced comprehensive inspection of the ambulance service, as not all core services were inspected in 2014. We visited the ambulance service on 22-24 November 2016. We visited the one main ambulance station, the emergency operations centre (EOC), located in a multidisciplinary hub office, and the patient transport services (PTS) office. These were all located on the site of St. Mary's Hospital in Newport. We carried out spot checks on emergency and

Detailed findings

PTS vehicles. We observed interactions of care, by accompanying staff on the ambulance and PTS vehicles when they responded to a call. We listened in to calls received by the EOC and observed how the dispatcher worked.

We reviewed two patient records. We spoke with around 45 staff, including paramedics, emergency vehicle operatives, facilities staff, clinical and performance support officers, team leader, call takers, dispatcher and PTS crew and members of the senior management team for the ambulance, urgent care and community business unit. Where possible we spoke with patients and reviewed patient records.

Our ratings for this service

Our ratings for this service are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate
Patient transport services	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Emergency operations centre	Good	Requires improvement	Good	Good	Inadequate	Requires improvement
Overall	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate

Emergency and urgent care services

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

Information about the service

Isle of Wight NHS Trust provides the emergency and urgent care service for people who live on or are visiting the Isle of Wight. The ambulance station and headquarters are based at St Mary's Hospital, Newport. The service responds to 999 calls, 24 hours a day, 365 days a year.

On average, the service responds to just over 2000 calls a month. This can increase during certain times of the year, such as during the summer months or for specific events. The service had 12 emergency ambulances, 10 rapid response vehicles (RRVs) and three co-responder vehicles, with five ambulances and one car normally used per shift. There were over 80 staff working in frontline services' including 52 paramedics and 29 emergency vehicle operatives (emergency care assistants).

The service has specific vehicles equipped for major incidents and chemical, biological, radiological or nuclear attack. In addition, there is one 'Jumbulance' that can carry up to four stretchers and is available to transfer patients to the mainland. The service supports and co-ordinates the work of voluntary community first responders living on the island who give basic lifesaving interventions to patients prior to the arrival of the ambulance crew.

During our inspection, we visited the ambulance station and relevant departments at St Mary's Hospital to observe how the ambulance staff worked with other teams at the hospital, including in the emergency department and critical care.

We observed staff providing care to four patients by accompanying ambulance crews when they responded to emergency calls. We reviewed two patient records. We spoke with around 25 staff, including paramedics, emergency vehicle operatives, facilities staff, clinical and performance support officers and members of the senior management team for the ambulance, urgent care and community business unit. We completed spot checks on four vehicles at the station; three ambulances and one rapid response car. We also analysed data provided by the trust after the inspection.

Emergency and urgent care services

Summary of findings

We rated this service as inadequate because:

- The ambulance station was not secure.
- The trust could not be assured that staff were reporting all accidents and incidents and learning was cascaded. Front line staff did not have an understanding of the duty of candour.
- The mobile data terminal used to provide staff with patient information and navigation was unreliable. Confidential information, medicines and cleaning products were not always securely stored.
- Staffing levels meant shifts operated at minimum staffing levels, which made it difficult to support the transfer of patients to the mainland.
- Compliance with mandatory training was below the trust target level of 80% and not all staff had received an annual appraisal. Staff had not completed specific training on supporting patients experiencing a mental health crisis.
- For patients, for whom English was not their first language or who were not able to communicate verbally, there were no communication aids on the ambulances.
- The governance framework used to monitor the quality and risks of the service was not effective. The risk register did not reflect all of the current risks of the service.
- Delays in handover at the emergency department and the service running at minimum capacity meant people could not always access the service in a timely way.
- The trust response times were consistently below the expected target and patient outcomes where not as expected for patients suffering a heart attack.
- The trust did not monitor if they had responded to complainants within the agreed timeframe as part of the quality monitoring of the service.
- Morale was low amongst ambulance staff. While they had confidence in their immediate managers, they felt there was insufficient knowledge and experience amongst the senior managers within the clinical business unit to manage the service effectively. There were no team meetings and memos and emails were the main route for communication

However:

- Staff followed infection prevention and control procedures to reduce the risk of the spread of infection. Vehicles were clean and tidy and staff kept ambulance well stocked.
- Staff provided care to patients in line with national guidance. The service had processes in place for staff to get additional clinical advice, if needed and completed audits to monitor staff adherence to national clinical guidelines.
- The service had a comprehensive induction programme in place for staff. Staff had an individual learning plan in place to support their development.
- There was good multidisciplinary team working between ambulance crews and other emergency teams. The multi-agency hub was used effectively to co-ordinate care with other agencies when patients were discharged at the scene. The proportion of patients who had suffered stroke who followed the correct initial patient's pathway was good.
- Staff asked patients for consent before starting observations or treatment and completed mental capacity assessments when patients were unable to provide consent.
- Ambulance staff took the individual needs of people accessing the service into account when providing care and treatment. Frontline staff were focused on giving good quality care to patients.
- The trust had processes in place to respond to feedback from patients and members of the public. Managers investigated complaints and provided a written response to the complainant.
- Staff provided compassionate to patients and their families care. They were kind and showed empathy when caring for patients.

Emergency and urgent care services

Are emergency and urgent care services safe?

Inadequate

By safe, we mean people are protected from abuse and avoidable harm.

We rated safe as inadequate because:

- The garage area was not secure as the garage door was broken. We were also able to access vehicles and equipment stores as these were left unlocked. The issues with unlocked vehicles was rectified by the last day of the inspection.
- Staff could not always report incidents themselves on the electronic reporting system due to the slow speed of the computers. They completed paper forms and a team leader uploaded the information. There was no assurance learning from incidents was considered and implemented by front line staff.
- Frontline staff did not understand duty of candour and how this related to their role. They had not completed any training on this.
- The mobile data terminal used to provide staff with patient information and navigation was unreliable; the system sometimes froze. We raised this as a concern at our inspection two years ago. Although there were plans to upgrade the system, there had been no progress on this since February 2015.
- Medicines were not always securely stored. The codes for the medicines cupboards on vehicles were never changed to prevent unauthorised access. Two bottles of Entonox gas were stored in a cupboard rather than in the secure medical gases store.
- Confidential information, including patient identifiable information was not securely stored at all times.
- Recruitment and retention of staff was a continuing challenge for the service. Shifts operated at minimum staffing levels, which made it difficult to support the transfer of patients to the mainland. Staff worked extra shifts to cover gaps in the rota.
- The completion of mandatory training was below the trusts expected level of 80% Ambulance staff had not completed the required refresher training on resilience in the event of a major incident.
- Cleaning products were not securely stored in line with the Control of Substances Hazardous to Health (COSHH) requirements, which requires all storeroom doors to be kept locked.

However:

- Staff followed infection prevention and control procedures to reduce the risk of the spread of infection.
- Vehicles were clean and tidy and staff kept ambulance well stocked. There was an effective cleaning schedule for regular and deep cleans. Servicing, MOT and insurance information was current for all ambulances.
- Ambulance crews assessed patients using national clinical guidance and knew what action to take if a patient started to deteriorate.

Incidents

- Staff told us they knew how to and felt able to report incidents, however, they did not always receive feedback. Sharing of learning from incidents tended to be by memo or verbal update as team meetings were not held.
- Staff reported incidents using either the trust's electronic reporting system or paper based forms. They tended to use the paper forms as they could complete these whilst on shift. In addition, staff told us the computers at the station were slow and there was not sufficient time to enter the information electronically, if they returned to base during their shift. Staff generally did not have time to complete the electronic forms at the end of their shift. Staff could not access the electronic reporting system from the laptop carried on the vehicle.
- Performance support officers (PSOs) or clinical support officers (CSOs) uploaded the information for staff from the paper forms to the trust incident database, the following day. The lack of access to useable computers and that staff were not directly reporting incidents were not on the ambulance, urgent care and community clinical business unit (CBU) risk register. There was no service level risk register.
- PSOs or CSOs reviewed the grading of the incident and they or a senior manager for the CBU completed the investigation. Staff told us feedback was shared via email, memos or verbal update from their immediate managers. Due to the computer issues staff did not regularly access their emails and could not access them

remotely from home, meaning they found it difficult to keep up-to-date with any changes to practice. No staff we spoke with could describe learning from a recent incident.

- We reviewed four sets of minutes for the weekly senior managers meeting for the CBU, although staff were reminded to close incidents there was no discussion or learning shared from incidents to improve safety across the trust.
- We reviewed four sets of minutes for the Ambulance Clinical and Quality Effectiveness Group (CQEG), these showed that incidents were discussed including the required action although staff were reminded to close incidents there was no discussion or learning shared from incidents to improve safety across the trust.
- From October 2015 to September 2016, there were 47 incidents reported by staff for the whole ambulance service; this represented 1.2% of the total incidents reported for the trust. It was not possible to determine how many incidents related to emergency and urgent care. Forty one were no harm, five low harm and one moderate harm. There were no never events. The most prevalent incident category was infrastructure (including staffing, facilities, environment). This accounted for over half (53.2%) of the total incidents for the ambulance service. None of these incidents resulted in moderate/severe harm or death. This was followed by treatment, procedure incidents (eight or 17.0%). One of these incidents resulted in moderate harm.
- There were no never events over the same period. Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- None of the frontline staff we spoke with could explain what duty of candour was or had completed any training on this or being open and honest. Staff did not know if the trust had a duty of candour policy. Middle managers had some understanding, with senior managers able to explain the regulation in more detail. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of'certain notifiable safety incidents'andprovide reasonable support to that person. Duty of candour was introduced to NHS bodies in November 2014. There was no assurance the trust had provided frontline staff with relevant training so staff could meet their requirements of the regulation.

Mandatory training

- Staff told us they completed mandatory training which was a mix of e-learning and practical assessed courses. Information provided by the trust, following the inspection, indicated across 30 mandatory training subjects, the compliance for the ambulance service varied from 16% to 100% with an overall compliance of 78% . This was below the trust target of 80%. The overall percentage completion rate for this group of staff was reported as 75%. There was no further break down by subject for this team.
- They told us they struggled to complete all their training due to the lack of protected time. Staff had six hours allocated as part of their individual learning plan but due to staff shortages it was not always possible to get cover for shifts. The slow IT access at the station and no IT access at home added to the difficulties staff experienced when completing online training.
- Time to complete mandatory training for ambulance staff was on the CBU risk register but senior managers had not updated this since August 2015. There was no assurance continuing action was being taken to manage the risk. There was no person allocated to have oversight of the risk and the due date for any actions.
- Staff required to drive under blue lights completed a three week competency based course as part of their induction. Following a vehicles collision, staff completed an additional assessment to demonstrate they were still competent to respond to emergency calls.
- There was no hazardous area response team (HART) based on the island, an agreement was in place with the nearest HART based on the mainland. The expected response time of this team was two hours. Ambulance staff therefore needed to complete training on resilience in the event of a major incident on the island to be able to provide an initial response. However, there was no set training programme for staff on this. Ambulance staff who responded to chemical, biological, radiological and nuclear (CBRN) incidents or marauding terrorist firearms attack (MTFA) were meant to complete two days refresher training each year. There were no records

available to confirm this had taken place and staff told us refresher training was on an ad hoc basis. There was no assurance the trust was providing the required level or frequency of training for ambulance staff.

Safeguarding

- Frontline staff we spoke with could describe the signs of abuse, knew when to report a safeguarding incident, and knew how to do this. Staff gave examples of when they had made a safeguarding referral; they told us they did not always receive feedback unless they contacted the local safeguarding team
- Staff completed separate training modules on safeguarding vulnerable adults and safeguarding children. Frontline staff completed safeguarding children training to level 2. Date provided by the trust showed as of November 2016, 72% of staff from the Ambulance Emergency Services were up to date with their safeguarding training
- Data showed staff had made 20 referrals to the local safeguarding team from November 2015 to October 2016. Daily reporting took place on the number of referrals made across the ambulance and emergency department.
- Frontline staff were stood down from their shift to enable them to complete the safeguarding referral form.
- We saw memos on display in the crew room, advising staff of the need to consider the risk and need for safeguarding referral for patients under the age of 18, who were under the influence of drugs and or alcohol. This was because of the increased risk to the patient of child sexual exploitation, neglect and abuse. There was also guidance on other services that should be involved to support the child or young person, such as the mental health team.

Cleanliness, infection control and hygiene

- All vehicles we inspected were visibly clean and tidy. Records we checked confirmed vehicles had been cleaned daily and had a monthly deep clean.
- We saw staff cleaning relevant areas and pieces of equipment on vehicles between patient contact. Staff had access to spare linen on the vehicle and could also collect this from the emergency department. Staff ensured there was spare linen available when they completed their daily vehicle check.
- The service provided spills kits on all vehicles, to minimise the hygiene risk until the vehicle could be cleaned more thoroughly.
- Staff responsible for cleaning and stocking provided cover from 7am until 11pm. Out of these hours, staff would swap to a spare vehicle, if theirs could no longer be used and needed to be cleaned. Staff put warning tape on the vehicle and updated the staff notice board so other staff did not use the vehicle by mistake.
- Although vehicles were deep cleaned monthly, swab testing was not performed pre and post the deep clean, to demonstrate the clean had been effective. This is considered best practice. Records were kept by the service and were found to be complete.
- Staff used different colour cloths to clean the inside and outside of vehicles and disposable mop heads to reduce the risk of cross infection.
- For all observations of care, staff followed best practice to minimise the risk of the spread of infection between staff and patients, such as cleaning their hands prior to and after providing care and wearing gloves. This was in line with the trusts Infection prevention and control policy. Personal protective equipment, such as gloves and aprons were provided for staff, both on vehicles and at the station, to protect staff from contact with infectious materials.
- Staff were provided with sufficient uniform, so they could change during a shift if necessary. However, the lockers for staff were narrow and made it difficult for them to keep spare uniform on site and their personal belongings. Staff were responsible for cleaning their own uniform, unless it had been heavily contaminated, when it was disposed of as clinical waste. There were showers for staff to use at the station.
- Dispatchers at the emergency operations centre advised staff of any known infection and hygiene risks prior to staff arriving at a call.
- Porters collected the clinical waste from the station on a daily basis. The correct coloured waste bins were provided so staff could separate waste according to the type, for example, general waste or soiled waste. Waste bins, including the sharps bin, were kept locked to prevent unauthorised access.
- In the cleaning store at the station, we found chlorine based cleaning products (tablets and liquid). The door to the storeroom was unlocked and the room potentially accessible to anyone visiting the station, as the station was also not secure, due to no garage door.

This did not meet the Control of Substances Hazardous to Health (COSHH) requirements, which requires all storeroom doors to be kept locked. There was no sign on the door reminding staff to keep the door locked.

Environment and equipment

- The ambulance station was not secure as there was only a garage door at the exit. The door at the entrance had been removed as it was faulty but had not been replaced. Staff had raised this as a concern approximately a year ago but the trust had taken no immediate action to repair the door, to maintain the security of the premises, vehicles and equipment. This risk was not on the CBU risk register. The trust told us funding to replace the door was due to be approved at an executive team meeting in early December 2016.
- During our inspection, we checked on four separate occasions if vehicles were locked due to the security risk. On three occasions, we found two or more vehicles unlocked and the keys in the ignition. On one occasion, the saloon doors were open to two vehicles, with access to equipment. Neither the trust or staff had taken sufficient action to reduce the potential risk of vehicles or equipment being tampered with and the impact on patient safety. A memo was issued to staff on the last day of the inspection, advising all vehicles should be locked; all eight vehicles we checked were locked. The memo did not tell staff what action the trust were taking to repair the fault to the garage door and provide assurance action would be taken.
- The lack of secure premises meant there was access to spare patient chairs and stretchers stored in the station. Three equipment cupboards were also unlocked, containing spare equipment such as kit bags and spinal boards. We discussed the risks with the manager on duty who planned to escalate our concerns.
- The working environment for the make ready team was difficult in the winter months due to the open building access. There was a heater but this was ineffective and the trust had not provided staff with additional warm clothing.
- Staff responsible for stocking vehicles, followed a set written list and had a pictorial guide of where items were stored on the vehicles. The layout was the same on all ambulances to enable staff to find items easily. There was good used of tamper evident tags on cupboards in vehicles and for kit bags to show when checks had been completed. The tag number was logged on the make ready carbonated form. Copies were kept by the make ready team, put on the vehicle and given to the PSO. Make ready staff told us spot checks were done by the PSO but there was no routine audit programme to monitor the standard of their work.
- We checked three ambulance and one rapid response vehicle, all were well stocked with single use items. We checked approximately 20 items and all were all within their expiry date and safe to use. All staff were responsible for maintaining stock on vehicles, by restocking when back at base, or during a shift if needed.
- Staff completed a daily vehicle check prior to starting their shift. If they had any concerns about equipment or the vehicle, the service had capacity for them to use another vehicle. There were 12 ambulances and three rapid response vehicles, with five ambulances and one car normally used per shift. We saw staff return to base and swap to another ambulance due to a vehicle fault.
- Although staff updated the information board to show a vehicle was off the road, there was no notice kept in the vehicle to make this immediately apparent to staff when in the garage.
- Keys for vehicles were kept in keypad entry safes in the ambulance station, the safes were not always locked when we checked, despite a notice reminding staff to do so. Staff told us the access codes were changed when a member of staff left.
- The fleet team maintained an asset register for medical equipment. This included the item number, next service date and the frequency of service. We checked two items and both were in date for their service. The fleet team also managed the logistics of arranging servicing of both equipment and vehicles and ensuring enough vehicles for a safe service well. They told us external companies worked flexibly with the service to meet their needs.
- All vehicles had an up-to-date MOT, annual service and were insured. Vehicles had a safety inspection every six weeks. Although the trust informed us there was a rolling program for the replacement of vehicles, a procurement bid had to be submitted each time. T there was a potential financial impact of higher maintenance costs for older vehicles.

- There was some provision on vehicles to transport children, with access to a car seat. However, there were no additional straps to use with the stretcher. Parents would lie on the stretcher with their child and both be secured.
- Staff raised concerns and we saw issues with the reliability of the mobile data terminal on vehicles. During two observations, the system froze meaning staff had no navigation system and had to contact the dispatcher to confirm the details of the call. Staff relied on local knowledge of the area to get to the address. There was also a map kept on vehicles. We highlighted this as a concern during our inspection two years ago. Although, the issues with the system were on the CBU risk register, with plans to upgrade, there was no update to planned actions since February 2015. There was no assurance the trust were continuing to manage this high level risk or had made progress since our previous inspection.

Medicines

- The trust had taken action since the last inspection in 2014 to address concerns relating to medicines management and had installed a new medicines storage unit at the station, with regular temperature monitoring of the room and an air conditioning unit in place. The unit was kept in locked room.
- Staff accessed the unit via fingerprint scanning for added security. Medicines were stored in compartments, with access restricted to only relevant compartments, depending on staff role.
- Medicine grab bags and morphine boxes had a yellow tag added prior to delivery from the pharmacy department, to confirm the contents and stock levels were correct. The pharmacy department numbered the morphine boxes, with the PSO entering the number into the data management system on the storage unit, as they put the boxes away, to enable boxes to be traced. Bags were returned to pharmacy with a red tag, when stock needed replacing. The service kept a log to trace which grab bags had been returned.
- PSOs completed a medicines stock check twice a day. They were required to enter the quantity of each type of medicine. During an observation, stock levels differed for three out of the five items checked, including there being one more box of morphine. There was no governance process in place with pharmacy to manage or explore the reasons for these difference or consideration given by staff that this should be done when a difference was found.
- Paramedics signed out which morphine box they had taken. Drugs including controlled drugs were stored securely on vehicles in the medicines safe. However, the codes were never changed as they were the vehicle call sign. This was a risk as all staff, including those who did not handle medicines, knew the codes.
- When paramedics administered morphine, they completed a form, which required them to record the quantity given and disposed of. This information was then transcribed into the controlled drugs book. The morphine box number was also recorded to enable the service to trace the number of vials that had been used from each tin.
- Paramedics administered medicines to patients under a patient group directive (PGD). A PGD provides a legal framework that allows some registered health professionals to supply and/ or administer a specified medicine(s) to a pre-defined group of patients, without them having to see a doctor. A PGD is used in situations that offer an advantage to patient care, without compromising patient safety. Staff were competency assessed prior to signing to work within the framework of the PGD.
- We found in an unlocked cupboard in the station, two full cylinders of entonox gas. This was a risk due to the station not being secure and the potential for the gas bottles to be removed. There was a label on the cupboard identifying the contents. All other medical gas cylinders were stored securely at the station, with full and empty cylinders segregated.
- Ambulance staff explained to patients why they needed a specific medication and documented this in the patient electronic record. No written information was given to patients to support these discussions.

Records

- Ambulance staff recorded patient records on an electronic patient record (ePRF), which followed Joint Royal Colleges Ambulance Liaison Committee (JRCALC) 2016 guidance.
- We observed the laptops containing the ePRF were not stored securely as staff left vehicles unlocked at the station and when they responded to a call. The laptop was attached to the wall in the ambulance saloon but

not secured, meaning the laptop could easily be removed. On one call, staff left the saloon door open whilst they went into a building. Equipment, including the laptop was visible to people passing by.
- We also saw that patient identifiable data was visible on the screen, as staff did not lock the screen to prevent access. This was not in keeping with the trust Information Governance procedures. There was a potential risk of unauthorised access to this information should the laptop be removed from the vehicle.
- The ePRF provided staff with special notes if there was important information know about the patient by the emergency control centre. For example, if a patient had a do not attempt resuscitation order in place.
- Staff raised concerns the ePRF was not always available due to connection issues with the network. This had resulted in them losing information and having to re-enter it. This also prevented them sharing the ePRF with the emergency department, in advance of them arriving. The same system was used by the ambulance service and the hospital so information could be easily shared.
- If the system went down completely, staff completed paper records and handed these to the triage nurse in the emergency department.
- We requested outcomes form records audit but this information was not provided

Assessing and responding to patient risk

- Ambulance staff completed clinical observations on patients, as part of their care and treatment to assess for early signs of deterioration. If a patient did deteriorate, staff requested additional emergency clinical support. Staff had access to suitable equipment on the ambulance to enable them to monitor and assess patients.
- Staff assessed patients using guidance from the JRCALC. Staff knew the limitations of their role and the scope of practice they could work within. This ensured crews knew when to seek help, to so patients received safe care and treatment**.** If they needed additional clinical advice, staff contacted the clinical advisors based at clinical support desk in the emergency operations centre. This was manned 24 hours a day. Where appropriate staff could arrange for a patient to be transferred by air ambulance to a specialist hospital on the mainland, if they could not be treated at the hospital on the island.
- Staff used their training and clinical judgement to assess the patients' condition and if signs of deterioration were seen, contacted the emergency department to escalate the priority level and request a bed in resus or majors area. We observed a crew follow this process for a patient with a suspected stroke.
- Hospital staff working in critical care and on the medicines wards raised concerns the ambulance service was often working at capacity and this made it difficult to arrange transfers to the mainland by ambulance for less urgent patients. They did work with the PSOs to manage this, who could request a private ambulance provider to complete the transfer. If necessary, the request was escalated to a senior manager to confirm the air ambulance or the coastguard helicopter could be requested to transfer the patient; although the later was at a cost to the ambulance service.
- During our observations of care we saw appropriate manual handling techniques used for the transfer of all patients. This ensured that staff and patient safety was maintained and injuries avoided.
- Staff were experienced at transporting patients experiencing a mental health crisis, although they told us they had not completed specific training on this. They learnt from working with colleagues and through the calls they responded to.
- The ePRF would flag addresses where there was known violence or aggression towards ambulance staff. Emergency operations centre staff would request support from the police at the call.

Staffing

- Senior managers told us there were vacancies for paramedic posts and recruitment of paramedics to the island remained a constant challenge. Ambulance staff felt staffing of the service was a risk. There was minimal flexibility to manage situations such as patients needing a transfer to the mainland or if a major incident occurred.
- Acute hospital staff told us there was a lack of paramedic staff. If a patient required heart treatment on the mainland this could delay the patient transfer. Some patients went with a nurse from the ward , potentially leaving the cardiology unit short staffed.
- The service planned to staff the service for five double crewed ambulances (one paramedic and one EVO) and one rapid response vehicle during the day, reducing to four ambulances at night and at weekends. Staff worked

12 hour shifts. We reviewed the rotas for the week of our inspection which showed all shifts were covered as planned, with an additional ambulance during the daytime for three of the seven days.

- The trust resource team were responsible for planning the rotas in four week blocks. The PSOs managed any last changes to the rota, such as for staff sickness. Staff that had worked for the service for some time were on a set rota pattern, new starters worked a more flexible pattern, to better meet the needs of the service. No staff raised concerns about the length of their shifts or pattern of work.
- The service normally ran at minimum staffing levels due to vacant posts, which caused additional problems if a member of staff was off sick. To cover vacant shifts, staff worked additional shifts. Text messages were sent to all staff when shifts needed to be filled at short notice.
- Recruitment to vacant posts was ongoing. The service were considering supporting EVOs to train as paramedics, to help with retention of staff. Recruitment and retention of ambulance staff was not the on CBU risk register, to show senior managers were aware of and managing the risk.
- Private ambulance services were sometimes used to transport patients to the mainland so emergency ambulance crews could remain on the island to respond to 999 calls. This kept the number of vehicles on the island at five. This was in line with guidance in the 'Ambulance service conveyance policy' (2014). This policy also provided flowcharts for hospital staff to follow to show if a patient needed an emergency transfer or this could be completed by the patient transport service.
- Ambulance staff raised concerns that when events were held on the island there was not the capacity to manage the increase in the number of people on the island with the current staffing. The service did not provide cover at events but had to respond to fluctuations in the population and more calls.
- Staff told us they did generally had a meal break during their shift but this had been due to a recent change in policy and previously they had completed 12 hour shifts without a break.
- The bronze and sliver commanders worked a one six on call rota. The gold commander was the trust wide clinical director or trust CEO.

Anticipated resource and capacity risks

- We had concerns as business continuity plans were out of date for review, due 2015, and had not been signed off to confirm this was the agreed current action staff should take.
- Business continuity plans are used by services to agree a planned course of action for a foreseeable risk such as poor weather and disruption to hospitals receiving patients.
- There was though an effective command system in place to help co-ordinate the response if an incident did occur. PSOs and CSOs acted as bronze (operational) command, working with senior managers from the CBU, who acted as silver (tactical) commanders.
- Bronze commanders were on-call from home and worked to a set rota pattern. Staff told us this worked well. Ambulance staff raised concerns that silver commanders lacked operational awareness and experience due to being relatively new in post. They were concerned about lack of training for staff in this role.
- The service used the national indicator resourcing escalatory action plan (REAP). This triggers specific measures when the trust is operating at significant and sustained levels of increased activity. The level of REAP is scored on a scale from 1 (normal service) to 6 (potential service failure). REAP levels were displayed at the ambulance station so staff were kept informed about the level of demand on the service.
- PSOs and CSOs attended the daily bed meetings at the hospital so they were aware of any capacity issues which may have an impact on their service. Bronze command was used if there were delays in the emergency department, which were delaying ambulances being redeployed on the road.

Response to major incidents

- The evidence to show the trust's ability to meet its requirements under the Civil Contingencies Act 2004 and NHS England Core standards for Emergency preparedness, resilience and response (EPRR) was limited. This was a significant risk if an emergency or major incident occurred. This risk was not included on the CBU risk register, raising concerns senior managers were not aware of this risk.
- The service was only partially compliant with its requirements under the Local Health Resilience Partnerships (LHRP). Ambulance staff told us they were the lowest rated in Wessex.

Emergency and urgent care services

- Whilst the service had Marauding Terrorist Firearms Attack (MTFA) and Chemical, biological, radiological and nuclear defence (CBRN) teams in place, ambulance staff were unsure who was the lead for these teams and who acted as commander if the teams were called to an incident.
- The service was receiving support from the local clinical commissioning group (CCG) to try and address some of these issues.
- The service had local arrangements with the fire service and council if a major incident occurred. The Hazardous Area Response Team (HART) was provided by a NHS ambulance trust on the mainland. The agreed response time for this team was two hours.
- The service had organised a practice major incident exercise the week prior to our inspection, however, staff told us these did not take place on a scheduled basis. Staff had received verbal feedback on how they responded, which was generally positive. Staff told us they had last completed a practice to test the major incident plans with all emergency services and the hospital about two years ago.
- Staff understood their responsibilities if a major incident occurred. They would attend for work as soon as possible, to help the service respond to the needs of patients.
- The service had a Emergency preparedness, resilience and response' (EPRR) core standards document. This referred to relevant legislation and guidance, including from the Civil Contingencies Act 2004 and NHS England EPRR documents and supporting materials. This has been approved at the board meeting in October 2016.

Are emergency and urgent care services effective?

(for example, treatment is effective)

Requires improvement

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.

We rated effective as requires improvement because:

- There was no assurance that all staff had received an appraisal. There was little clinical support or supervision for Emergency care practitioners and there were no governance arrangements for this role.
- Although training was said to be provided , there was no assurance that staff had attended the required amount for the specialist teams such as the MTFA/Ambulance Intervention Team and CBRNe/ Special Operations Response Team.
- There was no assurance as to the number of staff who had completed training on the mental capacity act.
- The trust response times were consistently below the expected target.
- Patient outcomes where not as expected for patients suffering a heart attack.
- For all patient suffering a cardiac arrest the overall return of spontaneous circulation rate for this trust was worse than the England.

However:

- Staff provided care to patients in line with national guidance. The service had processes in place for staff to get additional clinical advice, if needed and completed audits to monitor staff adherence to national clinical guidelines.
- The service had a comprehensive induction programme in place for staff. Staff had an individual learning plan in place to support their development.
- We saw good multidisciplinary team working between ambulance crews and other emergency teams. Information shared during patient handover was relevant and enabled continuing care of the patient.
- The multi-agency hub was used effectively to co-ordinate care with other agencies when patients were discharged at the scene as they did not need to attend hospital.
- The proportion of patients who had suffered stroke who followed the correct initial patients pathway was good.
- Staff asked patients for consent before starting observations or treatment. Staff completed mental capacity assessments and understood the reasons why they should do this.
- The proportion of all patients who survived following a cardiac arrest was better than the England average.

Emergency and urgent care services

Evidence-based care and treatment

- Ambulance service staff followed both National Institute for Health and Care Excellence (NICE) and Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidance when providing care and treatment to patients.
- We saw staff carried the JRCALC pocket guide with them and referred to it when assessing patients, such as, following a pathway to decide whether a patient needed to be taken to hospital.
- The service was implementing the 2016 JRCALC guidance, with additional training provided and memos sent to staff with any updates. In response to the new guidance, the clinical support officers (CSOs) were developing a training tracker to show what training on mental health staff had completed.
- The CSOs also reviewed new NICE guidance, using the baseline assessment tool. If the guidance was relevant to the ambulance service, it was discussed at the ambulance clinical quality and effectiveness group. A change to the NICE guidance on the age range for thrombolysis treatment had been shared with ambulance staff, to ensure patients who could receive this treatment were transferred to hospital promptly.
- The service completed regular audits to monitor staff compliance with evidence-based guidance, actions plans were used for areas of non-compliance or where relevant included as part of staff's individual learning plan.

Assessment and planning of care

- Staff adhered to relevant national and local clinical guidance and protocols for their role, when assessing and providing care for patients of all ages, including children.
- If staff needed clinical advice, they contacted the clinical support desk, based in the emergency operations centre. Staff told us generally the advice provided enabled them to support the patient further.
- There was only one hospital on the island, with the majority of patients taken to the emergency department. Sometimes ambulance staff took patients direct to critical care or the maternity unit, so they could receive care and treatment from a specialist team.
- Staff could explain the process for not taking a patient to hospital (see and treat) and were encouraged to refer patients to other care pathways when appropriate, such as the falls team. A memo had recently been sent to staff on changes to the referral pathway for non-conveyance of falls for patients over 65 years.
- The emergency operations centre team was located within 'The Hub'. This was a multi-agency office, which made it easier for ambulance staff and dispatchers to co-ordinate care with other agencies when the ambulance service discharged patients.
- Staff followed guidance and protocols, if the police detained patients under section 136 of the Mental Health Act and they needed to transport the patient to hospital.

Response times

- Ambulance staff worked hard to try and meet nationally set targets for response times to emergency calls. They told us and we saw, the rural layout of the island made it a challenge to reach patients within the agreed response times. Delays in handover at the emergency department also affected response times.
- Ambulance crews were based at three stand-by points around the island to help improve response times.
- Category A (Red 1) incidents are patient presenting conditions, which may be immediately life threatening and should receive an emergency response within 8 minutes irrespective of location in 75% of cases. The trust breached the eight minute standard for responding to Red 1 calls between November 2015 and October 2016. Performance was worse than the overall England performance in eight out of 12 months. For October 2016, the trust achieved 67% against the target of 75%.
- Category A (Red 2) incidents are patient presenting conditions, which may be life threatening but less time critical and should receive an emergency response within 8 minutes irrespective of location in 75% of cases. The trust breached the eight minute standard for responding to Red 2 calls in eight out of 12 months (November 2015 and October 2016). However, its performance was better than the England average in all 12 months. For October 2016, the trust achieved 70% against the target of 75%.
- Category A (Red 1 and Red 2 referred to as Red 19) requires a patient carrying vehicle to reach a Red 1 or Red 2 incident within 19 minutes, 95% of the time. Sometimes a rapid response vehicle was sent to initially respond to a call and an ambulance dispatched to take the patient to hospital. In July 2016 there was a

deterioration in performance as measured by the 95th percentile to 25 minutes and 18 seconds. There was then an improvement, though performance in October 2016 remained worse than it had been in July 2016. There was a declining trend in performance. For October 2016, the trust achieved 93% against the target of 95%.

- We saw on noticeboards at the ambulance station current Red 1 and Red 2 response times performance information displayed. All staff we spoke with were aware of the expectations of them in regards to these times and the reasons why a prompt response was needed for certain calls.
- The performance of the ambulance service was discussed at trust executive team meetings and reported on in the trust performance report. The CCG had issued two contract notices to the trust in January and April 2016, in relation to the performance of the ambulance service when responding to Red 1 and Red 2 and delays in handover respectively. The trust did not provide a copy of the action plan to show how they had addressed these areas of concern.
- A 'Group calling for outstanding Red 1, Red 2 and Multi agency calls' (2016) procedure was in use to alert all crews to any outstanding Red 1, Red 2 or multi-agency calls such as a road traffic accident. Crews contacted the dispatch team if they were clear from their current job and able to respond.

Pain relief

- Paramedics were trained and able to give a range of pain medicines that included Entonox gas and morphine.
- Records showed and we observed staff asking patients about their level of pain as part of their initial observations and assessment. For patients who were unable to communicate verbally, or who did not speak English staff used a visual faces pain tool. Patients pointed to the face which best represented their level of pain.
- When pain relief medicines were given to patients, we saw staff checking these had been effective and updating the patients' pain score. Additional pain relief was given as appropriate. Staff recorded the pain medicines they gave to patients on the electronic patient report form (ePRF).

Patient outcomes

- The ambulance service monitored patient outcomes using a number of national clinical quality indicators to assess if the intended outcome for patients was being achieved.
- The proportion of patients managed without the need for transport to the A&E department was consistently higher than the England average between November 2015 and October 2016.
- There was a step change in performance in December 2015. A higher percentage of patients were managed without the need for transport in the 11 months from December 2015 than in the four preceding months
- At the time of inspection the proportion of patients who re-contacted the service following treatment and discharge at the scene, within 24 hours, was 3% which was better than the England average of 5%.
- 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 can be achieved through immediate and effective treatment at the scene. The overall return of spontaneous circulation rate for this trust was worse than the England average in 10 of the 12 months between August 2015 and July 2016. There was a declining trend in performance.
- However, using the Utstein comparator group, the trust performed better than the overall England performance in eight of these 12 months. 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 call are included in the figures for all patients, but are excluded from the Utstein comparator group figure.
- The overall rate measures the overall effectiveness of the urgent and emergency care system in managing care for all out-of-hospital cardiac arrests. The proportion of all patients discharged from hospital alive following a cardiac arrest was better than the England average in seven of the 12 months between May 2015 and April 2016. For patients in the Utstein comparator group, the proportion discharged alive was also better than the England average in seven of these 12 months.

- Heart attack or ST segment elevation myocardial infarction, (STEMI) is caused by a prolonged period of blocked blood supply. It is therefore vital that blood flow is quickly restored through clinical interventions such as thrombolytic ("clot-busting") treatment or primary percutaneous coronary intervention. 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, patients should be administered pain relief medicines to help alleviate their ongoing discomfort.
- The proportion of patients receiving primary angioplasty within 150 minutes of call connect was below the England performance in six of the 12 months between August 2015 and July 2016. In April 2016 none of the six patients that received a primary angioplasty underwent the procedure within 150 minutes of call connect. Although in August, September and November 2015 the proportion was also zero, only one patient underwent a primary angioplasty in each of these months. In February, June and July 2016 there were no relevant patients and hence no data.
- The proportion of patients with ST-elevation myocardial infarction who received an appropriate care bundle was below the England performance in eight of these 12 months. The trust was implementing an action plan to improve this.
- For the month of March 2016 the following care bundles were also reported against national targets. The use of care bundles for patients with Hypoglycaemia was 100% against a target of 98%; asthma 74% against a target of 82%; limb fractures 50% against a target of 46% and febrile convulsion of 94% against a target of 87.5%
- The trust participated in the Sentinal Stroke National Audit Programme (SSNAP). This provides information on acute stroke service performance, with trusts able to compare their performance to national outcomes.
- The proportion of relevant patients arriving at a hyperacute stroke unit within 60 minutes was better than the England performance in nine of the 12 months between August 2015 and July 2016. There was a trend of improvement.
- The proportion of suspected stroke patients assessed face to face who received an appropriate care bundle was better than the England performance in eight of these 12 months. In six of these months, all relevant patients received an appropriate care bundle.
- The trust had produced an action plan in response to the most recent audit completed in July 2016. Ambulance staff were to ensure they contacted the critical care outreach directly prior to arrival with a patient with a suspected stroke. This was to help improve the number of patients seen by a stroke consultant within 24 hours of admission.
- The trust also participated in the Myocardial Ischaemia National Audit Project (MINAP). This is a national audit looking at the management of heart attack. Although the trust provided the most recent audit results, no action plan was sent to show how the trust planned to respond to the results.

Competent staff

- Staff told us they had access to clinical advice and support from the clinical support officers (CSOs). Staff found their individual learning plans constructive and helpful but there was not always time to complete additional training due to pressures on the service.
- An induction programme was in place for all ambulance staff. For emergency vehicle operatives (EVOs), there was a one week teaching programme which included competency assessments at the end. Staff were required to complete additional work at home, using a study guide produced by the Association of Ambulance Chief Executives. Three consolidation days were then completed before staff were allocated to a crew. This was initially as an additional member of the team until the EVO had completed their emergency driving course which took three weeks.
- For all four observations of care, the standard of driving was good. Staff drove smoothly and safely, to enable the paramedic to continue to provide care and complete observations.
- CSOs completed clinical supervision for paramedics, aiming to complete two observations a year. This was included in the ambulance service procedure on ‘Clinical supervision’ (2013). Additional sessions were allocated if there were concerns about staff

performance. The CSO also completed the appraisal and checked annually that paramedics remained registered with the Health and Care Professions Council (HCPC).

- CSOs produced a monthly clinical newsletter for staff which gave information on changes to clinical practice or policies, to keep staff up-to-date.
- The performance support officers (PSOs) completed appraisals for the EVOs. PSOs raised concerns it was sometimes difficult to find time to complete staff appraisals. Paramedics provided clinical support for EVOs.
- Following the inspection the trust provided information, which showed that only 13% of ambulance emergency service staff had completed an appraisal as of November 2016.The individual learning plan for staff included a number of hours allocated for training. Staff could use these to attend training courses to help support their development. EVOs told us there were limited opportunities for career progression in their role. The service was aiming to support EVOs to train as paramedics.
- Emergency care practitioners provided care to patients beyond the normal scope of practice for a nurse or paramedic. Whilst initial training had been provided, there was little clinical support or supervision for staff in this role. The governance arrangements for this role had not been developed.
- Specialist teams such as the MTFA/Ambulance Intervention Team and CBRNe/ Special Operations Response Team were said to do have up to two days refresher training each year. However, there was not a robust recording method in place.
- The operations manager had completed national ambulance resilience unit recognised course for silver commander. We were told that six people had completed the silver level training and six the bronze level training had completed operational commanders course. We were told the CEO and chief operating officer had completed the gold commander training.

Coordination with other providers

- Ambulance staff told us they had good working relationships with other emergency services. This included the fire and rescue service, police and coastguard.
- The ambulance service followed agreed care pathways when assessing patients, deciding if they should be taken to hospital or to consider support from other services.
- There were processes in place to ensure ambulance staff transported patients who were detained under the mental health act to the most appropriate location for their care. Ambulance staff worked with the police and staff on the acute mental health wards, based on the hospital site.
- A co-ordinated response was provided for patients who were end of life. Ambulance staff worked with the patient's GP and Macmillan nurses when making decisions about whether transfer to hospital or if the patient's needs could continue to be met at home. Staff told us the integrated hub made working with other services much easier.
- Whilst the service was part of the Joint Emergency Services Interoperability Programme (JESIP), it had not completed any recent refresher training in relation to this. JESIP is a national programme to improve the way emergency service work together when responding to major multi-agency incidents. This was a further risk around the trust resilience response.

Multidisciplinary working

- We saw good multi-disciplinary team working between ambulance crews and other emergency staff when responding jointly to a call. The teams worked together to coordinate the care for the patient and agree onward transfer arrangements to hospital.
- We also observed four handovers between ambulance crew and other professionals, such as care home staff. There was good engagement from all teams to manage the continuing care of the patient. Once staff where at the receiving hospital they gave clear information during the handover and brought any urgent concerns to the attention of staff. On two occasions, ambulance crews called ahead to provide an update on the patient, so the correct team was ready in the emergency department.
- We heard staff from the emergency operations centre providing ambulance crews with any changes to a patient's condition and on one occasion a change in the reported location for the patient, to support the team to respond quicker to the call.
- Staff told us one of the positive aspects of their job was the integrated working with different teams and services.

- The trust were completing a review to look at the flow of patients through the emergency department, which included the time ambulance crews were delayed at the hospital waiting to hand over patients. However, ambulance staff told us they sometimes found it a disadvantage that all the services were part of the same trust. This was because the use of penalties had little impact and it was more of a challenge for them to get changes made compared to standalone NHS ambulance trusts.

Access to information

- Ambulance staff told us and we saw that they had access to the information needed to deliver effective care and treatment to patients.
- Staff had access to 'special notes' about a patient such as pre-existing conditions, safety risks or advanced care decisions. This information was provided by the emergency operations centre who dispatched the crew to the call or the crew could see the information on the ePRF. Staff told us they would check for a care plan in a patients' home or if they collected a patient from a nursing home. Staff also knew to check for this information in the patient's home, via the 'message in a bottle scheme'. A bottle in the fridge contained information on where the do not attempt resuscitation form was located
- The ambulance service and emergency department used the same electronic patient record. This enabled staff to access information about a patient in a timely way when make decisions about care and treatment.
- If staff needed information on alternative services for patients, they called staff at the emergency operations centre who provided them with the contact information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed staff, in non-emergency situations, explaining procedures, giving patients opportunities to ask questions and seeking verbal consent from patients before providing care or treatment. Staff recorded consent to treatment in the patient's record.
- Staff completed training on the Mental Capacity Act and Mental Health Act as part of their initial training and at continuing professional development sessions. We requested data from the trust on the number of staff with current training but none was provided. Staff told us the mental health team had also provided some training around consent for patients who did not have capacity.
- Ambulance staff understood the Mental Capacity Act (2005) and how it applied when obtaining consent, including the assessment of capacity and completing a best interest assessment. Staff knew when they could and should give treatment to patients without consent, such as in an emergency to preserve life. Staff used a form of the ePRF to guide them in the assessment of a patient's mental capacity.
- If a patient did not have capacity and refused transfer to hospital, ambulance staff would contact the police for support.
- When a patient with capacity declined treatment, ambulance staff asked them to confirm this by signing in their medical record.

Are emergency and urgent care services caring?

Good

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

We rated caring as good because:

- We observed staff providing compassionate care to patients and their families. Staff anticipated and responded to patients' needs. Staff maintained patients' privacy and dignity at all times. Staff were kind and showed empathy to patients' they were caring for, particularly when upset or in pain.
- Staff explained clearly to each patient the care and treatment needed, so they understood. They encouraged patients to be partners in their care and always asked for consent before they gave care.
- Staff supported patients who were distressed, anxious or had a mental health condition. Family members and carers were also provided with emotional support, with staff recognising the impact of the patient's health condition on the whole family not just the patient.

Compassionate care

- We saw staff were respectful, friendly, kind and compassionate when providing treatment or care to patients. They spoke with patients in a gentle manner and offered reassurance, particularly if the patient was distressed.
- Ambulance staff were professional in their approach and spoke politely to patients and carers travelling with the patient. They always introduced themselves prior to giving care.
- Crews maintained patients' privacy and dignity, ensuring they covered the patient using a blanket or sheet. One observations of care took place in a public building, staff found a discrete area to complete their assessment to help maintain the patient's dignity. Staff shut the ambulance doors after loading patients to ensure patient were kept warm and their privacy and dignity maintained, whilst staff completed any assessments.
- Hospital staff commented on the professional behaviour of the ambulance staff they worked with and the considered and caring approach the staff used when talking with parents.
- Relatives and patients told us they were happy with the treatment and care they received from ambulance crews.
- We requested friends and family test results for the ambulance service but the trust was unable to provide specific data for this service.
- We did observe a lack of privacy for patients arriving in the emergency department from an ambulance. Crews had to wait with the patient, who was often on a trolley, in the thoroughfare through the department. There were no receiving cubicles for patients to wait in prior to ambulance staff completing a handover. The area used for the handover meant other patients in cubicles close to this space could overhear conversations.
- The friends and family test has had a low response rate but with 100% of people recommending the ambulance service.

Understanding and involvement of patients and those close to

- Staff gave clear verbal explanations to patients about the care and treatment they could provide and explained why they needed to attend the hospital.
- We observed patients being involved in decisions about their care and treatment. Staff checked with patients to ensure they understood the treatment offered, before they asked for consent. Explanations given by staff, were given in a way the patient could currently understand based on their clinical condition, for example, when attending a patient with a suspected stroke.
- Where a patient did not require hospital treatment, we observed ambulance staff discussing this with the patient to ensure they were happy to remain at home or be referred to another care provider, for example their GP.
- Staff showed kindness towards relatives and carers of patients and were aware of their needs, ensuring they were kept updated. Staff explained things in a way they could understand to enable them to support their relative. We saw staff ask relatives if they wished to travel in the ambulance so they could continue to offer support.
- If a patient travelled to the hospital alone, we saw ambulance staff speak with emergency department reception staff to let them know a relative or friend should arrive. They could then show them to the cubicle where the patient was waiting to be seen.

Emotional support

- We observed staff showing empathy to patients, their partners and other family members. Discussions took place in a timely manner and at an appropriate stage prior to and during the journey to hospital.
- Ambulance crews provided plenty of reassurance when patients were anxious. They would check on the patients symptoms but also talk about 'everyday things' to help the patient relax. We observed a crew member explain to a patient why they had decided to change to a blue light transfer but without overly worrying the patient.
- We observed staff using a personal approach, specific to patients' additional needs, for example, for patients who were accessing other healthcare services and needed input from more than one team.
- Staff were aware of the need to support patients experiencing a mental health crisis and could describe situations where they had done so. Frontline staff knew their responsibilities when transporting patients detained under the Mental Health Act.
- The service provided training for staff on looking after the deceased with care and dignity should they transport a deceased patient.

Emergency and urgent care services

- Staff who encountered difficult or upsetting situations at work were stood down for part of or all of their shift. The bronze officer on call was able to attend to speak with staff. A 'hot debrief' was also held to enable staff to share and talk about their experience. Where appropriate staff were referred to occupational health or changed to different clinical duties for a period of time.

Supporting people to manage their own health

- The operation centre staff identified frequent and high volume callers and told the ambulance crew before the arrived at the address. Staff told us they completed a new clinical assessment each time to ensure patients received the most suitable care, although they did not always needs to transport the patient to hospital.

Are emergency and urgent care services responsive to people's needs?

(for example, to feedback?)

Requires improvement 

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

We rated responsive as requires improvement because:

- Although the ambulance service worked with commissioners and other hospital departments to consider how the service could best meet the needs of local people. Delays in handover at the emergency department and the service running at minimum capacity meant people could not always access the service in a timely way.
- Staff had not completed specific training on supporting patients experiencing a mental health crisis
- Multi-lingual phrase books were not available on vehicles to support communication with patients who were non-English speaking. Also there was no communication aid to support patients who had additional communication needs or who were unable to verbalise their concerns, other than for their level of pain.
- The trust did not monitor if they has responded to complainants within the agreed timeframe as part of the quality monitoring of the service.

However:

- Ambulance staff took the individual needs of people accessing the service into account when providing care and treatment, making adjustments where they could. Staff could access specialist equipment, such as for transporting bariatric patients.
- The trust had processes in place to respond to feedback from patients and members of the public. Managers investigated complaints and provided a written response to the complainant.

Service planning and delivery to meet the needs of local people

- The ambulance service worked with commissioners of services on the island, such as the clinical commissioning group (CCG) and local council to consider how the service could continue to best meet the needs of local people.
- The service worked with the local NHS ambulance trust on the mainland, who provided the air ambulance service, should a patient need an urgent transfer to a specialist centre.
- Pressures on the service meant patients could not always be transferred by vehicle to the mainland as needed. Escalation plans were in place to manage this.
- Information from the trust quality improvement plan 2016/17 showed an A&E delivery board was set up in September 2016. Their aim was to improve the performance in the emergency department, which would result in shorter handover times for ambulance crews and more ambulances being free to respond to calls. The trust were also considering using the dispatch on disposition system, where for non-life threatening calls, more time is taken to gather information rather than an ambulance automatically being sent. Patients are signposted to other services or an ambulance dispatched as needed.
- Around 15 community first responders volunteered with the ambulance service. They responded to life threatening emergencies across the island where ambulances took longer to arrive. The ambulance service also had three stand-by points on the island. These was based in areas where the highest number of calls were received.

Meeting people's individual needs

- We saw that ambulance staff were considered in their approach and where possible met peoples' specific individual needs.
- Staff told us they would transport a patient in their own wheelchair if possible, rather than transferring them to a trolley, so they were more comfortable.
- A staff member described how they had communicated with a patient who was hard of hearing by writing things down, to enable them to be fully involved in their care and treatment.
- Staff respected patients' spiritual or cultural needs, however, if these were in conflict with their health needs, staff spoke with the clinical support desk. In an emergency, the patient was taken to hospital for care.
- The service had an ambulance to transport bariatric patients and staff could access additional pieces of equipment to help transfer patients to the ambulance. This included a bariatric wheelchair and a specialised air filled cushion. If staff needed additional advice, they spoke with the back care team.
- Ambulance staff knew to look for a just-in-case medicines pack when they visited patients who were end of life. The pack contains key medicines to help keep patients comfortable who are end of life. Although ambulance staff did not administer the medicines, they could request a GP or specialist nurse visit, rather than having to transport the patient to hospital.
- There was no multi-lingual phrase book to help staff speak with patients and their families if they did not speak English. To reduce the risk staff told us they used a translation app on their mobile phone to help them communicate and had access to a telephone interpretation service. However, should they be in an area with no mobile signal, there was a potential risk to patient care as effective communication could not take place.
- There was no communications book, containing pictures for common words and medicals problems, such part of the body affected, to support patients who were unable to speak due to their medical condition or who had complex needs. This was a potential risk if patients could not explain what was wrong or understand the treatment they needed.
- Staff did not complete specific training on supporting people experiencing a mental health crisis or responding to challenging situations. They told us they 'learnt on the job'. Where patients were detained by the police under section 136 of the Mental Health Act, staff would follow agreed guidance and procedures.

Access and flow

- Staff told us there were not always a sufficient number of ambulances on the road affecting timely access to the service for patients. Crews were delayed handing over at the emergency department or an ambulance was sent to the mainland to collect a patient, reducing the number of ambulances available on the island. The service normally ran at minimum staffing levels due to vacant posts, which caused additional problems if a member of staff was off sick.
- The patient transport service did not run after 8pm, which meant emergency ambulances were sometimes used to transport patients. This frustrated frontline staff as they were not available to respond to calls. We were told from December 2016, the patient transport service would run until midnight to better meet the needs of patients and release emergency vehicles.
- Data provided by the trust showed the number of hospital handover delays was 48 % from September to November 2016.
- Staff described and incident data showed there were occasions when all five ambulances were waiting to hand patients over in the emergency department. To release crews, staff looked after two patients. They felt this was a risk, as they were not handing over a patient they had directly cared for. The trust was undertaking a review of the flow of patients through the emergency department and the ambulance service were involved with this. The review was due for completion in 2017.
- The service had a 15 minute handover standard when a patient arrived at the hospital. Crews told us they did not always meet this as they also had to clean the ambulance and equipment within this time. Crews were able to contact control and make themselves unavailable if cleaning would take longer.
- The service had introduced escalation plans to ensure higher-priority calls took precedence, that clinical advisors supported people with welfare checks and there were stand-by points at fire stations on the island which included basic facilities for staff. Community first responders were also being used. However, the shortage of ambulance crews was a limiting factor in the responsiveness of the service. Overtime was offered to

front line staff prepared to work, in order to increase the number of staff available. Staff were also encouraged to join the staff bank to be able to work additional hours when they wanted to.

Learning from complaints and concerns

- The trust's website contained information on how patients could provide feedback, either a compliment or complaint. There was also information on the expected timelines for a written response to be sent.
- We did not find written information on how to complain on the vehicles we checked. Staff told us they would tell patients or their carers to look at the trust's website.
- The trust procedure was for all complaints to receive an acknowledgement within three working days, which included the expected timescale when the complainant would receive a formal written response. Where possible service leads spoke or meet with the complainant to understand their concerns.
- From November 2015 to October 2016, there were seven complaints about the ambulance, service. The trust has closed five of the complaints. Data provided by the trust did not show how many complaints were upheld or partially upheld or whether the trust had responded to the complaint within the agreed timeframe. The majority of complaints were about ambulance delays.
- Staff told us senior managers investigated complaints and any learning was shared with them verbally by the station lead on duty. Staff were unable to describe any recent learning from complaints.
- We saw thank you cards from patients displayed in the crew room and staff were also acknowledged by the service in the monthly newsletter.

Are emergency and urgent care services well-led?

Inadequate

By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high- quality person-centred care, supports learning and innovation and promotes an open and fair culture.

We rated well-led as inadequate because:

- Morale was low amongst ambulance staff and there was a disconnect between frontline and senior staff.
- Staff had confidence in their immediate managers however, they felt there was insufficient knowledge and experience amongst the senior managers within the clinical business unit to manage the service effectively. They also raised concern about the number of managers in interim roles and their ability to make decisions.
- There was no clear vison or strategy for the service.
- The number of meetings and the complexity of the reporting structure made it difficult to clearly see how over sight of the quality and risk of the service were maintained.
- There was no formal process for engaging with patients.
- The risk register was not current did not reflect all of the current risks.
- It was not clear how the governance process provided assurance about the quality of the service and that risk were managed .
- The demands on the service meant there were no team meetings. Communication was often via email but the slow computer speeds meant staff did not have time to read these updates.
- There was limited engagement with people who use the service.

However:

- Frontline staff remained focused on giving good quality care to patients despite the challenges they faced.

Leadership of service

- The ambulance service was part of the ambulance, urgent care and community clinical business unit (CBU). The CBU had been running since November 2015. A clinical director, supported by a head of operations and head of nursing, allied health professionals and quality, led the CBU. There was also an operations manager for each of the three main services.
- At the time of the inspection, there were three vacant posts within the senior management team for the CBU. Also, some further roles were being filled on an interim basis due to ongoing human resources investigations.
- Ambulance staff raised significant concerns with us during the inspection about the skills, knowledge and experience of the senior managers within the CBU. Only

one member of the team had an ambulance background. They felt staff who did not fully understand the issues made decisions about the service. The move to the joint CBU had not been to the benefit of the ambulance service. Also, the vacant service delivery manager post made it more difficult for the station team leaders to raise issues.

- The operational manager was also covering the service delivery manager role for operations, this impacted on their ability to have clear operational over sight.
- The CCG had requested a review in April 2016 to consider whether the trust had sort the views of key ambulance staff when reorganising the CBUs. The CCG were concerned the integrated CBU was not effective and had placed at risk the ambulance services capacity to deliver a safe sustainable service. Senior managers told us staff were consulted prior to the changes taking place.
- Ambulance staff did not feel the senior team were visible. They visited when there was a problem. However, staff did have confidence in their station team leaders and told us they were approachable, accessible and competent.
- Senior manager met on a weekly basis to discuss operational issues across the CBU. Minutes and actions were recorded and shared with those unable to attend. Recent actions included completion of staff appraisals and management of vacant posts.

Vision and strategy for this service

- The trust's vision was to deliver 'quality care for everyone, every time', supported by the values 'We care, we are a team and we innovate and improve'.
- Ambulance staff told us they did not always feel part of the trust, despite being on the same site. Whilst staff could not recall the trust's vision or values, we observed and staff discussed with us they were committed to providing a good quality service to patients.
- There was no local vison or strategy.

Governance, risk management and quality measurement

- We had concerns around how effective the governance systems were to monitor the quality and identify, assess and mitigate risks of the service.
- There were a number of different meetings held within the CBU to monitor service quality and effectiveness but the size of the CBU and the disparate nature of the services led to challenges for senior manages being able to address all issues. However, ambulance staff did find the clinical quality and effectiveness group a useful meeting to get clinical changes approved so staff continued to work to best practice guidance.
- The number and complexity of the meetings made it hard to understand the reporting structure.
- There was an operational management group (OMG), which met on a Friday. The senior managers group (SMG) met every other Monday. Actions from the OMG requiring second or final approval or issues not resolved at OMG were discussed at SMG. Anything needing escalation went to the business unit meeting. There was also a clinical quality and effectiveness group (CQEG) which linked into the SMG and OMG through the clinical quality lead, but had a direct link the clinical business unit meeting (CBU). The CBU head of nursing and quality attended the CQEG.
- The trust's Patient Information Decision Support (PIDS), disseminated ambulance performance data to the clinical commissioning group and all senior managers. Ambulance performance data was said to be discussed at the performance review meeting on Monday morning. This meeting was attended by the head of operations, head of nursing and quality, the service operational manager clinical quality lead and performance team.
- The CBU risk register had not been updated since September 2015 and did not include current risks, such as the broken garage door. The ambulance service did not have its own local risk register. There was no assurance the CBU were managing the risks, thereby placing staff and patients at risk. There were actions that remained outstanding, with no named person allocated to each action to ensure it was completed.
- Actions included the purchase of mechanical devices to carry out chest compressions on patients in cardiac arrest. This was on the 'worry list' for station managers. The business case had been approved in principal in March 2015 but was still awaiting funding. Without the devices two vehicles needed to be sent to ensure there were enough staff to complete compressions. The service did not have capacity to dispatch two vehicles for each cardiac arrest.
- Two procedures we reviewed were out of date for review, so there was no assurance staff were still

following best practice. These were for 'Emergency care practitioners procedures', review due December 2014 and 'Double crewed emergency vehicle operatives' due review April 2016.

- There was no system in place with the pharmacy service to monitor and investigate any differences when station leads completed a medicines stock check.
- We requested information and evidence from the trust, however only a proportion was provided. In some cases the information was not collected and if others no reason was provided. Therefore it was not clear how the rust could be assured of the quality of the service being provided.

Culture within the service

- Morale was low amongst ambulance staff. They felt unsupported by senior managers in the CBU and were feeling the strain of the demands made on the service. Frontline staff felt overworked which impacted further on morale, however, they remained passionate about giving good care to patients.
- The trust had commissioned a review of the culture within the ambulance service in April 2016 due to concerns relating to bullying and harassment of staff, with staff feeling unable to raise concerns. The review and report were complete by the time of our inspection but ambulance staff had not seen the report. Staff were concerned the trust had not shared the report with them or their action plan to address any concerns raised in the report. They felt the trust were withholding the information from them. The operations manager described the initial findings as "people now felt able to speak out", as historically this had not been the case. We have been able to verify this as the report was not available, when requested.
- Staff did though value the support from the clinical support officers (CSOs) and performance support officers (PSOs) and felt able to speak with them and take concerns to them. Crews told us since changes to ambulance management, staff could have more open and honest discussions but there remained a disconnect with the senior management team of the CBU.

Public engagement

- There was some information for the public about the ambulance service on the trust website. This included information on the first aid training offered.
- Feedback forms were available on some vehicles but staff told us the nature of their work meant it was often not appropriate to give these out. The service recognised there was a low engagement level with patient surveys and the limited value of the results due to this. However, there was no action plan in place to address this. Patients could leave feedback about a service via the trust's website.
- The ambulance, fire and police service had completed a joint project called 'Head On' with local secondary schools. The aim was to reduce the number of casualties and deaths on the road for young adults.

Staff engagement

- The service tended to communicate with staff by newsletters, emails and verbal updates from station leads. There were no team meetings, staff could not remember when they last had a team meeting. They told us this was because of the demands on the service.
- Ambulance staff told us they found it a challenge to read emails due to the slow speed of the computers at the station. However, we saw important updates were pinned on noticeboards in the crew room. Staff were not asked to sign to confirm they had read an update, to provide assurance to managers they were aware of any changes to practice.
- Staff were dedicated and reported regularly working more hours than their shift allocation which was having a detrimental effect on their work-life balance and they were frustrated and tired.
- Crews felt the CSOs and PSOs listened to suggestions to develop the service. There was also a suggestions board in use, staff could leave ideas, with these removed on a monthly basis so new ideas could be left. The process around how managers shared any changes made (You said, we did) was not robust.
- The facilities staff used a communication book as they worked single handed for their shifts. They told us this system worked well.
- The trust's sickness rate between June 2015 and May 2016 was mostly higher than the England average of 4%. The trust now benchmarked for specific services and sickness continued above target for ambulance 7.6% with target 5.5%. The highest reason for sickness remained as anxiety, stress and depression.

Emergency and urgent care services

Innovation, improvement and sustainability

- The combined ambulance, urgent care and community clinical business unit (CBU) contained a number of senior managers who were interim or new to their roles. There was limited evidence at the time of our inspection, showing how they planned to develop and sustain the ambulance service.
- Some ambulance staff felt the trust placed financial savings ahead of quality and improvement, an example being the time taken to repair the garage door at the station.
- Staff were stretched by the demands placed on the service and this impacted on time to consider how to improve the quality of care. The low morale and lack of confidence in the leadership also contributed to this.
- However, the service had been successful in a bid to the League of Friends to purchase fluid warmers. The warmers bring fluid for patients up to body temperature to prevent hypothermia when it is administered. Staff had followed the correct process seeking approval from the clinical quality and effectiveness group, with input from the infection, prevention and control team and medical electronics department.

Patient transport services (PTS)

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

Information about the service

The Isle of Wight (IOW) NHS trust provides patient transport services (PTS) for people who meet the eligibility criteria and resident in the IOW. The IOW clinical commissioning group contracts the service. The PTS is part of the ambulance, urgent care and community clinical business unit in the trust.

The IOW covers 147 square miles and is home to a permanent population of 140,000. Between April 2016 and September 2016 the PTS provided 4677 journeys, an average of 780 journeys per month. The service has eight vehicles including ambulances and cars. Two of the ambulances were equipped for transporting bariatric patients; these were shared with the front line ambulance service. Approximately 25 staff work in the PTS service, 15 of the staff are permanent and approximately 10 are employed on zero hour contracts.

During our inspection, we visited the resource centre and contact centre. We spoke with nine staff including managers, team leader, dispatcher and crew and three patients. We also accompanied two PTS crews on four journeys.

Summary of findings

We rated this service as requires improvement overall because:

- Policies relating to the PTS were past their review date. There was no regular monitoring of the quality and performance of the PTS through, for example, setting of key performance indicators (KPI) including the national KPI for arrival and collection time of patients attending for dialysis.
- No audits of the service had been carried out including infection control audits to ensure compliance with policies and procedures.
- Although staff said they had undertaken mandatory training, the trust did not provide data to confirm uptake of all the mandatory training.
- Radio reception and connectivity in some areas of the island was poor which meant staff used their own mobile phones to contact dispatch or use satellite navigation systems.
- Limited feedback on patients' experience was obtained for the service and patient information on complaints was not readily accessible.

However,

- The service was able to meet the individual needs of patients and was accessible to patients who met the eligibility criteria set by commissioners. There was good use of risk assessments to reduce the risks to patients and staff.

Patient transport services (PTS)

- Team leaders demonstrated strong leadership and used their skills and experience to improve the service.
- There were systems in place to manage anticipated resource and capacity risks with a flexible workforce. A new late shift had been agreed to extend the operating hours of the service and facilitate discharge from the emergency department.
- Staff were caring and compassionate in their interactions with patients and made an effort to develop supportive relationships with patients, particularly regular users of the PTS.
- Staff reported incidents, received feedback and learning was shared across the service. However, staff were not familiar with their responsibilities under the Duty of Candour regulation.
- Staff were positive about the induction process and the support they received from their team leaders. All permanent staff had received an appraisal in the previous 12 months.

Are patient transport services safe?

Requires improvement

By safe, we mean people are protected from abuse and avoidable harm.

We rated safe as requires improvement because :

- Not all staff cleaned their hands before and after each patient contact. No infection control audits had been conducted to monitor compliance with infection control policies and procedures.
- Although staff said they had undertaken mandatory training, the trust did not provide data to confirm uptake of mandatory training in the service.
- Staff and managers were not familiar with their responsibilities under the Duty of Candour regulation.
- The mobile data terminal used to provide staff with patient information and navigation was unreliable; the system sometimes froze. Radio connectivity in some areas of the island was poor and staff resorted to using their own mobile phones to contact dispatch or use satellite navigation systems.
- The service did not report on the national KPI for arrival and collection time of patients attending for dialysis (NICE quality standard 72: QS6 patient transport (January 2015).

However,

- Staff reported incidents, received feedback and learning was shared across the service.
- Staff carried out risk assessments to ensure transport provision accommodated patients' individual needs.
- There were systems in place to manage anticipated resource and capacity risks with a flexible workforce.
- Staff completed a daily vehicle inspection check lists, although some of the vehicles were old, an effective repair and maintenance system was in place.

Incidents

- The majority of staff we spoke with said they reported incidents and received feedback. The manager of PTS told us few incidents were reported by the service. When incidents were reported they were assigned to the manager for investigation and subsequent closure.

Patient transport services (PTS)

- Staff were aware of a recent incident regarding a defect on a vehicle seat. The manager described the prompt actions taken by the service in response and the current status of the investigation. Staff were made aware of the issue and additional checks were introduced to reduce the risk of reoccurrence. Staff confirmed they reported incidents using the trust electronic incident reporting system.
- Data provided by the trust showed the ambulance and urgent care business unit had reported 432 incidents between August 2016 and October 2016, three incidents had been reported by PTS with no themes identified.
- There were no never events in the PTS over the same period. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of'certain notifiable safety incidents'andprovide reasonable support to that person. The trust's policy on being open (March 2015) incorporated the trust's responsibilities under the Duty of Candour regulation. However, staff and managers we spoke with did not have an understanding of Duty of Candour or the responsibilities in relation to this duty. Although, the manager told us they were aware Duty of Candour was flagged as a prompt on the electronic reporting system for incidents.

Mandatory training

- Mandatory training for staff included information governance, moving and handling and conflict resolution. Training modules were a mix of online e-learning or practical sessions.
- Staff we spoke with said they had undertaken mandatory training and were allocated time to do e-learning during their working hours.
- Although data was requested no data on overall mandatory training uptake was provided by the trust.

Safeguarding

- Staff we spoke with were aware of the trust's policies for safeguarding children and safeguarding adult. Staff had access to the policies via the trust intranet. Staff felt confident to make a referral, although staff we spoke with said they had not had cause to raise a concern.
- Staff described the occasional situation when they transported a patient to their home and there was no one present to receive them, for example, family members or carers. In such cases staff said they contacted the dispatcher who advised them what action to take or made enquiries. Staff said they would only leave a patient when they were assured they were safe. This was confirmed by our observations during the inspection when a similar incident occurred.
- Data for the last 12 months showed on average outside the holiday season, the PTS transported five or less children each month and during holidays the number peaked to 11 in August 2016.
- PTS staff we spoke with said they completed safeguarding adults and children training as part of their mandatory training. The trust provided data for November 2016 which showed 79% of PTS staff had completed safeguarding adults training and safeguarding children level 1 training. This was in line with the trust target of 80%.

Cleanliness, infection control and hygiene

- The PTS used eight vehicles. During the inspection, we viewed four vehicles. The interior of the vehicles were visibly clean, and one was dirty outside.
- The team leader informed us the vehicle cleaning and stocking team, known as the 'washer stocker', cleaned and restocked vehicles daily.
- Deep cleans normally took place outside the standard operating hours of the service to limit the impact on patients, through vehicles being off the road. If a vehicle became significantly contaminated, the crew returned to base for vehicle cleaning and a replacement vehicle. A notice board in the resource centre recorded the dates PTS vehicles had been deep cleaned and these were all in the last month. Staff did not report any issues with the standard of cleaning.
- Staff had access to personal protective equipment (PPE) such as gloves and aprons on their vehicles to reduce the risk of the spread of infection between staff and patients. Crews carried a spills kit on their vehicle to

manage any small spillages and manage the infection and hygiene risk to other patients. Staff completed a vehicle inspection checklist at the start of their shift which included checks for PPE.

- The trust provided data for November 2016 which showed 88% of PTS staff had completed infection control training and this was above the trust target of 80%.
- Staff wore uniforms and were aware of the trust uniform policy which included standards of cleaning and PPE to reduce the risk of contamination. We observed not all staff carried or used hand gel in between contact with patients. Not all staff were free of stoned rings and nail polish. This was not in accordance with the trust infection prevention and control policy and dress code and uniform policy, to minimise the spread of infection.
- The trust reported there had been no infection control audit of PTS vehicles in the last six months and no hand hygiene audits had been conducted. The last infection control audit for PTS was undertaken in 2014 and the next audit was planned for 2017.

Environment and equipment

- PTS had eight multi use vehicles; some with stretchers and some with seats only and two vehicles suitable for bariatric patients.
- The vehicle stock was of variable age, the majority of the vehicles were more than eight years old; the oldest vehicle over 10 years old was due to be replaced shortly. Staff said most of the vehicles' suspensions were poor which did not facilitate a comfortable journey especially on failed road surfaces. Staff felt this was of particular concern when transporting end of life patients on a stretcher. The manager informed us that approval had been given to replace one of the oldest vehicles.
- There was a monthly schedule of vehicle inspection and maintenance for vehicles used by the PTS and we saw a log of planned and completed service records for the PTS vehicles, which showed all vehicles were up to date with their service schedule.
- The washer stocker team checked and restocked consumables daily at the resource centre. PTS staff undertook daily vehicle checks as part of the standard operating procedure. Staff used a vehicle inspection checklist at the start of their shift. They were allocated 15 minutes to perform the checks and complete the record for vehicle and equipment checks, including for example, the defibrillator check. The trust reported the PTS manager reviewed the checklists, however, there was no audit of documentary completion of the checklists undertaken.
- We saw one of the vehicles had a very worn down floor on the driver side. The team leader said this issue would have been reported to the maintenance team and should be repaired in due course.
- Staff used a mobile data terminal (MDT) and radio to communicate with the dispatcher. We observed staff had to reboot the MDT on more than two occasions as jobs did not come through on time. Staff also used a paper log system as a backup.
- The radio reception on the island was poor in certain areas and the signal kept dropping out. We observed staff managed this risk on the road by using their own mobile phones to contact dispatch and for satellite navigation. We also observed the delays and time taken to communicate from the dispatcher's end when a crew had conveyed a patient home and there was no family to receive them. The dispatcher retried the radio and used the mobile phone to speak to the crew to update them.
- Staff told us they could access child seats or appropriate seat belts to ensure children were transported safely. Vehicles to transport bariatric patients were available across the service. We observed staff transported a patient in their own wheelchair and used safety straps to secure the wheelchair to the vehicle floor before the start of the journey.

Medicines

- There was a PTS procedure on use of oxygen (May 2014) with a review date of May 2016. The procedure stated 'To ensure that PTS staff are aware of safety considerations and familiarisation of oxygen cylinders, to facilitate the self-administration of oxygen by appropriate patients, or administration by a trained escort. The procedure also stated 'PTS staff will be responsible for the operation and maintenance of the oxygen cylinder to the level and scope detailed in their PTS training.' PTS staff told us they were not trained to administer gases or medicines. Patients or a qualified escort were responsible for the oxygen administration. PTS staff received training on the safe storage and handling of oxygen.
- We observed oxygen cylinders were safely secured on the vehicles we viewed.

- Patients travelling on PTS vehicles were informed they were responsible for all their own medicines.

Records

- There was a mixture of electronic and paper records. Staff had secure access to the MDT with their personal log in.
- Information on whether a patient had a do not attempt cardiopulmonary resuscitation order in place (DNACPR) was recorded on the patient notes section of the electronic record. Staff we spoke with said they would always check if a completed DNACPR was available when collecting patients, for example, from a care home.

Assessing and responding to patient risk

- There were appropriate systems and processes in place to assess and respond to patients who were at risk. Either a reoccurring risk that required the service to put a risk assessment in place or a sudden change to a patient's health that staff needed to escalate promptly.
- The service used an e-booking system which included details of the patients' mobility, needs and environmental considerations, for example, access to the property. This information was reviewed and a risk assessment undertaken by the team leader or an experienced staff member.
- We reviewed five risk assessments carried out in the previous three months; they were all completed appropriately with sufficient detail and a clear outcome. Risk assessments were stored electronically and printed for the crew to review.
- The risk assessments were conducted over the phone or by visiting the property. The outcome of the risk assessment determined the size of the crew needed and additional aids. For example, patients who needed to be conveyed on a stretcher, or if there were steps at the property, or transfer from a first floor accommodation.
- Staff said they occasionally had to ask for back up but the trust reported they did not record how often single crewed ambulances had to ask for back up as this was 'very rare.' However, staff did not describe this as a rare situation. They told us sometimes patients needed hoisting and they would wait for carers or another crew to arrive. We were also informed of a situation where a patient was in pain and could not be transported in a chair so the crew had to wait for a stretcher vehicle for transport.
- Staff we spoke with said they had confidence in the dispatcher and generally journeys were allocated to them appropriately, for example, they allocated a double crew to patients needing a stretcher lift.
- Staff were aware of how to escalate any concerns, for example, if a patient became unwell during a journey, staff told us they stopped their vehicle when safe to do so and assessed the severity of the situation. If needed they would call 999.
- Staff said they had completed basic life support training. However, although data was requested no data on training uptake was provided by the trust.

Staffing

- The PTS had a flexible workforce of 15 employed staff and approximately 10 staff employed on zero hour contracts. We reviewed the PTS staffing rota for 1 November 2016 to 21 November 2016, which showed all shifts had been filled as planned.
- Staff told us they recorded their availability in the shift diary and the resource team filled the shifts, three months in advance. A text was sent to all staff to inform them of available shifts and these were filled by staff on a first come basis. We saw a text message to staff during the inspection.
- The team leader considered the flexibility of the workforce worked well. For example, at quiet times bank staff could be 'stood down' and at busier times more staff were booked on. For example, journeys to the mainland meant a crew would be unavailable for the majority or whole of their shift and bank staff would be needed to cover.
- There were two team leaders, who covered Monday to Friday from 7.45am and 5.15pm. There was a day of overlap during the week, which allowed one of the team leaders to go on the road, to complete risk assessments.

Anticipated resource and capacity risks

- The PTS manager and team leader were aware of the service reliance on bank staff. However, they considered that all staff were highly motivated and demonstrated a loyalty and commitment to the service.

Patient transport services (PTS)

- An increasing pressure on the service was the proportion of same day bookings. As of October 2016, the rate was over 40%. This created significant resource demand.
- The number of journeys to the mainland and repatriations also significantly affected the service by occupying a crew for most of, or their entire shift.
- Staffing of the dispatch team was under pressure due to staff sickness. A plan was in place to merge the PTS dispatch role into the emergency control function to manage the service.

Response to major incidents

- The staff induction and procedures handbook (May 2014) included a section on response to major incidents and staff responsibilities. Staff we spoke with were aware of the trust's major incident policy and the role of the PTS, although staff said they had not been involved in a major incident response.
- The hospital major incident plan (February 2014) had no review date. It stated the PTS service would be under the command of the ambulance service and respond accordingly. There were action cards but not specifically for PTS staff.
- The trust reported PTS teams were invited, and included in, chemical, biological, radiological, nuclear and explosions (CBRNe) / special operations response team (SORT) refresher training. We saw debrief notes of an incident that had taken place in April 2016.

Are patient transport services effective?

Good

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.

We rated effective as good because:

- Staff had access to the information they needed to enable them to provide suitable care for patients.
- Risk assessments were carried out for all new referrals
- Staff were positive about the induction process and the support they received.
- All permanent staff had received an appraisal in the previous 12 months.

However:

- Limited key performance indicators (KPI) had been set or were reported including the national KPI for arrival and collection time of patients attending for dialysis.

Evidence-based care and treatment

- The patient transport service (PTS) provided transport to patients according to guidelines in the Department of Health 'Eligibility criteria for patient transport services' document. The patient's GP/ consultant or allied healthcare professional determined the patient's eligibility for PTS. The dispatcher assessed patients' eligibility for the service at the time of booking by asking set questions. If patients did not meet the criteria, staff gave advice on alternative transport services.
- To enhance the delivery of care the service had introduced an online booking system for health care professionals so they could book and track journeys efficiently.
- The service did not take into account all current and national evidence based guidance, for example, quality statement 6, patient transport of National Institute for Health and Care Excellence NICE quality standard 72- renal replacement therapy services for adults.
- The trust had a specific guidance on the transfer of children detailed in the conveyance policy. An appropriate escort was required to accompany the child.

Assessment and planning of care

- A basic risk assessment was completed for all new patients to ensure the service could provide suitable care for them during their journey. A detailed moving and handling risk assessment was conducted if needed based on the responses to the initial screening.
- Staff accessed care plans for patients on the computer aided dispatch system mobile data terminal (MDT) as part of the patient's record.
- We observed staff asked patients if they were comfortable and well enough to undertake the journey before setting off.

Nutrition and hydration

- The PTS did not routinely provide food or drink for patients during their journeys. The service reported the

majority of the journeys were short. However, for longer journeys for example, to the mainland, the wards provided a packed meal or the patient would be advised to bring their own food if travelling from home.
- During extremely hot weather it had become normal practice for water bottles to be offered, and this had resulted following concerns raised by staff.

Patient outcomes

- The PTS management team were in discussion with the commissioners to determine the new key performance indicators (KPIs) for the PTS based on national guidance. KPIs are a set of quantifiable measures used to measure or compare performance in terms of meeting agreed levels of service provision.
- NICE quality standard 72: QS6 patient transport (January 2015) states patients who use transport service to attend for dialysis should be collected from home within 30 minutes of the allotted time and collected to return home within 30 minutes of finishing dialysis. This KPI for arrival time prior to appointment and collection of renal patients was set nationally. The trust did not report on this performance.

Competent staff

- There were 25 PTS staff, two team leaders and one manager. Approximately 40% of PTS staff were employed on zero hour contracts. Through discussions with PTS staff and managers we found the PTS workforce was an experienced team with a wealth of knowledge and skills derived from previous careers in the public and private sectors.
- The trust appraisal policy applied to all permanent and temporary staff but it did not apply to bank workers this included zero hour contract staff. Permanent employed staff confirmed they received an annual appraisal and we saw an appraisal review which was fully completed and staff we spoke with confirmed it was a meaningful process. We saw a log of appraisals (November 2016) which showed 15 appraisals had been completed for PTS staff eligible for an appraisal in the previous 12 months.
- Staff were provided a copy of the staff induction and procedures handbook (May 2014). This comprehensive information regarding equipment, training requirements and customer care. We spoke with staff who were undertaking their induction programme and were supernumerary on crews until their competencies had been approved.
- PTS staff were not trained to administer oxygen, this meant that the patient was responsible for their own administration or the hospital had to provide a trained escort.
- Some PTS staff had undertaken emergency vehicle operator (EVO) training to enable them to also work in the front line ambulance service.

Coordination with other providers

- We observed the dispatcher contacted the referring departments and liaised with staff to coordinate patients' transport around their care, treatment and discharge.
- The dispatcher also provided information to departments if transport was delayed.

Multidisciplinary working

- Staff said they were a separate service from the ambulance service but had a good relationship with their ambulance colleagues.
- We observed effective team working between PTS staff, emergency department and outpatient department staff.

Access to information

- Staff felt they had access to sufficient information for the patients they cared for. If they needed additional information or had any concerns, they spoke with their team leader or staff working in dispatch.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- PTS staff we spoke with were aware of the Mental Capacity Act (2005) and how to care for patients with dementia. However, although data was requested no data on training uptake was provided by the trust.
- We observed staff seeking patients' consent before they used seatbelts or straps to ensure they were secure for the journey.

Are patient transport services caring?

Patient transport services (PTS)

Good

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

We rated caring as good:

- Feedback from patients about the care they received was positive
- We observed staff were caring and compassionate in their interactions with patients and made an effort to develop supportive relationships with patients, particularly regular users of the PTS.
- Staff were conscious about maintaining a patient's privacy and dignity.

However

- Limited feedback on patients' experience was obtained for the service.

Compassionate care

- We spoke with three patients, all of whom had used the service before. They all told us they were happy with the care provided. The only issue was occasional long waits for the return journeys from the hospital.
- We observed the crew were familiar with the needs of a patient who was conveyed three times a week for dialysis. They took care to ensure the reclining position of the stretcher met the patient's needs. On other occasions, staff asked patients if they needed a blanket and were comfortable with the temperature. We observed staff treated patients with dignity and respect.
- In July 2016, the trust began using the friends and family test (FFT) feedback for the PTS service. However, no feedback for the PTS service had been received thus far.

Understanding and involvement of patients and those close to them

- We observed the dispatcher called patients/ carers 24 hours before the scheduled journey to confirm details on the booking form, for example ensure access to the property or whether patients had their own wheelchair.
- Staff told us, if appropriate, escorts were booked onto journeys but there was strict eligibility criteria due to the limited space and demand for the PTS. For example, conveyance of children required an escort.
- Staff provided clear information to patients about their journey and informed them of any delays.
- We observed staff accompanied patients to their destination and assisted with booking-in at reception when attending for an outpatient appointment.

Emotional support

- Staff told us they enjoyed the patient contact part of the job and genuinely took an interest in getting to know their patients, especially those who travelled with them regularly.
- In our discussions and observations, we found PTS staff demonstrated a calm and reassuring attitude in their interactions with patients.

Supporting people to manage their own health

· Patients were encouraged where possible to use their own mobility aids to walk to and from the vehicle. We observed staff supported patients appropriately. They were mindful not to rush and worked at the patient's pace.

- Specific eligibility criteria were followed to access the PTS. We observed staff directed patients and health care professionals to alternative transport services if they did not meet the eligibility criteria. This information was also accessible on the trust website.

Are patient transport services responsive to people's needs?

(for example, to feedback?)

Good

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

We rated responsive as good because:

- The PTS planned and delivered the service to meet the needs of the local population in line with national eligibility criteria.
- The implementation of the e-booking system improved accessibility of the service.
- A new late shift had been agreed to extend the operating hours of the service and facilitate discharge from the emergency department.

However:

Patient transport services (PTS)

- Patient information on complaints was not available on the PTS vehicles

Service planning and delivery to meet the needs of local people

- The PTS service was commissioned to run as a separate entity from the rest of the ambulance service.
- PTS provided non-emergency transport for patients who were unable to use public or other transport due to their medical condition. This included those attending hospital, outpatient clinics, being discharged from hospital wards or requiring treatment such as chemotherapy or renal dialysis. PTS bookings were scheduled for 10am and 2pm appointments to coincide with hospital appointments.
- The manager told us the service was currently undertaking approximately 40% non-planned work mainly discharges from hospital on the same day. An e-booking system had been rolled out so ward staff could book online PTS. A new late shift (1pm to 10.30pm) was about to commence to manage the demand.

Meeting people's individual needs

- Staff said they had access to language booklets but these were not usually used for PTS staff except for repatriation duties for holiday makers. In which case they would be made aware of the patients' language needs beforehand.
- Data for November 2015 to October 2016 showed of 8000 PTS journeys approximately 50% patients conveyed used their own or ambulance wheelchair, 25% were on a stretcher and the remainder required assistance with walking.
- Staff said parents provided their own seat belt for children, if appropriate. Usually the patient faced forward and carried the child. Staff said on occasions when children were transported it was often with a parent and nurse escort.
- At the time of booking a journey, the dispatcher asked relevant questions to obtain information on the patient's mobility, additional needs such as hearing or sight impairment and if the patient needed an escort, for example, if they were suffered from dementia or had a learning disability. Staff also recorded whether a patient was bariatric. This detailed recording enabled the correct allocation of crew to the journey. For example, a two or three staff crew was used to support patients' individual needs.
- Where patients with mental health conditions needed to be conveyed a risk assessment was undertaken to ensure the safety of patients and staff. The team leader had carried out a risk assessment on violence and aggression in April 2016 which did not highlight any areas for action.

Access and flow

- Data for the last six months showed the service provided on average 780 journeys per month, of which 40% were less than 24 hours notice. Other data showed on average 15% PTS journeys each month were cancelled.
- At the time of the inspection limited data on performance response times of the service was collected and reported on.
- During the inspection, we attended the emergency department to be informed by staff the family had already taken the patient home. PTS staff said sometimes it took additional time to locate the patient if the patient had moved from ED to the fracture clinic or had gone for a blood test and hospital staff had not informed dispatch of the updated pick up location.
- The introduction of the e-booking system had improved the planning of the service. Patients were not auto allocated a return journey until hospital staff or the patient contacted the dispatcher to confirm they were ready for collection. This helped to improve efficiency and save time.
- We observed the dispatcher planning on the day and future bookings. The dispatcher was extremely able and knowledgeable about the island geography. They factored in the needs of the patient, estimation of how long the journey would take and the direction of travel. They used this information to improve the service efficiency by allocating journeys to a crew that was travelling in the same direction.
- The dispatcher also managed the booking of journeys to the mainland. On average there was at least one patient journey to the mainland daily which meant a crew was occupied for the most or part of their shift.

Learning from complaints and concerns

- Staff said they did not believe the service received many formal complaints. Occasionally they heard patients

complaining about the delays to pick up journeys. Staff we spoke with were aware of learning from a complaint where staff were reminded to ask patients if they wanted staff to assist with securing their seat belt or preferred to secure it themselves. Complaints date for the clinical business unit for November 2015 to November 2016 showed the ambulance service had received seven formal complaints, none of which related to the PTS service specifically.

- Staff described the process they followed to support a patient who wished to make a complaint, including contacting a team leader if appropriate.
- Patients we spoke with said they had not had cause to complain, however, if they needed to they would call the service or speak to the hospital. Information for patients on how to make a complaint was not available on the PTS vehicles we inspected.

Are patient transport services well-led?

Requires improvement

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation and promotes an open and fair culture.

We rated well-led as requires improvement:

- There was no regular monitoring of quality and performance through setting of key performance indicators.
- There were no audits of the service to monitor or drive service improvement.
- All the policies relating to the PTS were past their review date, which meant they may not have reflected up to date guidance.
- Staff were not aware of the vision for the service, although the manager was involved in the development of the PTS.

However:

- Staff were positive about the leadership of the PTS and described a positive culture within the team.
- Team leaders were exceptional and used their skills and experience to improve the service. For example, the team leader had analysed information to support a bid for an additional late crew.

Leadership of service

- We spoke with the trust integrated transport manager and one of the team leaders. The team leader was very experienced and skilled in managing the service.
- Staff spoke positively about their team leaders. They had confidence in their ability to lead their team. Staff felt the team leaders had a good understanding of the current concerns that affected their team and where possible addressed these concerns or escalated them to their manager. For example, the team leader had worked with the dispatcher to understand the demands of the role.
- There had been major organisational changes in the ambulance service over the previous 12 months, which had led to a transition from the directorate structure to clinical business units. This meant there were currently unfilled posts or staff in interim positions. Staff we spoke with described the 'massive loss of ambulance experience' and time needed for the new structure to bed down.

Vision and strategy for this service

- There was a PTS information pack (February 2014) which explained the aims and operation of the service, how to book PTS, patient eligibility and service response times.
- Staff we spoke with on the front line were not aware of the vision for the PTS service. However, the manager of the service was clear the vision for PTS was integrated with the overall ambulance strategy and the service would be developed in line with the new clinical business units.

Governance, risk management and quality measurement

- The PTS service was in the ambulance, urgent care and community business unit. The manager was currently in discussion with the commissioners to determine the performance measures. Draft reports had been produced which included information such as delayed

arrivals and discharges, risk assessments and mainland trips. There was clear evidence of progress and partnership working with commissioners. Although no internal or external KPIs were currently reported.

- The team leader had undertaken a review of demand and capacity using the data from the e-booking system. The results had contributed to the successful bid for an additional late crew to transport patients' home from the emergency department (ED) and facilitate patient flow through ED.
- In April 2016, the team leader had carried out a range of risk assessments in the PTS, including control of substances hazardous to health risk assessment, fire safety, lone working, manual handling and violence and aggression. None of which identified any areas of non-compliance.
- The clinical business unit had a joint risk register for ambulance, urgent care and community. We noted there were no risks recorded regarding the PTS.
- Policies were in place, which governed the patient transport service functions, and standard operating procedures to ensure consistency and safe practice. However, all the policies we reviewed relating to the PTS were past their review including: local induction procedures (May 2014, review date May 2016), PTS information pack (July 2013, no review date), ambulance service conveyance policy (February 2014, review date December 2015), use of oxygen (May 2014, review date May 2016). This meant the policies may not have reflected up to date information and posed a risk to staff and patients using the service.
- Staff recorded the time they arrived to collect a patient, their departure time, arrival time at the destination and time when they left the patient. This was recorded on paper as the electronic system was not accurate due to the poor connectivity in certain areas of the island. We were told the information from the e-booking system was analysed. However, the paper records provided more accurate data and it was not apparent that this data was used for analysis.
- No internal audits had been completed to monitor compliance with infection control practices. There was potential risk to staff and patient safety, through lack of observation and monitoring of performance.

Culture within the service

- Staff were passionate about their work and very caring. However, PTS staff did not feel part of the wider ambulance service and consequently not integrated with the trust. An example of this was that PTS staff wore a different uniform to ambulance staff, which contributed to the separation of the services. Staff felt their role was under-valued by the organisation, due to the band 2 position of PTS staff. Although, it was acknowledged the banding was due in part to PTS staff not trained to administer oxygen.
- We observed effective team work, support and mutual respect between staff. The team leader valued the skills of the PTS staff and recognised the varied experiences staff brought to the service from previous roles; they described the staff as 'exceptional and high calibre.' The motivation and commitment of bank staff was also noted.
- The service had received a trust award in October 2016 in recognition of their 'outstanding accomplishments' in 'going the extra mile'.

Public engagement

- Staff said there were patient satisfaction questionnaires but these were not normally offered to patients.
- The trust reported they received limited feedback from patients through surveys. A survey had been undertaken between 1 May 2016 and 30 June 2016. Nine responses were received. All the responses were positive. In July 2016 the trust began using the friends and family test (FFT) feedback for the PTS service. However, no feedback for the PTS service had been received thus far.
- The PTS provided eligibility information for the public on its website to identify who could access and use the service.

Staff engagement

- Although there had been no formal team meetings held within PTS in the last 12 months, a meeting was planned for December 2016. However, our discussions with staff and managers indicated staff were well informed about issues affecting the service and information sharing took place informally in the PTS base office.
- Staff we spoke with said the team leaders were very good at communicating information. Key information was emailed to staff and we saw notices placed on the office notice board.

Patient transport services (PTS)

- PTS staff had come from a mix of backgrounds and different careers. They were experienced staff and told us they did the work because they enjoyed it.

The majority of staff told us they felt able to raise concerns and senior staff sought their views on how the PTS could be improved.

Innovation, improvement and sustainability

- An e-booking system for PTS had been implemented to improve efficiency and facilitate data capture for analysis and service planning.
- A late shift had been introduced to improve patient flow through the ED

Emergency operations centre

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

Information about the service

The emergency operations centre (EOC) for the Isle of Wight Ambulance service is located on the site of St. Mary's Hospital in Newport. The EOC is located in a multidisciplinary hub office that contains desks for other trust services such as community health services, and 111 services.

The emergency operations centre took 24597 last year. The EOC takes 50-60 999 calls a day on average.

During our inspection, we spoke with 11 staff and listened to 20 calls.

Summary of findings

We rated this service as requires improvement because:

- There was no assurance all staff members had received an annual appraisal and learning plans developed as part of this process. There was no formal system for ensuring those Community First Responders registering for duty were competent in their role. Call handlers had not had training in the Mental Capacity Act (2005), or learning disability or dementia awareness.
- The proportion of emergency calls resolved by telephone advice was lower than expected and calls abandoned before being answered was consistently higher than expected.
- Staffing levels in the EOC consistently did not meet the planned levels. Although staff worked flexibly to manage the potential risk.
- Staff they felt there was insufficient knowledge and experience amongst the senior managers within the clinical business unit to effectively manage the service. They also raised concern about the number of manager in interim roles and their ability to make decisions.
- There was no clear vison or strategy for the service. The number of meetings and the complexity of the reporting structure made it difficult to clearly see how over sight of the quality and risk of the service were maintained. The risk register was not reflective all of the current risk.

Emergency operations centre

- There was no formal process for engaging with patients.

However:

- Staff were aware of how to report incidents and learning from incidents were displayed for staff to read, however most staff where not able to describe any learning from incidents
- Staff were aware of how to give safe advice on self-medication.
- Staff had a good understanding of how to recognise and report safeguarding.
- The EOC had plans and back up arrangements to ensure service continuity in the event of a business continuity incident.
- The service co-ordinated effectively with other emergency and community healthcare services.
- The service used the accredited NHS pathways system to triage calls and provide clinical advice.
- The trust consistently had the shortest waiting times of any trust in England for call answering. The proportion of patients who re-contacted the service following discharge of care, by telephone within 24 hours was lower than the England average.
- Staff treated people with dignity, respect and kindness during all interactions.
- The service made reasonable adjustments and took action to remove barriers to enable people to access the service easily.
- Staff in the EOC spoke highly of the support they were given from their direct line managers and were proud of the strong sense of team work.

Is emergency operations centre safe?

Good

By safe, we mean that people are protected from abuse and avoidable harm.

we rated safe as 'good' because

- Staff were aware of how to report incidents and learning from incidents were displayed for staff to read, however most staff where not able to describe any learning from incidents
- Staff were aware of how to give safe advice on self-medication.
- Staff had a good understanding of how to recognise and report safeguarding.
- The EOC had plans and back up arrangements to ensure service continuity in the event of a business continuity incident.
- Staff had completed their mandatory training to a level expected by the trust

However:

- Staffing levels in the EOC consistently did not meet the planned levels. Although staff told us that flexible working by all staff helped to manage the potential risk.

Incidents

- From October 2015 to September 2016, there were 47 incidents reported by staff for the whole ambulance service; this represented 1.2% of the total incidents reported for the trust. It was not possible to determine how many incidents related just to the emergency operations centre. Forty-one were no harm, five low harm and one moderate harm. The most prevalent incident category was infrastructure (including staffing, facilities and environment). This accounted for over half (53.2%) of the total incidents for the ambulance service. None of these incidents resulted in moderate/severe harm or death. This was followed by treatment, procedure incidents (eight or 17.0%). One of these incidents resulted in moderate harm.
- There were no never events over the same period. Never Events are serious incidents that are wholly preventable

as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

- Staff told us they were aware of how to report incidents and they would be confident to report an incident if they needed to. However, they said they would usually inform the performance support officer (PSO) or dispatcher during the night shift of the incident for them to submit an electronic incident form.
- Staff told us learning from incidents would be displayed on the noticeboard display screen and at staff meetings. However, most staff were unable to describe learning from incidents. The PSO could describe the learning from a recent serious incident as the recommendation following the investigation involved them directly this being the PSO should be performance managing rather than answering calls. A clinician described how the non-conveyance policy had been updated following an incident.
- We reviewed four sets of minutes for the weekly senior managers meeting for the CBU, although staff were reminded to close incidents there was no discussion or learning shared from incidents to improve safety across the trust.
- We reviewed four sets of minutes for the Ambulance Clinical and Quality Effectiveness Group (CQEG); these showed that incidents were discussed including the required action. Although staff were reminded to close incidents there was no discussion or learning shared from incidents to improve safety across the trust.
- The Operational Management Group and the Senior Management Group reviewed incidents.
- The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. Staff understood Duty of Candour meant they had a duty to be open and honest with patients if things went wrong.
- The operations managers demonstrated an awareness, and commitment to, Duty of Candour. At the time of the inspection, the service had never had to invoke Duty of Candour.

Mandatory training

- Mandatory training for EOC staff included: safeguarding adults and children, incident reporting, control of substances hazardous to health, dignity at work, fire safety, health and safety, infection prevention and control, information governance. Domestic violence awareness was not included in mandatory training.
- The trust set a target of 80% completion for all training courses.
- Staff in the EOC told us they did not have protected time to complete mandatory training, although staff were able to use quiet times, usually during night shifts to do this.
- Staff recorded their mandatory training on a training tracker. Information provided by the trust, following the inspection, indicated across 30 mandatory training subjects, the compliance for the ambulance service varied from 16% to 100% with an overall compliance of 78% . This was below the trust target of 80%. The EOC is part of the 'Hub' and the overall percentage completion rate for this group of staff was reported as 88%. There was no further break down by subject for this team.

Safeguarding

- Staff were aware of the trust standard operating procedure for safeguarding. The PSO explained clinicians would raise safeguarding alerts by emailing the central referral team at the local authority.
- Staff had good awareness of identifying concerning situations. We observed call handlers listening out for background noises that could alert then to safeguarding issues. Call handlers described how they would identify child-safeguarding risks for example, very young children with head injuries.
- Call handlers noted in the computer aided dispatch system (CAD) when they identified a safeguarding concern; they would then pass the call onto a clinician to triage and alert the local authority.
- If staff had urgent safeguarding concerns, the police were called to attend the scene.
- A noticeboard with information about safeguarding was displayed in the hub. The board displayed contact details for the trust safeguarding lead, the local authority safeguarding team. Guidance on child protection awareness was also displayed.
- Staff we spoke with were aware of the trust named safeguarding lead. There were plans to have a safeguarding representative in the hub.

- Staff could not describe learning from safeguarding reviews. A clinician told us learning from safeguarding reviews would be sent out via email.
- Information provided by the trust showed that for the hub, which includes the EOC, for each staff group, compliance with the trust safeguarding training target of 80% was achieved for all staff groups except for allied health professionals, safeguarding adults at 50%,and nursing and midwifery staff, children safeguarding Level 2 at 50%.

Cleanliness, infection control and hygiene

- Staff could access the trust infection prevention control lead for advice.
- Clinicians described how they would inform crews if a patient had a known infection.
- EOC staff all wore trust uniforms. Alcohol hand gel was available at the entrance to the EOC.
- Staff desks in the EOC were visibly clean. We observed staff wiping down desks with alcohol wipes. Staff did not eat at desks and only drank from bottles or lidded-cups.

Environment and equipment

- Information was displayed on seven large screens in the emergency control room. The screens displayed the following information – a staff noticeboard, CCTV of the island provided by the local authority, hospital CCTV, live performance data, a map of the island with the location of ambulance vehicles, tracking of call activity and TV screen showing the news.
- Staff completed a Display Screen Equipment risk assessment as part of their mandatory training. A PSO told us that they would refer people to occupational therapy for back care if necessary.
- The noise levels in the EOC did not interfere with staff handling calls.
- The EOC was secure and only accessible to staff with a key card.
- The EOC had a kitchen where staff could go to take some time out if they had dealt with a particularly distressing call.
- The PSO carried out checks on the airwaves store daily.
- The EOC was built to RIBA Designing for Counter Terrorism standards 2010.

Medicines

- We saw call handlers passing on appropriate self-medication advice generated from the NHS pathways triage system.
- Clinical advisors described how they would support patients to self-medicate safely. Clinicians confirmed the dosage with the patient and stay on the phone until the medication had been taken. A clinician described how they would listen for the spray sound if they had advised a patient to take their glyceryl trinitrate spray to relieve angina.
- Call handlers described that they were only allowed to advise patients to take paracetamol or ibuprofen. If patients needed advice on other medications they would be passed to a clinician.
- At all times of our visit, we saw there was at least one clinician present in the EOC to provide medical advice, this is a licensing requirement of NHS pathways.

Records

- It was trust policy to record all patient calls for safety and performance monitoring. This was also a requirement of NHS pathways licensing.
- The EOC handled 999 and NHS111 calls. There were two separate software systems for recording patient notes, one for each service.
- Special notes were recorded on the system – clinicians searched the patient's name to see if there were any notes relating to pre-existing conditions or safety risks.
- We observed staff in the EOC updating patient notes with relevant information during and after calls.
- Records included time stamps from the ambulances – call received, case submitted, scheduled, en route, on scene, at destination.
- The electronic system was secured with passwords. Staff logged into the electronic system with a password and were observed locking their computer when away from the desk.
- Staff had access to paper log books for use in the event of system failure.
- We saw confidential waste bins available in the EOC where staff could discard of confidential waste securely.
- Displays screens in the control room showed the priority of the calls coming in and showed which callers were in a call, available or on a break. The screen also displayed whether a call handler was taking a 111 or a 999 call. The PSO monitored the display screens to ensure calls were responded to promptly.

Emergency operations centre

Assessing and responding to patient risk

- The EOC used the NHS pathways system to triage and prioritise calls. We saw call handlers ask a set of questions to priorities calls guided by NHS pathways. The result of the triage assessment prompted the actions of EOC staff. When clinically indicated the EOC dispatched an ambulance for treatment at the scene or transfer to hospital. Alternatively, call handlers could transfer calls to a clinician for "hear and treat" advice when the NHS pathways tool indicated this was appropriate.
- Clinical advisors listened in to all 999 calls when possible. A clinical advisor told us that this allowed for more effective and timely triage. This was important as due to the limited number of ambulance crews available. When there were calls with the same triage code needing a response the clinician could make a decision as to which case was more urgent. We observed the despatcher clarifying with the clinician which calls were most urgent when there were two urgent calls at once.
- Clinicians could communicate with call handlers through instant messaging. We observed clinicians instant messaging call-handlers to prompt them to ask questions that are more specific about sepsis in order to improve triage.
- Clinicians telephoned patients to check their welfare whilst they waited for an ambulance. When calls were stacking we observed clinicians calling patients to reassure them, assess their symptoms and triage them appropriately.
- Special notes were attached to the individual on the patients records . The clinician would look up all patient names on this system to check for special notes in order to advice crews of any known concerns or instructions.
- If a patient became uncontactable during a call a clinician would triage the call and send an ambulance urgently if they thought it was necessary.
- Dispatchers liaised with the clinical support desk to ensure that a crew with an appropriate skill mix was dispatched to meet the care and treatment needs of a patient. The service had a standard operating procedure on the use of the response care paramedic, which was to be used at the discretion of the dispatcher having taken advice from a clinician.

Staffing

- A resourcing team was introduced in February 2016. The team managed the rotas for the control centre staff. Rotas were populated eight weeks in advance and covered four weeks. The rostering team monitored staff hours to ensure they did not work an excessive number and had adequate breaks.
- There was a three shift pattern for call handlers Monday to Friday and a two shift pattern at the weekend. The expected number of call handlers cover for weekdays was three on the day shift, four from 6pm until midnight and three overnight. At the week end there should be five covering the day and three overnight. There was an expectation there would be at least one clinical advisor at all times. Shift overlaps meant that this should increase to two at busy times. The plan was for one dispatcher to be on duty at all times, with one PSO during the week with one on call cover from midnight to 7am.
- Staffing level for the control centre was 2.5 call handlers below the commissioned level. A staffing scoping exercise with a few to optimise 'ways of working' had been undertaken and this had suggested they were under staffed by 5.5 call handlers.
- For the two weeks 13th November to 26th November 2016 the EOC met its establishment 3 out of 14 days. At no time was the centre without a clinical advisor, a PSO or a dispatcher. At times when they had been short by one call handler we were told all staff supported each other and all members of the team who had completed the required training would take calls. The service did not use agency staff.
- There were 45 whole time equivalent staff in the EOC. The staff worked across 999 and 111 services and were multi-skilled to ensure resilience.
- NHS pathways licensing rules required at least one clinician to work in the EOC at all times. We saw clinicians present in the EOC at all times during the inspection. The staff rotas also confirmed this.
- Dispatchers booked breaks for frontline crews within a four to six hour window to optimise their availability to respond to category red 1 and red 2 calls. On the day of inspection, six out seven crews had their breaks in the four to six hour window. The dispatcher submitted data on meal breaks to the PSOs.
- The PSO covered for the dispatcher when they needed a break.

Emergency operations centre

- The bronze and sliver commanders worked a one six on call rota. The gold commander was the trust wide clinical director or trust CEO.

Anticipated resource and capacity risks

- Staff told us additional call handlers would be put on shift during busy periods such as festivals during the summer and bank holidays. The service operated a weekend rota, with one extra call handler than during the week, for bank holiday periods to meet increased demand.
- There was a business continuity plan. Staff had access to this plan which included details of how to respond in the event of: a minor fire in the hub, radio failures, power supply failures, telephone failures, evacuation of the hub due to fire and failure of the CAD and electronic records system. Staff told us they would use laptops and paper logbooks if the computer systems crashed.
- EOC had 16 hour uninterruptible power supply battery back-up and a generator for use in the event of a power cut. At the time of inspection, the back-up battery had been tested and worked well.
- At the time of inspection, the service had no capacity to take a patient to the mainland the next day. This was escalated and a private ambulance was booked to transfer the patient. Staff explained this was in order to maintain the capacity of the fleet available on the island. Trips to the mainland were discussed at the bed management meeting.

Response to major incidents

- Action cards were available to staff with details of how to respond to major incidents. There were separate action cards for significant, major, chemical, firearms and Hazardous Area Response Team (HART) incidents with information on how each desk should respond.
- At the time of inspection, a major incident table top exercise was received from a neighbouring ambulance service. The PSO informed the local trust the level of resource they could offer to the local trust under mutual aid agreements.
- We observed that staff had access to national ambulance resilience unit (NARU) log book to record their actions during a major incident.

Is emergency operations centre effective?

Requires improvement

We rated effective as requires improvement for the emergency operations centre because people were at risk of not receiving effective care or treatment.

We found:

- There was no formal system for ensuring those Community First Responders registering for duty were competent in their role.
- Call handlers did not have training in the Mental Capacity Act (2005).
- There was no assurance all staff members working for the emergency operation centre had received an annual appraisal and learning plans developed as part of this process.
- The proportion of emergency calls resolved by telephone advice was lower than expected and calls abandoned before being answered was consistently higher than expected.

However:

- The service co-ordinated effectively with other emergency services and community healthcare services.
- The service used the accredited NHS pathways system to triage calls and provide clinical advice.
- The trust consistently had the shortest waiting times of any trust in England for call answering. The proportion of patients who re-contacted the service following discharge of care, by telephone within 24 hours was lower than the England average.

Evidence-based care and treatment

- The service used the NHS pathways system to triage calls and provide clinical advice. NHS pathways, was accredited as a “safe and appropriate” system for 999 calls. The Royal Colleges, an independent clinical group and an evaluation study supported the system. NHS Pathways were under constant review and direction by the clinical community via the independent National Clinical Governance group.
- Clinical staff supported call handlers, and we saw call handlers seek clinical advice from clinicians. A clinician was present at all times in the EOC, throughout our visit, in line with NHS pathways licensing requirements.

Emergency operations centre

- If there was new guidance relevant to the ambulance service, it was discussed at the ambulance clinical quality and effectiveness group.

Assessment and planning of care

- We saw call handlers triage calls in line with national guidance. For example, category Red 2(serious but not the most life threatening) calls for patients at risk of sepsis.
- Dispatchers could send community first responders (CFRs) to patients when they could potentially arrive on the scene faster than the nearest ambulance crew. CFRs were volunteers trained to attend emergency calls and provide care until the ambulance arrived. CFRs allowed the service to provide a faster response in some rural areas of the island where there may be a longer wait for an ambulance due to their distance from an ambulance station. Dispatchers always sent an ambulance at the same time as a CFR to ensure the CFR had clinical back up.
- In order to assess a patients pain the NHS pathways triage tool had a “body map” screen. We saw call handlers select the area of the body where the caller told them they experience pain. This then prompted a serious of questions to assess the type and severity of pain remotely. We saw call handlers ask clinicians for advice if they needed help with a triage assessment.
- We observed clinicians assessing patients over the phone and giving “hear and treat” advice. Clinicians accessed a live directory of services to refer patients for treatment in their community where this was appropriate. A clinician arranged for a child with chicken pox and a temperature over 41C to be received by a doctor at A&E.
- The PSO told us the s.136 protocol was for the ambulance crew and police to attend to the patient together. Call handlers would identify patients as having mental health needs by passing the call to the clinician to assess the patient.

Response times

- National Ambulance Quality Indicator standards expected ambulance services to answer 95% of all 999 calls within five seconds. The service delivery manager told us the trust no longer asked them to report on this target as it was unachievable. The information was captured and reported and the trust median time to answer calls was consistently one second between December 2015 and November 2016. The trust consistently had the shortest waiting times of any trust in England over these 12 months. At the time of inspection, the live information displayed in the EOC showed that the trust was not meeting this target.
- The proportion of calls abandoned before being answered was consistently higher than the overall England proportion between August 2015 and July 2016. In December 2015 the proportion of calls abandoned more than doubled compared to November 2015.
- The proportion of calls abandoned before being answered was consistently higher than the overall England proportion between December 2015 and November 2016. However, the overall trend of improvement contrasted with a deteriorating trend in England performance. Between September and November 2016, performance was slightly better than the overall England performance.
- The trust had a policy on group calling for outstanding red 1, red 2 and multi-agency calls. The dispatcher would call on an open channel.
- The PSO in the EOC monitored real time performance of the service and discussed performance with the operations manager when it fell below targets. The PSO submitted daily performance information which was distributed to the senior management team through the Performance Decision System (PIDS)

Patient outcomes

- The proportion of emergency calls resolved by telephone advice was lower than the overall England proportion in 11 of the 12 months between August 2015 and July 2016.
- The proportion of patients who re-contacted the service following discharge of care, by telephone within 24 hours was lower than the England average in six of the 12 months between August 2015 and July 2016. The rate was highest between December and February, perhaps indicating winter pressures.
- Auditors carried out an NHS Pathways audit of at least three calls a month for every staff member taking calls. If there were concerns about staff performance, a higher number of calls per month would be audited an improvement was shown.
- Results of the NHS Pathways audit were displayed in the hub. For September 2016 10 staff scored 95% or above and in October 2016 11 staff scored 95% or above.

Emergency operations centre

Competent staff

- The induction programme to train staff in NHS pathways included two weeks in house learning, at least two weeks of mentoring and the competencies were signed off. Call handlers told us they felt well-supported during induction. Call handlers told us they felt well supported during induction.
- Information provided by the trust following inspection indicated that 33% of staff working in the hub, where the EOC was based, had received an appraisal as of November 2016.
- Clinicians told us they had their appraisals with clinical support officers. However, Independent Learning Plans with clinical objectives, which should be developed as part of this process, were not completed. A clinician told us they did not receive as much support for revalidation as frontline staff.
- Staff in the EOC did not have monthly 1 to 1 conversations or supervision with a line manager. Staff told us that line managers were approachable if staff needed to talk with them.
- Staff had access to further relevant training and gave us examples of courses the trust had funded them to complete for example, open university courses.
- The trust was not assured of the competency of Community First Responders (CFRs). The PSO told us they knew CFRs were competent, as they had been issued with equipment. The Operational Manager informed us that there was not a manager with a remit for managing the CFRs. There were plans to address this and work had been undertaken to ensure those CFR booking on for duty were actively attending training. There were 34 responders identified, 15 of whom were active and attending training.
- Staff were required to complete a six weeks training course on the use of the pathways they followed, this was followed by two weeks monitoring by a mentor before they were signed off as competent.
- Staff completed updates on NHS Pathways twice a year and staff had protected time to complete this.
- The operations manager had completed a national ambulance resilience unit recognised course for silver commander. We were told that six people had completed the silver level training and six the bronze level training had completed operational commanders course. We were told the CEO and chief operating officer had completed the gold commander training.

Coordination with other providers

- Dispatchers and clinicians telephoned hospital emergency departments to pass on "ASHICE" information from crews transporting a patient. ASHICE was information about the patient's age, sex, history, injury/illness, and estimated time of arrival at hospital. The purpose of ASHICE was to pass the most vital patient details to the receiving hospital. This allowed hospital staff to prepare for the patient's arrival.
- The EOC had direct telephone links to the fire service and the police. This allowed fast and responsive contact between emergency services. We observed a call handler take a call from the police and inform them that an ambulance crew was on the way to the scene. The call handler took the police reference number and gave the ambulance reference number for the job.
- The PSO was responsible for organising transfer of patients via helicopter to local hospitals on the mainland. A neighbouring ambulance trust would be contacted if an air ambulance was needed. At the time of inspection, a dispatcher had recently gone on a Helicopter Emergency Medical Service training course.
- We observed a call from social services asking for patient transport. The call handler quickly passed the call onto the patient transport desk located in the EOC hub office.
- A directory of services desk in the EOC was available to signpost patients to local pharmacy and GP services. Staff could also search a directory of services through clinical patient management system.
- Do not attempt cardio pulmonary resuscitation (DNACPR) orders were flagged on the clinical patient management system with an orange box. Staff described how they would ask the caller if the patient was terminally ill and advise them to have their purple DNACPR form ready for when crews arrived. The call handler would inform the crews that the patient had a DNACPR order in advance of them arriving at the scene.
- The local authority telecare service was based in the EOC hub.

Multidisciplinary working

- The EOC was located within a multidisciplinary hub office that included other services provided by the trust, these were single point of contact to access rehabilitation and community services, crisis response

(over 65 admission avoidance scheme), patient transport, pharmacy, district nursing co-ordination. Staff working for the ambulance service were grouped in one area of the hub.
- The crisis team, located in the EOC, could organise emergency packages of care for frail patients within 72 hours in order to avoid hospital admission.
- Staff were able to co-ordinated with the trust's mental health crisis team and "Serenity" team, a partnership with the mental health service and the police.
- There was a positive working relationship between dispatchers and crews. We saw a dispatcher carry out "welfare check" calls to paramedic crews.
- We observed good working relationships between call-handlers and clinicians. We saw call handlers getting advice from the clinical support desk when necessary.

Access to information

- The service used two software systems for NHS 111 and 999 calls, a clinical patient management system and a Command and Control' call taking and response management (CAD) system. There was no flagging for clinical risk/DNACPR/mental health on the CAD system. Clinician would look up patient on the clinical patient management system to check clinical risk flags. This meant call handlers would not be aware of the special notes until a call was transferred to a clinician.
- Frequent callers were not flagged in the CAD system. Staff told us they would identify frequent and high volume callers through their experience and knowledge of the service.
- Clinicians had access to a directory of services (DoS). This was a live database of community health services. Clinicians could signpost patients to an alternative service if they did not need an ambulance response.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Call handlers we spoke with had not received training in the Mental Capacity Act 2005 (MCA). Call handlers told us they would pass calls to clinicians if they were uncertain of a patient's capacity.
- A clinician described how they would use their professional judgement to assess capacity over the phone. The clinician described how they would prioritise patients they thought lacked capacity so they could have a 'face to face' assessment with a paramedic.
- We requested the training information from the trust but this information was not provided.

Is emergency operations centre caring?

Good

We rated caring as good for the emergency operations centre. This was because people were supported, treated with dignity and respect, and involved as partners in their care.

We found:

- Staff treated people with dignity, respect and kindness during all interactions.
- Staff gave information over the telephone that encouraged people and those close to them to be partners in their care, by giving advice on how to stay safe until the ambulance arrived.
- Staff helped people and those close to them to cope emotionally with their care and treatment by offering reassurance.
- Clinical staff encouraged patients to manage their own health.

Compassionate care

- We listened to call handlers and clinicians take patient calls. Staff treated patients with kindness, compassion, courtesy, respect and honesty. Staff prepared callers so they were aware they would need to ask routine questions to provide appropriate assessment.
- We saw staff remain calm and respectful with abusive callers. The service had a standard operating procedure for staff to use when they received an abusive call. Call handlers told us that they would pass abusive callers onto the clinical advisors where necessary. Clinical advisors we spoke with told us abusive callers were given two warnings; if the abuse continued, and if it was appropriate, the call would be terminated. Clinicians listened in to 999 calls and would take over the call from the call-handler if the caller was abusive.
- We listened to a call where a clinician questioned the caller, a nurse in a nursing home, to gather information about their patient observations in order to triage the

call. The clinician gave the nurse advice on care to provide in the meantime while waiting for an ambulance and directed them to call 999 if the patient deteriorated.
- The trust did not participate in the Hear and Treat survey. It was determined that their number of calls was too low to make participation worthwhile.

Understanding and involvement of patients and those close to them

- Staff involved patients and relatives in their own care and gave instructions over the telephone when clinically indicated.
- The NHS pathways system prompted call handlers to pass on relevant advice to callers while they waited for an ambulance. For example, we observed a clinician tell a parent how keep their child safe, during convulsions, whilst waiting for the ambulance to arrive.

Emotional support

- A call handler told us that 'after-care' was covered in Pathways training with signposting for support available. Call handlers told us the team was very supportive and they would have a debrief with the PSO for particularly distressing calls.
- We observed call handlers provide reassurance to distressed patients who had taken an overdose. We also observed clinician calm a mother who called 999 very agitated and concerned her child had not received the right care from the 111 service. The clinician arranged for the child to be received by a doctor at A&E. The mother apologised and thanked the clinician for their help.

Supporting people to manage their own health

- Clinicians who provided hear and treat services had access to a directory of services (DoS). This was a live database of health and social care services across the island.
- A clinician told us that there was only one person with a frequent caller plan in place at the time of inspection. The clinician talks to the caller to ensure that they are their usual self.
- The proportion of calls from patients for whom a locally agreed frequent caller procedure was in place was higher than the England average in 11 of the 12 months between August 2015 and July 2016.

Is emergency operations centre responsive to people's needs?

(for example, to feedback?)

Good

We rated responsive as good for the emergency operations centre. This was because the service was planned to meet people's needs.

We found:

- The service made reasonable adjustments and took action to remove barriers to enable people to access the service easily. These measures included an SMS emergency service system for people who were unable to talk on the telephone and a language line.

However:

- The trust did not provide staff with training in learning disability or dementia awareness. This may have made it more difficult for the service to engage with people with dementia and fully respond to their needs.
- Complaints were not always responded to in 25 days

Service planning and delivery to meet the needs of local people

- The service was planned on a continuous basis. There was no specific variation for demand except for weekends.
- The trust had emergency and community first responder schemes to respond to life threatening emergencies in rural areas where ambulances might take longer to arrive.
- The trust had a 'hear and treat' service. The clinical support desk (CSD) staff could assess and triage patients who required medical help without sending an ambulance. This meant more patients could be treated and assessed in their home allowing ambulances to be deployed more appropriately to serious incidents.

Meeting people's individual needs

- Patients and callers who had hearing or physical disabilities that prevented them using the telephone could contact 999 via the SMS emergency service system.

Emergency operations centre

- EOC staff had access to a language line and told us they would access it if a language barrier was preventing safe triage. The language line translated for patients who spoke limited English.
- A dispatcher told us all ambulance vehicles were accessible to bariatric patients.
- Call handlers told us they had no specific training on patients with a learning disability or living with dementia. Information provided by the trust following the inspection indicated 71 members of ambulance staff had completed dementia awareness training; however, it was not clear when the training had been completed or in which department the staff worked. If call handlers were unsure of how to triage a patient, they would refer the call to a clinician. The NHS Pathway system does not contain prompts to assist an emergency call taker in recognising when a patient is living with dementia or cognitive impairment and the emergency call taker decided if patients needed to speak to the clinical support desk (CSD) staff. We observed a CSD clinician listening to a call and asking to take over the call when it became apparent that the patient had cognitive impairment issues.

Access and flow

- Clinicians called to check the welfare of patients who were waiting for an ambulance to arrive.
- We saw clinicians monitor the status of calls and make a decision on the response following welfare checks with the patient. We saw the dispatcher working closely with the clinician to ensure the most appropriate response when two patients had the same triage code and resource was limited.
- The EOC handled NHS 111 and 999 emergency calls. Emergency (999) calls were prioritised above the 111 calls. If a call handler was not available to answer a 999 call the call would go out to a hunt group which included the clinical advisors, dispatchers and PSO on duty.

Learning from complaints and concerns

- Information on how to make a formal complaint was available on the trust website, as well as details of a local advocacy services. The trust website also gave information and contact details of the patient advice and liaison service (PALS). The website also linked to a leaflet with information on how to complain, which was also available in an easy read format.
- Staff we spoke with were not aware of any learning from complaints.
- Complaints were reviewed at the Operational Management Group and Senior Management Group. The trusts received seven complaints relating to the ambulance service between November 2015 and October 2016. Of these, three related or potentially related to the emergency operations centre. Two of these complaints were not responded to within the 25 day framework. There were no further details of these complaints.

Is emergency operations centre well-led?

Inadequate

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation and promotes an open and fair culture.

We rated well-led as inadequate because

We found:

- Staff had confidence in their immediate managers however, they felt there was insufficient knowledge and experience amongst the senior managers within the clinical business unit to manage the service effectively. They also raised concern about the number of managers in interim roles and their ability to make decisions.
- There was no clear vison or strategy for the service.
- The number of meetings and the complexity of the reporting structure made it difficult to clearly see how over sight of the quality and risk of the service were maintained.
- There was no formal process for engaging with patients.
- The risk register did not reflect all of the current risks.

However:

- Staff in the EOC spoke highly of the support they were given from their direct line managers.
- Staff were proud of the strong sense of team work.

Leadership of service

Emergency operations centre

- The ambulance service was part of the ambulance, urgent care and community clinical business unit (CBU). The CBU had been running since November 2015. A clinical director, supported by a head of operations and head of nursing, allied health professionals and quality, led the CBU. There was also an operations manager for each of the three main services.
- A service delivery manager led the EOC and a resourcing officer managed the rotas for the EOC. The service delivery manager for the EOC reported to the Operational manager who reported to the Head of Operations, who reported to the Clinical Director.
- The leadership of the ambulance service had recently been restructured. Many of the leadership roles were interim, due to HR process and legal proceedings. This had an impact on staff's confidence in people in interim roles particularly their ability to make any change. Staff raised concerns about the skills, knowledge and experience of the senior managers within the CBU. Only one member of the team had an ambulance background. They felt managers who did not fully understand the issues made decisions about the service.
- The operational manager was also covering the service delivery manager role for operations; this was impacted on their ability to have clear operational over sight.
- A 'who's who' board was displayed in the EOC with details of the leadership team.
- Staff in the EOC spoke highly of the support they were given from their direct line managers.
- Managers at a local level were supported to complete management and leadership courses.

Vision and strategy for this service

- Staff we spoke with in the EOC were not aware of a vision or strategy for the service.

Governance, risk management and quality measurement

- We had concerns around how effective the governance systems were to monitor the quality and risks of the service.
- There were a number of different meetings held within the CBU to monitor service quality and effectiveness but the size of the CBU and the disparate nature of the services led to challenges for senior manages being able to address all issues. However, ambulance staff did find the clinical quality and effectiveness group a useful meeting to get clinical changes approved so staff continued to work to best practice guidance.
- The number and complexity of the meetings made it hard to understand the reporting structure.
- There was an operational management group (OMG), which met on a Friday. The Senior managers group (SMG) met every other Monday. Actions from the OMG requiring second or final approval, or issues not resolved at OMG, were discussed at SMG. Anything needing escalation went to the clinical business unit meeting. There was also a clinical quality and effectiveness group (CQEG) which linked into the SMG and OMG, through the clinical quality lead, but had a direct link the clinical business unit meeting (CBU). The CBU head of nursing and quality attended the CQEG.
- The trust's Patient Information Decision Support (PIDS) team disseminated ambulance performance data to the clinical commissioning group and all senior managers. Ambulance performance data was said to be discussed at the performance review meeting on Monday morning. The head of operations, head of nursing and quality, the service operational manager, clinical quality lead and performance team attended this meeting. The Ambulance and NHS 111 action plan developed alongside the ambulance trajectory improvement plan, with an aim to addressing performance deficit, were also reviewed during the Monday morning performance meeting.
- There was no service specific risk register. The CBU risk register had not been updated since September 2015 and did not include current risks, such as management of the community first responders or increase in volume of calls with staff working at capacity. There was no assurance the CBU were managing the risks, thereby placing staff and patients at risk. There were actions that remained outstanding, with no named person allocated to each action to ensure it was completed.
- The key issues facing the service was its ability to provide a high quality of care against a back drop of system wide pressures and flow of patients through the hospital setting leading to delays in response times. In response, a daily performance 'huddle' had been implemented to review daily requirements, and where any exceptions and failures to red 1 and red 2 were discussed.

Emergency operations centre

- While we were told that audits did take place we did not receive any information to support this. We reviewed three set of minutes from the CQEG but did not find any reference to audits that related to the EOC.
- We requested information and evidence from the trust, however only a proportion was provided. In some cases the information was not collected and if others no reason was provided. Therefore it was not clear how the rust could be assured of the quality of the service being provided.

Culture within the service

- The trust commissioned an independent third party review into the ambulance. At the time of the inspection, this report was completed but not yet published. The operations manager described the initial findings as “people now felt able to speak out”, as historically this had not been the case. We have not been able to verify this as the report was not available.
- Staff we spoke with were proud of the strong teamwork in the service.

Public and staff engagement

- The trust website displayed information encouraging the public to use health services appropriately, accessing pharmacy, GP and NHS111 services in non-emergency situations. There was no formal process for engaging with patients.
- The hub had a newsletter for communication with staff. Staff received operational updates through the noticeboard, emails and letters. There were no formal staff team meetings
- Senior managers told there had been a staff consultation process during the recent changes to the structure, staff felt they had been told what was happening rather then begin listened to.

Innovation, improvement and sustainability

- Patients and callers who had hearing or physical disabilities could contact 999 via the SMS emergency service system.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve
Action the Ambulance service MUST take to improve

The ambulance service **must** ensure:

- All ambulance staff are provided with training on Duty of Candour regulation and this is adhered to
- The ambulance station door is repaired to ensure the station is secure.
- Vehicles are kept locked and secure at all times
- There are sufficient numbers of suitable qualified and competent staff, and managers, to provide a safe, effective and responsive ambulance service.
- Cleaning products are securely stored in line with the Control of Substances Hazardous to Health (COSHH) requirements.
- Risks across the ambulance services are identified, assessed and managed appropriately. Risk registers are current, with a responsible person allocated to monitor completion of each action.
- A review and action to ensure the ambulance service and trust are meeting all national requirements in relation to emergency preparedness, resilience and response.
- Patient records are stored securely at all times.
- Improved response times and performance on key performance indicators and national targets for urgent and emergency ambulance service.
- Staff observe good hand hygiene practice and this is audited.
- The quality and performance of the patient transport service is monitored.
- Staff are able to report incidents and learning is shared and implemented.
- All staff have an appraisal and individual learning plans.

Action the hospital SHOULD take to improve
Action the Ambulance service SHOULD take to improve

The service **should**:

- Complete a review of the storage of medical gases at the ambulance station and ensure all gas bottles are stored securely and in line with national guidance.
- Regularly changes the codes for medicines cupboards on vehicles
- Ensure the practice in patient transport services and trust medicines policy are aligned.
- Review the system provided on the mobile data terminal to ensure it is reliable and fit for purpose.
- Review the provision of equipment for the safe transportation and care of children.
- Provide adequate staff training in mental health and dementia awareness, which is updated at regular intervals to ensure that mental health knowledge is current.
- Ensure a multi-lingual phrase book is stored on all vehicles at all times to support patients to receive safe care and treatment.
- Consider providing a communication aid to support patients who are unable to communicate verbally.
- Implement actions in response to the investigation reports and improve the ambulance service culture.
- Implement a formal system for ensuring those Community First Responders registering for duty are competent in their role.
- Provide training for all staff in Mental Capacity Act (2005).
- Ensure timely response to complaints.
- Monitor staff are up to date and compliance with mandatory training is monitored.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: · Patient transport services staff did not always adhere to infection control policy and there was no regular audit of hand hygiene. · The service was not meeting all national requirements in relation to emergency preparedness, resilience and response.· Regulation12(1)(h)

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment How the regulation was not being met: • Cleaning products were not securely stored in line with theControl of Substances Hazardous to Health(COSHH) requirements. • No immediate action had been taken to properly maintain the ambulance station by repairing the garage door. The station was not secure, with access to equipment and vehicles. • Vehicles were not kept locked and secure at all times Regulation 15 (1)(a)(b)(e)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** • There was not a service risk register. The clinical business unit, risk register was not up to date.There were not systems in place to identify, assess, monitor and mitigate the risks to service users and others. • Policies relating to the patient transport service (PTS) were past their review date. • Patient records were not always kept securely • There was no regular monitoring of the quality and performance of the PTS • The service did not monitor the national KPI for arrival and collection time of patients attending for dialysis. • No audits of the service had been carried out • There was limited feedback on patients' experience of the service. **Regulation 17 (1)(2)(a)(b)(d)(e)**

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing • There were not sufficient numbers of suitable qualified and competent staff, and managers, to provide a safe, effective and responsive ambulance service. • The service was not meeting all national requirements in relation to training for emergency preparedness, resilience and response. • Not all staff had appraisal and associated learning plans. **Regulation 18(1); (2)(a)**

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour **How the regulation was not being met:**

This section is primarily information for the provider

Requirement notices

- Staff did not understand the principles of on duty of candour and how apply this in their role.

Regulation 20 (1)