Lincolnshire COUNTY COUNCIL Working for a better future		**THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE**	
Boston Borough Council	East Lindsey District Council	City of Lincoln Council	Lincolnshire County Council
North Kesteven District Council	South Holland District Council	South Kesteven District Council	West Lindsey District Council

Open Report on behalf of Richard Wills, the Director Responsible for Democratic Services

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**13 September 2017**
Subject:	**East Midlands Ambulance Service: Outcomes of Care Quality Commission Inspection and Ambulance Response Programme**

Summary:

The purpose of this item to consider information from the East Midlands Ambulance service, following the publication of the Inspection report by the Care Quality Commission.

The Committee is also requested to consider information on the Ambulance Response Programme, which has replaced the former response time arrangements for all ambulance trusts.

Richard Henderson, the Chief Executive, and David Williams, the General Manager, from the East Midlands Ambulance Service, are due to attend for this item.

Actions Required:

The Health Scrutiny Committee is recommended to consider and comment on: -

(1) the outcomes of the Care Quality Commission Report on the East Midlands Ambulance Service, and their response to the report;

(2) the information on the Ambulance Response Programme, in which the East Midlands Ambulance Service has been participating since 19 July 2017; and

(3) the other information submitted by the East Midland Ambulance Service.

1. Care Quality Commission Report

On 13 June 2017, the Care Quality Commission (CQC) published its report on the East Midlands Service NHS Trust, following an inspection visits on 21-23 February 2017 and on 3 March 2017.

The full report is available on the CQC website: -
http://www.cqc.org.uk/sites/default/files/new_reports/AAAG3548.pdf

The overall finding for the Trust was "Requires Improvement" for both emergency and urgent care services; and for the emergency operations centre. The CQC stated that its key findings were as follows:

- *"The trust had made significant improvements as required by the July 2016 warning notice. However we remained concerned about response times.*
- *Response times for Red 1, Red 2 and A 19 calls were consistently below the national target and patients were not receiving care in a timely manner.*
- *There were variable standards of incident investigation, limited recommendations, lack of learning at an organisational level and a lack of evidence that recommendations had been actioned.*
- *There was a lack of consistency in the management of risk due to trialling a revised risk register pro forma.*
- *Staff did not know about the Duty of Candour requirements or their responsibilities under it and the trust had not consistently fulfilled their responsibilities under the Regulation.*
- *We found pockets of concern about the potential bullying and harassment of staff who were not confident to report this. We found instances where policies and procedures relating to staff wellbeing were not followed in practice.*
- *Not all staff had been trained on the use of and supplied with filtered face piece masks (FFP3). Those that had been supplied with a mask did not always have them available for immediate use.*
- *The trust were not compliant with the requirements of the Fit and Proper Persons Regulation.*
- *Whilst the trust had a clear vision and strategy, frontline staff were not aware of these.*
- *Whilst training completion rates for statutory and mandatory training had significantly improved, mandatory training completion rates for equality and diversity and risk management modules were too low and there were challenges in two specific divisions around completion rates in general.*
- *The trust had taken appropriate actions which had been successful in increasing the number of front line staff.*
- *Standards of cleanliness had improved.*
- *The majority of equipment and vehicle checks were appropriately completed.*
- *There was an increased number of operational vehicles available to deliver emergency and urgent care services.*
- *Medicines were stored securely and the management of controlled drugs was in line with the trust's policy. However, we had some concerns about the lack of robust audit trail for access to controlled drugs on solo responder vehicles.*

- *There were notable improvements in the security of patient records.*
- *Potential risks to the service were anticipated and planned for in advance.*
- *The trust had taken action to provide frontline staff with the knowledge and information they needed to respond to a major incident.*
- *People's care and treatment was planned and delivered in line with current evidence-based guidance, standards and best practice.*
- *Patient outcomes were mainly above or equivalent to national average levels.*
- *Staff had received timely appraisals which had been perceived by most to be a meaningful process.*
- *Improvements in training and development opportunities were evident and staff told us about them.*
- *Where patients received care form a range of different staff, teams or services this was effectively coordinated.*
- *Staff were confident in their understanding of the principles for patient consent and the Mental Capacity Act 2005 and they followed them.*
- *There was a governance framework able to support the delivery of safe, high quality care.*
- *There was a high level of confidence in and respect for the leadership of the acting chief executive.*
- *There was increased confidence in the effectiveness of the board and frontline leaders were better equipped with skills and knowledge.*
- *The culture of the trust from board to frontline staff was overwhelmingly patient focussed. Our inspection team observed caring, professional staff delivering compassionate, patient focussed care in circumstances that were challenging due to the continued demand placed on the service.*
- *Staff engagement and satisfaction had improved since our last inspection.*

"We saw several areas of outstanding practice including:

- *The trust had run a highly effective recruitment campaign and received a national award for equality and diversity in recruitment.*
- *The trust were trialling a pre-hospital sepsis treatment in North and North East Lincolnshire. Where patients presented with the symptoms of sepsis, blood cultures were taken and a pre-hospital dose of intravenous antibiotic therapy administered to the patient. This saved valuable time and provided prompt lifesaving treatment. The results of the study had not been published at the time of our inspection but early indications showed positive outcomes for patients. The trust was the only ambulance trust in England providing pre-hospital care to this group of patients.*
- *The trust had extended the provision of a mental health triage car in Lincolnshire and also to include patients in Derbyshire increasing the provision of appropriate care and treatment for patients with mental health conditions.*
- *We observed caring, professional staff delivering compassionate, patient focussed care in circumstances that were challenging due to the continued demand placed on the service.*

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

- *The trust must ensure patients receive care and treatment in a safe way by meeting national and locally contracted response time targets for Red1, Red2 and A19 categorised calls.*
- *The trust must take steps to improve EOC call taking response times therefore reducing the number of calls abandoned and the length of time callers are waiting on the phone.*
- *The trust must ensure all staff know how to report incidents. The trust must ensure serious incidents are appropriately and consistently investigated with lessons learnt acted upon and shared widely.*
- *The trust must ensure all staff understand the Duty of Candour Regulation and their responsibilities under it.*
- The trust must ensure all staff access and attend mandatory training with particular focus on compliance rates for equality and diversity and risk management training.
- The trust must ensure all staff are fitted for and trained in the use of a filtered face piece mask to protect them from air borne infections.
- *The trust must increase the percentage of frequent callers who have a specific plan of care.*
- *The trust must ensure there are systems in place to ensure staff have received, read and understand information when there are updates to trust policies, procedures or clinical practice.*
- *The trust must ensure they comply with the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014)."*

The detailed findings from the CQC in June 2017 are as follows: -

CQC Findings – June 2017							
	Safe	Effective	Caring	Responsive	Well Led		Overall
Emergency and Urgent Care	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement		Requires Improvement
Emergency Operations Centre	Requires Improvement	Requires Improvement	Good	Good	Good		Requires Improvement
OVERALL	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement		Requires Improvement

This compares with the CQC findings of May 2016 (based on inspection visits in November and December 2015):

CQC Findings – May 2016							
	Safe	Effective	Caring	Responsive	Well Led		Overall
Emergency and Urgent Care	Inadequate	Requires Improvement	Good	Good	Requires Improvement		Requires Improvement
Emergency Operations Centre	Requires Improvement	Good	Good	Good	Good		Good
OVERALL	Inadequate	Requires Improvement	Good	Good	Requires Improvement		Requires Improvement

Response of EMAS to the CQC Report

The response of EMAS is set out in the presentation in Appendix A.

EMAS Trust Board – 4 July and 5 September 2017

On 4 July 2017, the outcomes of the CQC inspection were reported to the EMAS Trust Board. On 5 September 2017, the Board is due to consider an action plan, which details the required actions to meet the CQC's requirements.

East Midlands Health Scrutiny Network

On 27 June 2017, the Chairman attended the East Midlands Health Scrutiny Network and received a presentation from EMAS, together with the lead commissioner, Hardwick Clinical Commissioning Group.

2. Ambulance Response Programme

On 13 July 2017, NHS England announced the introduction of a new set of performance targets for all ambulance services. The main elements were as follows:

- National response targets to apply to every single 999 patient for the first time
- Faster treatment for those needing it, to save 250 lives a year
- An end to “hidden waits” for millions of patients
- Up to 750,000 more calls a year to get an immediate response
- New standards to drive improved care for stroke and heart attack
- World’s largest clinical ambulance trial updates decades-old system

NHS England stated that the new system was supported by the Association of Ambulance Chief Executives, the Royal College of Emergency Medicine, the Stroke Association and the British Heart Foundation amongst others. The House of Commons Public Accounts Committee also issued a report in April 2017 recommending the introduction of the Ambulance Response Programme across all ambulance trusts.

NHS England has advised that call handlers would change the way they assessed cases and would have slightly more time to decide the most appropriate clinical response. As a result cardiac arrest patients would be identified more quickly, with evidence showing this could save up to 250 lives every year. The redesigned system would focus on ensuring patients get rapid life-changing care for conditions such as stroke rather than simply “stopping the clock”. Currently one in four patients who need hospital treatment – more than a million people each year – undergo a “hidden wait” after the existing eight minute target is met because the vehicle despatched, a bike or a car, cannot transport them to A&E.

Ambulances would now be expected to reach the most seriously ill patients in an average time of seven minutes. The ‘clock’ will only stop when the most appropriate response arrives on scene, rather than the first. This would release more vehicles and staff to respond to emergencies. Currently, three or even four vehicles may be

sent to the same 999 call to be sure of meeting the eight minute target, meaning that across the country one in four ambulances are stood down before reaching their destination.

The changes also introduce mandatory response time targets for all patients who dial 999. Currently half of all ambulance calls, around five million a year, are classed as “green” and not covered by any national target. Response times for these patients, who are often frail and elderly, have been under pressure, with some patients waiting 6 hours or more. It will also help to make patients in rural areas less disadvantaged than they can currently be.

Set out below in the two tables are the ambulance response time standards, which are due to be replaced, and the new standards (as set out in the letter from Professor Sir Bruce Keogh, the National Medical Director of NHS England to the Secretary of State for Health on 13 July 2017)

Ambulance Response Time Standards – Due To Be Replaced				
Category	**Percentage of calls in this category**	**National Standard**	**How long does the ambulance service have to make a decision?**	**What stops the clock?**
Red 1	3%	75% within 8 minutes	The clock starts at the point the call is connected to the ambulance service	The first ambulance service-dispatched emergency responder arriving at the scene of the incident
Red 2	47%	75% within 8 minutes	The earliest of: • The problem being identified • An ambulance being dispatched • 60 seconds from the call being connected	The first ambulance service-dispatched emergency responder arriving at the scene of the incident
Green	50%	No national standard	The earliest of: • The problem being identified • An ambulance being dispatched • 60 seconds from the call being connected	The first ambulance service-dispatched emergency responder arriving at the scene of the incident

New Ambulance Response Time Standards				
Category	**Percentage of calls in this category**	**National Standard**	**How long does the ambulance service have to make a decision?**	**What stops the clock?**
1	8%	7 minutes mean response time 15 minutes 90th centile response time	The earliest of: • The problem being identified • An ambulance response being dispatched • 30 seconds from the call being connected	The first ambulance service dispatched emergency responder arriving at the scene of the incident (There is an additional Category 1 transport standard to ensure that these patients also receive early ambulance transportation)
2	48%	18 minutes mean response time 40 minutes 90th centile response time	The earliest of: • The problem being identified • An ambulance response being dispatched • 240 seconds from the call being connected	If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock. If the patient does not need transport, the first ambulance service-dispatched emergency responder arriving at the scene of the incident stops the clock.
3	34%	120 minutes 90th centile response time	The earliest of: • The problem being identified • An ambulance response being dispatched • 240 seconds from the call being connected	If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock. If the patient does not need transport, the first ambulance service-dispatched emergency responder arriving at the scene of the incident stops the clock.
4	10%	180 minutes 90th centile response time	The earliest of: • The problem being identified • An ambulance response being dispatched • 240 seconds from the call being connected	Category 4T: If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock.

East Midlands Ambulance Service and the Ambulance Response Programme

A report to the EMAS Board on 5 September 2017 is set out at Appendix B and explains how EMAs is implementing the Ambulance Response Programme, since joining the programme on 19 July 2017.

The Integrated Performance Report submitted to the EMAS Board on 5 September includes the following: -

"From 19 July, EMAS moved to the ARP to prioritise sending the right resource to the patient. Reporting under ARP means that there is no longer a performance 'hit' or a 'miss' based on the speed of response. Measures under ARP are based on a mean average, for Category 1 and Category 2 incidents and also a 90th percentile. The mean average relates to the average time it took the ambulance service to respond to a patient. The 90th percentile gives the time by which 90% of patients received a response, or sooner. Category 3 and Category 4 are also measured using a 90th percentile. The national move towards averages and percentile reporting are designed to report the spread of responses and highlight any length delays by using measures of the 90th percentile.

Due to 19 July being the changeover day for ARP at EMAS, a full accurate 24 hours performance data is not available (however complete incident recording was in place). Therefore information in the IBR using ARP reporting is based on 20 July onwards. With limited data on ARP reporting it is not possible at this stage to identify factors affecting performance, however as more data is collected over the coming months analysis will be undertaken to understand the interlinkages between different factors.

Reporting 20 July to 31 July

The percentage of calls split by Category was as follows:

Category 1: 7.65%
Category 2: 57.55%
Category 3: 27.14%
Category 4: 7.67%

Initial reporting is as follows:

	Mean average Hours: minutes: seconds	*90th percentile Hours: minutes: seconds*
Category 1:	*00:07:57*	*00:13:52*
Category 2:	*00:23:45*	*00:50:28*
Category 3:	*Not reported nationally*	*02:11:03*
Category 4:	*Not reported nationally*	*04:42:24*

"

3. Update from EMAS

A briefing paper from EMAS is attached at Appendix C.

4. Conclusion

Health Scrutiny Committee is recommended to consider and comment on the outcomes of the Care Quality Commission Report on the East Midlands Ambulance Service, and the response to the report; and the information on the Ambulance Response Programme, in which the East Midlands Ambulance Service has been participating since 19 July 2017.

5. Appendices – These are listed below and set out at the end of this report

Appendix A	EMAS Lincolnshire Division Update – Presentation from Richard Henderson, Chief Executive, and General Manager, David Williams
Appendix B	Ambulance Response Programme Pilot- Report to East Midlands Ambulance Service Board (Paper No PB/17/118) – 5 September 2017
Appendix C	East Midlands Ambulance Service NHS Trust Lincolnshire Overview and Scrutiny Committee Briefing Paper

6. Background Papers - None

This report was written by Simon Evans, Health Scrutiny Officer, Lincolnshire County Council: 01522 553607 – Simon.Evans@lincolnshire.gov.uk

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