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JOINT OSC FOR THE NE & NORTH CUMBRIA ICS & NORTH & CENTRAL ICPS

Meeting on Monday, 3 July 2023 at 1.30pm in the Bridges Room - Gateshead Civic Centre

Agenda

1 Appointment of Chair
In line with the terms of reference of the Joint Committee, the Joint Committee is asked to appoint a Chair for the 2023-2024 municipal year.

2 Appointment of Vice Chair
In line with the terms of reference of the Joint Committee, the Joint Committee is asked to appoint a Vice Chair for the 2023-2024 municipal year.

3 Terms of Reference (Pages 3 - 10)
The Joint Committee is asked to note the attached Protocol / Terms of Reference.

4 Apologies

5 Declarations of Interest

6 Minutes (Pages 11 - 22)
The minutes of the meeting of the Joint Committee held on 20 March 2023 are attached for approval.

7 Neonatal Work (Central NENC ICB) (Pages 23 - 52)
Briefing attached.

Julie Turner, Head of Specialised Commissioning, North East North Cumbria Regional Networks Lead, will provide the Joint OSC with a presentation on this matter.

8 Integrated Care Strategy Implementation Plan (To Follow)
Peter Rooney, Director of Strategy and Planning, NENC ICB, will provide the Joint OSC with an update on this matter.

9 **NEAS CQC Inspection / Independent Review of NEAS** (Pages 53 - 124)
CQC Report attached.

Helen Ray, Chief Executive of NEAS and Julia Young, Director of Quality and Safety NEAS, will provide the Joint OSC with an update on this matter.

10 **Work Programme** (Pages 125 - 126)
Draft programme attached.

The views of the Joint OSC are sought on the work programme and any additional issues it may wish to consider as part of the 2023-24 work programme.

11 **Dates and Times of Future Meetings**
Joint OSC is asked to note the future meeting dates and times:-

- Monday 25 September 2023 at 1.30pm
- Monday 20 November 2023 at 2.30pm
- Monday 22 January 2024 at 1.30pm
- Monday 18 March 2024 at 2.30pm

Contact: Rosalyn Patterson, Email: rosalynpatterson@gateshead.gov.uk
Tel: 0191 433 2088, Date: 20 June 2023

Revised Protocol for Joint Health Scrutiny Committee

Joint OSC for the NE & NC ICS and North of Tyne and Gateshead and Durham, South Tyneside and Sunderland area ICPs

1. This protocol provides a framework under the Local Authority (Public Health, Health and Wellbeing Boards and Public Health) Regulations 2013 for considering any proposed formal consultation in relation to the Integrated Care System for the North East and North Cumbria and any subsequent proposals for substantial development and variation to health services arising from / as a consequence of the development / establishment of an Integrated Care System for the North East and North Cumbria and / or arising from / or as a consequence of the development of an Integrated Care Board, Integrated Care Partnership and area ICPs covering the geographies of Northumberland, Tyne and Wear and Durham and the below mentioned groups and bodies:-

North of Tyne and Gateshead area ICP

- Primary Care Networks within the North of Tyne and Gateshead area ICP geography
- Northumbria Healthcare NHS FT
- Newcastle Hospitals NHS FT
- Gateshead Hospitals NHS FT
- Gateshead Council
- Newcastle City Council
- North Tyneside Council
- Northumberland County Council

Durham, South Tyneside and Sunderland area ICP

- Primary Care Networks within the Durham, South Tyneside and Sunderland area ICP Central geography
- Sunderland Hospitals NHS FT
- South Tyneside Hospital NHS FT
- County Durham and Darlington NHS FT
- South Tyneside Council
- Sunderland City Council
- Durham County Council

Plus the following bodies which cover both area ICP geographies

- Northumberland, Tyne and Wear NHS Foundation Trust
- Tees, Esk and Wear Valleys NHS Foundation Trust
- North East Ambulance Foundation Trust

The terms of reference of the Joint Health Scrutiny Committee are set out at **Appendix 1**.

2. A Joint Health Scrutiny Committee ("the Joint Committee") comprising Durham County Council; Gateshead Council; Newcastle City Council; North Tyneside Council; Northumberland County Council; South Tyneside Council and Sunderland City Council ("the constituent authorities") is to be established in accordance with the Regulations for the purposes of formal consultation by the relevant NHS Bodies in relation to the matters referred to at paragraph 1 above. In particular in order to be able to:-

(a) respond to any consultations in relation to proposals for substantial development and variation to health services arising from / as a consequence of the development of /establishment of an Integrated Care System for the North East and North Cumbria and / or arising from / or as a consequence of the development of an Integrated Care Board, Integrated Care Partnership and area ICPs covering Northumberland, Tyne and Wear and Durham (currently the " North of Tyne and Gateshead " and " Durham, South Tyneside and Sunderland " area ICPs as outlined in paragraph 1 above).

(b) require the relevant NHS Bodies to provide information about the proposals;

(c) require members/employees of the relevant NHS Bodies to attend before it to answer questions in connection with the consultation.

4. The Joint Committee formed for the purposes outlined at paragraph 1 will, following approval of this protocol and terms of reference at its first meeting, circulate copies of the same to:-

Local Authorities

Durham County Council; Gateshead Council; Newcastle City Council; North Tyneside Council; Northumberland County Council; South Tyneside Council and Sunderland City Council;

- **NE & NC ICS**

NHS Foundation Trusts

City Hospitals Sunderland NHS Foundation Trust
County Durham and Darlington NHS Foundation Trust
Gateshead Health NHS Foundation Trust
Newcastle-upon-Tyne Hospitals NHS Foundation Trust
Northumbria Healthcare NHS Foundation Trust
South Tyneside NHS Foundation Trust
Northumberland, Tyne and Wear NHS Foundation Trust
Tees, Esk and Wear Valleys NHS Foundation Trust
North East Ambulance Foundation Trust

- **Primary Care Networks covering the North of Tyne and Gateshead and Durham, South Tyneside and Sunderland area ICP geographies**

Membership

5. The Joint Committee will consist of equal representation, with three representatives to be appointed by each of the constituent authorities on the basis of their own political balance.

6. The term of office for representatives will be for the period from the date of their appointment by their constituent authorities until their relevant authority's next annual council meeting. If a representative ceases to be a Councillor, or wishes to resign from the Joint Committee, the relevant council shall inform the joint committee secretariat and the replacement representative shall serve for the remainder of the original representative's term of office.

7. To ensure that the operation of the Joint Committee is consistent with the Constitutions of all the constituent authorities, those authorities operating a substitution system shall be entitled to nominate substitutes.

8. The Joint Committee may ask individuals to assist it (in a non-voting capacity) and may ask independent professionals to advise it for the purposes of the consultation process.

9. The quorum for meetings of the Joint Committee shall be a minimum of seven members from five local authorities except where there is a formal consultation process in relation to a proposal for a substantial variation and development where the quorum shall be made up from a minimum of one member representative from each of the constituent authorities electing to participate in the consultation process.

Chair and Vice-Chair

10. For the purposes of the consideration of the developing / established ICS for the NE and North Cumbria and the development / establishment of the Integrated Care Board Integrated Care Partnership and area ICPs covering Northumberland, Tyne and Wear and Durham the Chair and the Vice-Chair of the Joint Committee will be appointed annually at the first meeting of the Joint Committee following the relevant authorities' Annual Council Meetings. The Chair will not have a second or casting vote.

11. If the agreed Chair and Vice-Chair are absent from a meeting, the Joint Committee shall appoint a member to chair that meeting from the representatives present who are members of the same constituent Council as the Chair.

12. For the purposes of the consideration of any proposals for substantial development and variation to health services arising from the development / establishment of an Integrated Care System for the North East and North Cumbria and / or arising from / or as a consequence of the development of an Integrated Care Board, Integrated Care Partnership and area ICPs covering Northumberland, Tyne and Wear and Durham (currently " North of Tyne and Gateshead " and "Durham, South Tyneside and Sunderland" see para.1) that affect at least two but not all of the constituent authorities, the Committee will be chaired from one of the affected local authority areas.

Terms of Reference

12. The Joint Committee will be the formal consultee under the Regulations and the Directions for the purposes of the consultation by the relevant NHS Bodies concerning those matters outlined at paragraph 1. Terms of reference are set out at Appendix 1.

Administration

13. Meetings shall be held at the times, dates and places determined by the Chair in consultation with each of the constituent authorities.

14. Agendas for meetings shall be determined by the secretariat in consultation with the Chair.

15. Notice of meetings of the Joint Committee will be sent to each member of the Joint Committee at least 5 clear working days before the date of the meeting and also to

the Chairs of the constituent authorities' relevant overview and scrutiny committees (for information). Notices of meetings will include the agenda and papers for meetings. Papers "to follow" should be avoided where possible.

16. Minutes of meetings will be supplied to each member of the Joint Committee and to the Chairs of the constituent authorities' relevant overview and scrutiny committees (for information) and shall be confirmed at the next meeting of the Joint Committee.

Final Report and Consultation Response

17. The relevant NHS body is required to notify the Joint Committee of the date by which any consultation response is required, and the date by which it intends to make a decision. The Guidance highlights that it is sensible for the Joint Committee to be able to consider the outcome of public consultation before it makes its consultation response.

17. The Joint Committee is independent of its constituent councils, executives and political groups and this independence should not be compromised by any member, officer or relevant NHS bodies. The Joint Committee will send copies of any final report and formal consultation response to the relevant NHS Bodies and the constituent authorities.

18. The primary objectives of the Joint Committee will be to reach consensus, but where there are any aspects of any consultation as regards which there is no consensus, the Joint Committee's final report and formal consultation response will include, in full, the views of all of the constituent authorities, with the specific reasons for those views, regarding those areas where there is no consensus, as well as the constituent authorities' views in relation to those matters where there is a consensus.

Voting

19. Wherever a vote is taken, this will be done on the basis of a simple majority.

Following the Consultation

20. Any next steps following any initial consultation response will be taken with due reference to the 'Local Authority Health Scrutiny: Guidance to support Local Authorities and their partners to deliver effective health scrutiny' (Department of Health; June 2014).

Principles for joint health scrutiny

21. In scrutinising the proposals, the joint committee will aim to consider the proposal from the perspectives of all those affected or potentially affected by that proposal.

22. The constituent authorities and the relevant NHS Bodies will be willing to share knowledge, respond to requests for information and carry out their duties in an atmosphere of courtesy and respect in accordance with their codes of conduct. Personal and prejudicial and/or disclosable pecuniary interests will be declared in all cases in accordance with the code of conduct and Localism Act 2011.

23. The Joint Committee's procedures will be open and transparent in accordance with the Local Government Act 1972 and the Access to Information Act 1985 and meetings will be held in public. Only information that is expressly defined in regulations to be confidential or exempt from publication will be able to be considered

in private. Papers of the Joint Committee may be posted on the websites of the constituent authorities as determined by them.

24. Communication with the media in connection with the Joint Committee's views will be handled in conjunction with each of the constituent local authorities' press officers.

Appendix 1

Joint Health Scrutiny Committee

Joint OSC for the NE & NC ICS and North and Central ICPs OSC

Terms of Reference

1. To consider the development / establishment of an Integrated Care System for the North East and North Cumbria and any subsequent proposals for substantial development and variation to health services arising from / as a consequence of the development / establishment of an Integrated Care System for the North East and North Cumbria and / or arising from / or as a consequence of the development of an Integrated Care Board,and an Integrated Care Partnership and area ICP covering the geographies of Northumberland, Tyne and Wear and North Durham (currently the "North of Tyne and Gateshead " and "Durham, South Tyneside and Sunderland" ICPs)

2. To consider the following in advance of any formal public consultation:

    - The aims / objectives / programme of work of the developing ICS for the NE and North Cumbria and ;
    - The plans and proposals for public and stakeholder consultation and engagement in relation to the developing ICS for the NE and North Cumbria;
    - Any options for service change identified as part of the development of the ICS for the NE and Cumbria including those considerations made as part of any associated options appraisal process.

3. To consider any substantive proposals during any period of formal public consultation, and produce a formal consultation response, in accordance with the protocol for the Joint Health Scrutiny Committee and the consultation timetable established by the relevant NHS Bodies.

4. In order to be able to formulate and provide views to the relevant NHS bodies on the matters outlined above, the Joint Committee may:-

    a) require the relevant NHS Bodies to provide information about the proposals the subject of the consultation with the constituent local authorities and the Joint Committee; and

    b) require an officer of the relevant NHS Bodies to attend meetings of the Joint Committee, in order to answer such questions as appear to them to be necessary for the discharge of their functions in connection with the consultation.

5. To ensure any formal consultation response of the Joint Committee includes, in full, the views of all of the constituent authorities, with the specific reasons for those views, regarding those areas where there is no consensus, as well as the constituent authorities' views in relation to those matters where there is a consensus.

6. To oversee the implementation of any proposed service changes agreed as part of the development / establishment of an Integrated Care System for the North East and North Cumbria and / or arising from / or as a consequence of the development of the "North of Tyne and Gateshead " and "Durham, South Tyneside and Sunderland " area Integrated Care Partnerships.

7. The Joint Committee does not have the power of referral to the Secretary of State as this will be retained by individual local authorities.

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GATESHEAD METROPOLITAN BOROUGH COUNCIL

JOINT OSC FOR THE NE & NORTH CUMBRIA ICS & NORTH & CENTRAL ICPS MEETING

Monday, 20 March 2023

PRESENT: Councillor M Hall (Chair)

Councillor(s): Taylor (Vice Chair – Newcastle CC), Chisnall (Sunderland CC), Ezhilchelvan (Northumberland CC), J Green (Gateshead Council), Haney (Durham CC), Jopling (Durham CC), Kilgour (South Tyneside Council), Mulvenna (North Tyneside Council) and O'Shea (North Tyneside Council)

187 APOLOGIES

Apologies for absence were received from Councillors Pretswell (Newcastle City Council), McCabe and Malcolm (South Tyneside Council), Butler (Sunderland City Council) and Kirwin (North Tyneside Council).

188 DECLARATIONS OF INTEREST

Councillor Hall (Gateshead Council) declared an interest as a Director of Prism Care NECIC and as a member of CNTW FT's Council of Governors.

Councillor Taylor (Newcastle City Council) declared an interest as an Honorary Consultant at the Freeman Cancer Centre.

Councillor Haney (Durham County Council) declared an interest as a Governor of Tees Esk and Wear Valley NHS Foundation Trust.

189 MINUTES

The minutes of the meeting held on 21 November 2022 were approved as a correct record.

190 DRAFT REVISED ICS-ICP JOINT OSC TOR & PROTOCOL

The Committee received the draft revised Terms of Reference. Changes to the quorum were proposed to ensure the continued efficient and smooth running of the Joint OSC.

RESOLVED - That the revised Protocol and Terms of Reference be adopted.

191 NEXT STEPS FOR ICS

Dan Jackson, Director of Policy, Public and Stakeholder Affairs, NHS North East and North Cumbria ICB, provided an update on the proposed Place-Based Partnership and governance arrangements.

The Committee was reminded that the functions of eight CCG's transferred to NENC Integrated Care Board (ICB) from July 2022. The preservation of well-established place-based working arrangements has always been recommended. While ICS's focus on strategic system enablers, place is the level where work to join up budgets, planning and pathways for health and social care services will need to happen.

Committee was advised that ICB's can delegate some of its functions to local committees which can form part of Place-Based Partnerships. The priorities of each place will vary depending on the vision and goals agreed locally through Health and Wellbeing Boards, while Place-Based Partnerships will be responsible for overseeing the delivery of local strategies.

It is proposed that rather than separate partnerships and committees, the elements are combined into one streamlined meeting but with three parts;

- Place-Based Partnerships (Part A)
- Place Based Delivery Groups (Part B)
- Joint governance arrangements between ICB and local authority (Part C)

National guidance on ICB Place Committees states that members from Partner organisations can be included, and committees can have delegated authority from the ICB to make decisions in respect of ICB matters while remaining accountable to the ICB. The Committee would make decisions around the allocation of ICB resources at place in relation to the delegated functions. National guidance also states that the ICB must approve terms of reference and membership of the Place Committee. The Committee can only make decisions on ICB matters.

Joint Committee was advised that ICB functions and resources delegated to Place includes budgets and associated expenditure in relation to;

- Community / out of the hospital system
- Continuing healthcare
- Primary care
- Prescribing
- Mental health, learning difficulties and autism (community based budgets)
- Service development funding (approved for place based allocation)
- Local safeguarding teams
- Better Care Fund arrangements with Local Authorities

The key principle for the ICB is to ensure the model of financial delegation empowers all Place-based Partnerships whilst ensuring accountability to the ICB for how its money is spent. It was noted that the ICB needs to manage a 30% running cost reduction by 2025/26, tackling unnecessary spend and generating efficiencies through economies of scale.

The next steps from April 2023 include the ICB supporting the formation of ICB

Place Committees (Part B element of the Place-Based Partnerships). This part will involve the ICB, Local Authorities, NHS Trust, Primary Care and Voluntary and Community Sector. This ICB Place Committee (Part B) would remain accountable to the ICB and ICB officers would retain majority voting rights for that part of the meeting. Workshop sessions are planned around managing financial delegations locally.

It was noted that further ongoing development will take place around governance in terms of setting Terms of Reference, membership and quorum requirements for each meeting part. This will ensure appropriate decision making with an inclusive approach with all partners. It was acknowledged that terms of reference for each Place Based Partnership will need to reflect their relationship with their local Health and Wellbeing Board, which will retain responsibility for local needs assessments and strategy development.

Cllr O'Shea questioned whether there would be flexibility in terms of governance arrangements to take account of the differing demographic across the patch. It was confirmed that this would be the case, it was recognised that urban areas would have different needs to the more rural areas. Although there would be a degree of consistency required, in terms of the broader Partnerships that already exist they will be built on.

Cllr Taylor questioned whether the Place-Based Partnerships meetings would be open to the public. It was noted that this is currently being explored, although Health and Wellbeing Boards are required to be public, Place-Based Partnerships are not required to be.

Cllr Hall questioned whether the Better Care Fund and Section 75 agreements were a standard framework or a postcode lottery. It was confirmed that there will be harmonisation in terms of the ICB element and there is no proposal to change the funding formula.

Cllr Hall asked whether issues such as the situation in terms of recruitment and retention into Social Care would be looked at by Place arrangements. It was confirmed that the ICS allows the development of strategic responses to shared challenges such as workforce pressures.

Dan confirmed that the first meetings of the Place Based Partnerships will take place from April 2023 onwards.

192 WINTER PLAN EVALUATION AND LEARNINGS

Siobhan Brown, Transformation Director System Wide, NE & NC ICB, provided the Joint OSC with a presentation on the early learnings from the Winter Plan. It was noted that at its meeting in November the Joint OSC were informed of the national priority themes that were asked to be delivered and Siobhan gave an update on delivery and performance across the ICS.

It was reported that cases of cold and flu, including respiratory illness, spiked in December 2022 and January 2023. This led to huge peaks of demand and pressure

in the system. Following the Streptococcus A outbreak there was a peak in demand on the 111 system and Primary Care. It was reported that the 111 Online Service received almost three times the rate of activity than predicted in December as a result.

It was also noted that Covid remains within the care system which impacts on the number of beds available due to the need for infection control measures. Although mortality from Covid is now low, it still remains a challenge in the system.

In terms of achievements over the last four months it was noted that there are an additional 300 beds, with opportunities to open intermediary beds. There has been 21 Acute Respiratory Infection Hubs opened, offering same day access for patients dealing with Covid, Flu, Strep A and other respiratory infections. 320 beds have been created through Virtual Wards, this is a multi-disciplinary team wrapped around patients but managed at home. These cases have been for mainly respiratory issues but also for Frailty. It was also reported that there has been extra clinical capacity placed within the Ambulance call centre, this is to help with mental health crisis which takes up a lot of time. There is also now a whole system commitment to no Ambulance Handover delays of over 59 minutes at any hospital.

Members were advised that there are 1.4 million appointments per month delivered by Primary Care therefore work is underway to look at better integration and leadership of the primary care workforce within the Urgent Treatment Centre delivery. Development is also underway for the 2 hour urgent community response services to join to 24/7 falls response service across the system.

In terms of vaccination rates it was reported that 63.02% of the eligible population have received the Flu vaccine, and 64.2% of the eligible population have received the Covid vaccine.

It was reported that £37 million has been invested into the NENC ICS geography for Discharge Schemes, which will be tailored by place.

In order to tackle winter pressures a 7 days a week Strategic Co-Ordination Centre was established.

Siobhan then gave an overview on the impact these actions have had on patients and communities. It was noted that bed occupancy remains higher than hoped for and this impacts on the ability to flow patients through the system. This figure is now starting to plateau at 92%. It was noted that performance is good alongside the Yorkshire ICBs, with the overall lowest bed occupancy over a sustained period of time; and the second best since January 2023.

In terms of discharges, this is measured on those patients who are medically fit and ready to be discharged. This figure is around 8% currently and should ideally be as low as possible. In comparison to the Yorkshire ICB's there is more work to be done to lower this, however a lot of extra Discharge schemes are now in place to tackle this.

It was reported that the ICB has funded all hospitals to support the commitment to

have no Ambulance Handover delays over 59 minutes. It was noted that the NE&NC ICB is currently the best performing across the North East and Yorkshire in this aspect.

The North East Ambulance Service (NEAS) is performing strongly in relation to 111 and 999 call performance. This is measured by the number of 111 calls abandoned and the 999 call answering time. For 111 calls the standard is to have an abandonment rate of under 3% and for 999 calls to be answered in less than 20 seconds. It was reported that current performance for 111 call abandonment is 7% and the mean answering time for 999 calls is 7.4 seconds.

Members were advised that Ambulance service response to Category 2 patients (life and limb conditions) is an indicator for how responsive the system is able to be. The current standard to meet is an 18 minute average response time, however very few Ambulance services have been able to meet this. The current position for NEAS response is 29 minutes, this is similar to that of the Yorkshire Ambulance Service.

In terms of A&E delivery performance against the four hour standard, it was reported that NENC ICB is the highest performing ICB in the North East and Yorkshire region. However, it was acknowledged that there is still work to do and development of Urgent Treatment Centres is an important component in doing this.

Cllr O'Shea questioned why Covid cases remained high and whether there was any learning to be taken from this. It was confirmed that it is being looked at as to why Covid is still highly prevalent in the LA7 authorities. However, it is not thought to be because of poor vaccine take-up. Cllr Hall raised the point that many of our hospital estates are not set out for good infection prevention control and many patients are getting Covid when in hospital. It was acknowledged that work is underway to look at cause and affect reasons.

Cllr Taylor requested further information regarding virtual wards. Siobhan confirmed that most of these are respiratory wards, however utilisation rates are not high enough at present. It was noted that these virtual wards can offer assistance when patients move into frailty wards. Cllr Taylor also questioned whether there are cases of patients being discharged into Care Homes because they need to be discharged quickly, when they could be at home under the care of a virtual ward. It was acknowledged that this is an unintended consequence of discharging quicker and this is trying to be avoided.

Cllr Ezhilchelvan questioned whether demand on the system has reduced or if there is now a systematically different approach. It was acknowledged that this needs to be unpicked further; as so much has been thrown at winter planning a more complex system analysis is required. Cllr Ezhilchelvan also questioned whether outbreaks such as Strep A undermined winter planning. It was confirmed that because the national message was that every child with a temperature should present to A&E it was extremely difficult to plan for that pressure. This was an unintended consequence nationally.

Cllr Hall questioned whether there was enough critical beds for children and young people. It was confirmed that children were moved between sites but not out of the

North East area. This was managed by the Critical Care Network.

Cllr Jopling questioned what mitigation will be taken for next year to cope with further bad strains for Covid and Flu. It was acknowledged that as part of winter preparation, prevention needs to be considered, with the biggest prevention being to increase the vaccination rates for Flu and Covid. The World Health Organisation has recognised the Flu vaccine as a priority, therefore work will be ongoing to encourage take up of the vaccine over next year. Members were advised that Care Home outbreaks of Flu were prevalent this year and that the hospital bed stock struggles to meet demand when there are Flu and Covid outbreaks. Learning from this winter has identified that communication is vital, the system needs to be proactive in its messaging around what behaviours should be encouraged.

Cllr Hall queried where we are in terms of catching up on elective surgery. It was confirmed that all Trusts have plans in place and are in better positions than the rest of the country.

Cllr Hall raised the point that there is no longer a requirement to report Covid testing and people are no longer supported to stay away from work, therefore people who may be infected are still going to work. This is exacerbated as a result of the cost of living crisis as many people cannot afford to stay off work. It was confirmed that the Covid Inquiry is ongoing, this will look at outcomes and results. There is still more work to be done on this and how ED's and GPs use point of care testing. This work is being guided nationally and there is constant feedback to national colleagues.

Cllr Mulvenna queried if missed GP appointments are monitored and if awareness is being raised around people attending pharmacies before seeing GPs. Siobhan confirmed that missed appointments are monitored and work is underway to prevent missed appointments, for example through texting reminder services. Siobhan also acknowledged that community pharmacies are also being promoted. Through the Minor Ailment Scheme, Pharmacists can flag cases to GPs which can create earlier appointments.

Cllr Kilgour questioned whether there were any known deaths because of Ambulance Handover delays. Siobhan confirmed that analysis of excess death rates for December 2022 to January 2023 shows 500 excess deaths due to handover delays, however the figure in terms of this ICS patch are unknown.

Cllr Kilgour queried whether the pharmacies within hospitals could do more to triage minor ailments rather than this being done in A&E. It was confirmed that work is underway to make pharmacies more 24/7 so in effect this would prevent some patients going to A&E. It was acknowledged that this will improve with further communication strategies.

193 EMERGENCY PLANNING

Marc Hopkinson, Director of System Resilience, NE&NC ICB, and Tom Knox, Strategic Head of Emergency Planning, Resilience and Response, NE&NC ICB, provided a presentation on System Resilience.

Marc advised the Committee that the ICB is responsible for ensuring high quality and safe health services are accessible to all communities at all times. Due to changing demographics and patient behaviour there is further need to prepare for and transform services, to effectively manage pressures as well as any major unexpected disruptions to ensure system resilience. The key role for the ICB is to ensure good provider relationships across the system and outside of the ICB, for example with LRF's on cross boundary plans and responses and with out of area Ambulance Services.

It was confirmed that within the North East and North Cumbria ICS the key stakeholders include;

- 3 Ambulance Services
- Great North Air Ambulance Service
- 11 Foundation Trusts
- Urgent Care
- Community Services
- Urgent Primary Care Services / GP Out of Hours Services
- Clinical Networks
- Independent Contractors; GPs (351 practices and 64 Primary Care Networks), Community Pharmacies, Dentistry and Optometry.

The three priority areas for system resilience were outlined as;

- planning for and being able to respond to a wide range of incidents and emergencies (EPRR)
- planning, identifying and assessing the impact of operational/surge pressures then setting strategy for ICS, ICP and/or Place
- planning, preparing and then responding to outbreaks of infectious disease

Tom confirmed that ICBs are designated as Category 1 responders, whereas CCGs were previously Category 2 responders. The responsibilities of the ICB as a Category 1 responder are subject to the full range of civil protection duties. The ICB must set the strategic direction for EPRR, develop emergency plans and business continuity management arrangements including cross borders and respond to incidents, emergencies and operational pressures. The ICB will also share information with other local responders. It was noted that industrial action and winter pressures remain a constant challenge and there is a strategic framework in place to ensure there is engagement with all stakeholders.

There has been a move away from a reactive approach of managing operational problems to more proactive planning for and responding to system pressures. This was following learning from experiences, de-briefing after every incident.

Over the last few months, in order to maintain system resilience throughout the winter period, there has been a focus on; improving resilience in 111 and 999 services, provision of alternative community options, enhancing ambulance response times and reducing handover delays. There has also been a focus on reducing crowding in A&E, reducing hospital occupancy and ensuring patients are discharged when clinically appropriate. It was noted that providers shared learning around pressures and risks because any blockage in one area impacts on all areas. A number of improvement events were held to focus planning on key areas or to

rapidly implement key actions across the ICS.

Committee was informed about the System Coordination Centre (SCC) which provides system coordination, oversight and leadership. The SCC manages this in hours (8am-8pm) to alleviate out of hours pressure. The SCC provides situational awareness, real time view of data and visibility of operational pressures and risks across the system. This ensures immediate actions to mitigate pressures and assesses their impact. The Radar app monitors pressures across the ICS, it can look at individual providers and allows advice and support to be offered when required. It also allows for early dialogue if there are anticipated problems later on in the day and enables resources to be moved if any mutual aid is required. The information contained on the Radar app is available to all providers and all hospitals, this currently works well in secondary provision and work is ongoing to roll it out to all primary provision.

Marc gave an update on communicable disease outbreaks, those diseases transmissible from one person, or animal, to another, which can cause ill health, for example Measles, Mumps, Rubella, Hepatitis, Scarlet Fever and Influenza. Infectious disease generates significant costs financially, socially and on health and wellbeing. An outbreak is defined as;

- an incident in which two or more people experience a similar illness are linked in time or place
- a greater than expected rate of infection
- a single case for certain rare diseases, i.e. polio, monkeypox
- a suspected, anticipated or actual event involving microbial or chemical contamination of food or water

The role of the ICB is complementary in the public health system, it collaborates with a number of other agencies. The ICB commissions preventative programmes, such as vaccinations, and monitors uptake.

During incidents, the ICB provides overall leadership of the local NHS through the SCC. Incidents managed recently include; severe weather, pandemic influenza, communicable disease / outbreaks (seasonal influenza, avian influenza, Strep A, monkeypox), cyber attack, flooding, significant events and operational pressures and industrial action.

It was reported that a number of industrial actions have affected the Ambulance Service, Foundation Trusts, Junior Doctors, Nurses and Physiotherapists. In terms of the NEAS industrial action, this effected emergency crews, call handlers, passenger transport, 111 clinical advisory service and HART Team. The impact of this action meant 36% of the 3129 planned hours lost. Third sector and military support was available during this time, although there was a significant decrease in contacts and decreased incidents, which meant handover time was around 14-15 minutes. This was because patients had listened to the key messages prior to the strikes. In terms of the Royal College of Nursing industrial actions, derogations were agreed which enabled hospitals to function with ‘safe’ staffing levels, elective procedures were cancelled and there were more staff reporting for work than expected.

In terms of the BMA industrial actions, significant levels of members withdrew labour. Consultants and Senior Clinicians covered rotas but there were delays and processes were slow as a result of staff working on different systems, this impacted upon patient flow. There was also significant impact on activity with over 3000 outpatient clinics cancelled, over 200 inpatient procedures cancelled as well as long delays and waits in Emergency Departments.

It was reported that system coordination worked effectively during recent pressures and periods of industrial action, with positive feedback from all system partners. Work is now underway to plan for future winter periods in collaboration.

Cllr Haney questioned whether the Radar app would be rolled out to GPs. It was confirmed that this has been deployed but there is not a consistent approach yet as GPs are effectively a business. It was also suggested that the app should be available for the general public to see. It was confirmed that there is a public facing app which would be good to be utilised alongside 111 services on the app, work is underway with NHS Digital to explore this. Cllr Hall asked how accurate the information on the app was and it was confirmed that the information is refreshed every five minutes.

Cllr Taylor questioned whether there were any plans to involve local Councillors in future communications work. It was acknowledged that the ICB has to work with local authorities and in terms of resilience this could be improved and part of that could be through soft intelligence on the ground from local Councillors.

194 WORKFORCE INTERIM UPDATE

Leanne Furnell, Director of Workforce, NE&NC ICB, gave a summary update on the workforce.

Committee was advised that an updated offer was made to nurses last week and Trade Unions are speaking to members around this offer. It is hoped that this will be moved to Junior Doctors soon.

ICB working groups are currently looking at running cost reductions which are required to be made across the ICB.

The Integrated Care System People Group had its first meeting on 11 January 2023. Attendance was from across the system, voluntary and community sector, education and DWP. Work of that Committee is ongoing to look at how to formulate a strategy around workforce health and system leadership.

A Retention Lead has been appointed and work is ongoing to look at the gap between health and social care. Good work has been carried out in terms of the NHS and this needs to be rolled out to local authorities.

It was noted that the ICB is keen for the voice of local authorities to be part of developing the workforce strategy.

Cllr Hall asked how Social Care Providers are represented within the ICB. It was

acknowledged that this issue has been raised and slots are being awaited in order to speak to providers.

Cllr Hall asked whether there were trigger points at which to look at agency costs. It was confirmed that a scoping exercise is being carried out to look at data as all employers will know what they are spending on agency staff. It was acknowledged that agency staff are necessary when there are shortages but when this becomes a key feature it affects the quality of the service. It was also acknowledged that it is in the interests of everyone to have a more robust staffing model. It was noted that this issue is system wide and there needs to be an ethos of working as a whole system.

195 WORK PROGRAMME

The Joint Committee agreed its work programme for the next meeting should now include a presentation from NEAS on the CQC inspection and findings from the NHS Independent Review.

Meeting Date	Issues
3 July 2023	- Next Steps for the ICS - Strategic Options for Non-Surgical Oncology Services - Integrated Care Strategy Implementation Plan - NEAS CQC Inspection / Independent Review of NEAS

Issues to slot in (dates to be confirmed);

- Progress of Digital Strategy
- Children's Mental Health Provision – Update on Current Performance and Future Provision

The views of the Joint Committee were sought on the above and any additional issues it may wish to consider as part of the 2023/24 work programme.

Cllr Jopling requested an update on new contracts in Dentistry to be included on the work programme for the new year.

196 ANY OTHER BUSINESS

The Chair, on behalf of the Joint Committee, thanked Angela Frisby for all the hard work and years of service to overview and scrutiny arrangements, both locally and regionally, and wished her well in her retirement.

197 DATES AND TIMES OF FUTURE MEETINGS

It was agreed that future meetings of the Joint OSC are held at Gateshead Civic Centre on the following dates and times:-

- Monday 3 July 2023 at 1.30pm
- Monday 25 September 2023 at 1.30pm
- Monday 20 November 2023 at 2.30pm
- Monday 22 January 2024 at 1.30pm
- Monday 18 March 2024 at 2.30pm

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Update on Sunderland Neonatal Intensive Care services

1.0 Introduction and overview

NHS England commissions neonatal critical care, which encompasses intensive care, high dependency care and special care. Neonatal services are currently delivered as part of a networked arrangement across the North East and North Cumbria region. This means that when a baby needs a neonatal intensive care cot, it is dependent on cot availability – with families having to travel further to access the specialist care they need.

Babies born preterm have high rates of early, late, and post-neonatal mortality and morbidity. Extreme preterm birth, defined as birth before 27 weeks gestation, is associated with higher mortality and morbidity than later gestations, which is further compounded if babies are born outside of a neonatal intensive care unit.

For the North East and North Cumbria region, the highest level of specialist care is provided in a neonatal intensive care unit, which is currently provided from three sites:

- Royal Victoria Infirmary in Newcastle (part of Newcastle Hospitals NHS Foundation Trust)
- James Cook in Middlesbrough (part of South Tees Hospital NHS Foundation Trust)
- Sunderland Royal Infirmary (part of South Tyneside and Sunderland NHS Foundation Trust)

A further seven sites provide special care baby units (SCBUs):

- Northumbria Specialist Emergency Care Hospital, Cramlington
- Queen Elizabeth Hospital, Gateshead
- University Hospital of North Durham
- Darlington Memorial Hospital
- University Hospital of North Tees, Stockton
- Cumberland Infirmary, Carlisle
- West Cumberland Hospital, Whitehaven

The region has been progressing implementation of recommendations from a Royal College of Paediatrics and Child Health review carried out in 2015. Overview and Scrutiny Committee members may recall previous engagement regarding this review, with the most recent discussions taking place in 2018.

While most of the recommendations from the 2015 Royal College of Paediatrics and Child Health have been completed regionally, there is one outstanding recommendation that is now ready for implementation. This will see a small number of women whose babies are born before 26 weeks gestation no longer accessing intensive neonatal care at Sunderland Royal Infirmary. They will now instead travel to Newcastle or Middlesbrough depending on cot availability.

This small change is expected to impact on an average of five women per year who would previously have accessed these services at Sunderland.

The change will present an opportunity for Sunderland hospital to increase levels of activity in the care it provides for some of the more poorly babies that require a level of intensive neonatal care if they are born from between 26-30 weeks gestation and require intensive care. It is expected that this will become the routine pathway for women who originate from four Northern SCBUs (Northumbria, Gateshead, Carlisle and Durham) who will *default* in the first instance to Sunderland, if they require intensive care.

Wider neonatal care provision at the region's seven special care baby units will remain the same. These will continue to provide local care for babies born from 30 weeks gestation or more who require only special care or short-term high dependency care.

The table below summarises the proposed changes set out in this report:

What is the proposed changed?	Sunderland Royal Infirmary will provide care for pre-term babies born from 26 weeks gestation (instead of from 22 weeks gestation).
How many babies would be impacted?	This would impact on an average of five babies per year.
Why this is beneficial?	The region will be able to better maintain appropriate activity levels across all three neonatal intensive care units, which is needed to maintain expertise in the management of these very sick and complex babies Ultimately, this change will ensure the highest quality of care for extremely small babies across the region.
What this would involve?	Pre-term babies born before 26 weeks and requiring an intensive care cot will travel to Royal Victoria Infirmary in Newcastle as default or James Cook in Middlesbrough in the absence of a neonatal cot in Newcastle. Sunderland will increase its activity in providing care for pre-term babies born from 26 weeks from across the north of the region.

2.0 How neonatal care is organised

Neonatal critical care forms a key element of the NHS maternity service, providing part of the service available for all women and their new-born babies in the birthing room and during the early postnatal period.

Neonatal critical care also provides an emergency service and ongoing support for babies and their families when a baby is born very prematurely, becomes sick or develops a medical problem.

Ensuring that implementation of both neonatal and maternity transformation plans remain coordinated and proceed together is an important part of national, regional and local planning.

The national position

Over the past 20 years neonatal services have been organised into networks of providers that work together to deliver care. Neonatal care pathways involve highly specialist care being available in local Neonatal Intensive Care Units (NICUs) in each area to minimise necessary travel for parents and their child.

Ten Neonatal ODNs are commissioned by NHS England's Specialised Commissioning team. These have a mandate to develop and implement programmes of work to improve access to specialist resources, and to improve neonatal outcomes and patient experience, working closely with both providers and commissioners.

Maternity and neonatal care are inextricably linked and work together to produce the best outcomes for women and their babies who need specialised care. Neonatal Operational Delivery Networks (ODNs) work closely with Local Maternity Systems (LMSs) to ensure that high quality care is provided that is responsive to the needs of women and their babies and maintains care as close to their home as is possible.

There are nationally three types of neonatal unit, and these units deliver 3 types of care (special care, high dependency and intensive care).

The different types of units are set out below:

- *Neonatal Intensive Care Units (NICU)* provide care for the whole range of neonatal care.
- *Local Neonatal Units (LNU)* provide care for all babies born at their hospital who require high dependency care.
- *Special Care Units (SCU)* provide local care for babies who require only special care or short-term high dependency care

The regional position

The Northern Neonatal Network consists of ten hospitals which provide special care and intensive care to newborn infants. Within the North East and North Cumbria region there are:

- 3 Neonatal Intensive Care units / High Dependency units
- 7 Special Care Units

The breakdown of these sites and what they provide is set out in the table below:

Neonatal Intensive Care and High Dependency Units	Special Care Units
Covering North and South regions: • Royal Victoria Infirmary, Newcastle • James Cook University Hospital Middlesbrough • Sunderland Royal Infirmary	North region: • West Cumberland Infirmary, Whitehaven • Carlisle Infirmary, Carlisle • Queen Elizabeth Hospital, Gateshead • Northumbria • Durham South region: • Darlington Memorial Hospital • University Hospital of North Tees, Stockton

Newcastle is the only surgical unit, and consequently babies who require surgery can only be cared for in that hospital. Therefore, these units look after babies from their own local population, as well as babies from elsewhere, who were/would have been born in a hospital which only provides special care.

All three intensive care units currently look after babies from twenty-two weeks of gestation.

3.0 Recommendations for neonatal services in the future

A recap of recommendations from the 2015 Royal College review

In August 2015 following an invited review by NHS England, The Royal College of Paediatric Child Health (RCPCH) published a report outlining some key recommendations for the reconfiguration of Neonatal Intensive Care Units services across the then four units providing intensive care within the Northern Neonatal Network.

This included the merger of both neonatal intensive care units at North Tees and South Tees leading to the establishment of one, fully operational neonatal intensive care unit in the south of the region at James Cook University Hospital at South Tees as a centre of excellence for Teesside. It also recommended the development of a dedicated neonatal transport service (NNETs) to coordinate the movement of babies around the region, which is now fully functional.

The five main recommendations from that report are summarised in the table below:

Recommendation	Status
Re-designation of the Neonatal Intensive Care Unit at North Tees to a Special Care Units (SCU)	Complete
Increased capacity at South Tees to cater for the re-designation at North Tees	Complete
Development of a dedicated standalone neonatal transport service for the Northern Neonatal Network	Complete
Expansion of the Neonatal Intensive Care Unit at Royal Victoria Infirmary in Newcastle	Complete *4 Cots increased in 2018, a further 4 cots to be mobilised by July 2023*
Changes to service provision in Neonatal Intensive Care in Sunderland (part of South Tyneside and Sunderland NHS FT)	In progress

4.0 Why this proposed change is important

Sunderland is currently the smallest neonatal intensive care unit in the whole country with the lowest volume of activity for a neonatal intensive care unit. This means it currently does not meet important clinical standards on the volume of activity required for looking after extremely preterm babies.

This change means that the region will be able to better maintain appropriate activity levels across all three neonatal intensive care units.

Ultimately, this change will ensure the highest quality of care for extremely small babies across the region.

Although the Sunderland NICU will no longer see babies from 22-25weeks gestation, the change will result in overall activity increasing. This is because more babies from 26 weeks gestation will be cared for in Sunderland.

5.0 Expected impact in terms of activity and patient flow

Currently all babies born from 22 weeks gestation are cared for in either Newcastle, Sunderland or Middlesbrough. This means families from across the region already travel for this highly specialist care.

After the 26 week pathway change families will still need to travel to one of these three units, however, Sunderland will become the designated unit for 26 week gestation babies from Durham, Carlisle, Gateshead and Northumbria

All pre-term Newcastle and Middlesbrough babies will still be cared for locally.

Where will pre-term babies be looked after?

The table below shows where babies born from 22 to 26 weeks will be looked after:

Northern Neonatal Network – NICU level 1 units		
Royal Victoria Infirmary, Newcastle	**Sunderland Royal Hospital**	**James Cook Hospital, Middlesbrough**
All Newcastle babies	South Tyneside and Sunderland babies above 26 weeks	All Middlesbrough babies
Northumbria babies below 26 weeks	Northumbria babies above 26 weeks *	All North Tees babies *
South Tyneside and Sunderland babies below 26 weeks	Gateshead babies above 26 weeks *	All Darlington babies *
Carlisle babies below 26 weeks	Durham babies above 26 weeks *	All Whitehaven babies *
All surgical babies across the Northern Neonatal Network	Carlisle babies above 26 weeks	
* Any babies born at 30 weeks and over will be cared for in their local SCBU		
Indicates changes in patient flow due to the 26 week pathway change		

Expected impact in terms of patient numbers

Our neonatal intensive care units in the region look after approximately 1658 baby admissions every year. Of these 984 admissions are for pre-term babies (less than 37 weeks)

Of the total number of babies born less than 26 weeks:

- Newcastle looked after 128 admissions over 3 years
- Middlesbrough looked after 97 admissions over 3 years
- Sunderland looked after 37 admissions over 3 years

In a one year period, of 12 Sunderland admissions, five were Sunderland 'booked' Mums.

We expect the main impact of this 26 week pathway change will be for families in South Tyneside and Sunderland who would usually have gone to Sunderland Royal Hospital if their baby was born from 22 weeks.

This will affect approximately five families a year from Sunderland who will now go to Newcastle as default or Middlesbrough if there was no intensive care cot available in Newcastle.

This information is based on data provided by the Northern Neonatal Network from a three-year average for these services between 2019-2022.

6.0 Patient involvement and engagement to date

Patient involvement and engagement

Patient representation to date has fed back on the following considerations specific to the proposed changes to the Sunderland neonatal pathway:

> *'Parents need to understand the reasons why they are being sent where they are being sent'*
>
> *'There is a need for support travelling to a non-local neonatal unit – more information should be made available about this.'*
>
> *'There is a need to consider the mental health impact for Mums who are accessing neonatal services'*
>
> *'There is only a small number impact, but what about the financial impact for these families'*

The key themes from discussions to date have focussed on clearer communication for families accessing neonatal services, specifically in relation to support services that might be available.

In light of the patient feedback, further focus groups are being held with families that have recently used neonatal services to review and update patient information that is provided to families. The impact of the proposed recommendation on the patient experience will also be monitored as part of any transition to the new service arrangements.

Previous engagement following the 2015 Royal College Review

A comprehensive communications and engagement plan was developed as part a system wide response to Royal College Review in 2015. This included:

1. Attendance at Overview and Scrutiny
2. Patient engagement activities with parent advisory groups
3. Briefings to system partners, including Healthwatch
4. Staff engagement and communications
5. Patient communications, for those directly impacted by service changes
6. MP briefings
7. Media activity

Ongoing stakeholder involvement

There is a dedicated task and finish group that is overseeing the development of plans for the future delivery of neonatal services regionally, including the

implementation of this recommendation. This has cross system involvement and includes patient representatives.

Commissioner and wider stakeholder support

This proposed pathway change at Sunderland has been reviewed and is fully supported by the following stakeholders:

1. Northern Neonatal Network
2. The North East and North Cumbria Local Maternity and Neonatal System
3. South Tyneside and Sunderland NHS Foundation Trust

NHS England (North East and Yorkshire region) regional assurance team and North East and North Cumbria Integrated Care Board also have oversight of the proposed pathway change (via its Joint Committee arrangements with Specialised Commissioning).

7.0 Summary and next steps

Summary

The Northern Neonatal Network seeks support to progress with implementation of the 26 week pathway change. This is planned to take place on 1 August 2023.

This is the last recommendation from the 2015 Royal College review and seeks to make sure the best quality of care can be provided for pre-term babies across the region.

Further involvement and engagement with patients will take place over the summer as transition to the new pathway takes place. The impact of the change and on patient experience will be monitored closely.

Next steps

Since the Royal College review in 2015, a further national report has been published in 2019 called the Neonatal Critical Care Review (NCCR). This aims to facilitate the transformation of Neonatal Critical Care services even further by 2025 by:

- *Aligning capacity*
- *Developing the expert neonatal workforce*
- *Enhancing the experience of families*

Significant work has taken place for ‘developing the workforce’ theme including funding for neonatal nurses, allied health professionals and neonatal quality roles.

For the ‘enhancing the experience of families’ theme, The Northern Neonatal Network established the first neonatal care coordinator team in the UK in April 2021.

No work has taken place in the region yet in relation to the ‘aligning capacity’ theme. This is because we need to complete the recommendations from the 2015 Royal College review first. This will, however, help us towards meeting the NCCR ambition to ‘align capacity’ and work towards meetings standards set out in the NCCR.

We would welcome the opportunity to come back to scrutiny once we understand more about the NCCR and what this means for the region.

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Update on Neonatal Services

Northern Neonatal Network

NHS England - Specialised Commissioning, North East and North Cumbria

Today

- Introductions
- Overview of Neonatal Care
- Update on 2015 Royal College review
- Implementation of final recommendation (26 week pathway)
- Impact for patients and families
- Summary and next steps

Introductions

- Dr Sundeep Harigopal, Clinical Lead of Northern Neonatal Network and Consultant Neonatologist at Newcastle Hospitals
- Dr Imran Ahmed Consultant Neonatologist at Sunderland Royal Hospital
- Julie Turner, Head of Specialised Commissioning North East and North Cumbria, NHS England
- Yasmin Sultana Khan, Service Specialist, Specialised Commissioning, North East and North Cumbria, NHS England

Overview of Neonatal Care

Northern Neonatal Network

Neonatal Intensive Care Units **(NICU)**

- Royal Victoria Infirmary (RVI) Newcastle
- **Sunderland Royal Hospital**
- James Cook Hospital, Middlesbrough

This is what we are here to talk about today

Local Neonatal Units **(LNU)**

None

Special Care Baby Units **(SCBU)**

- NSECH, Cramlington
- Queen Elizabeth Hospital, Gateshead
- University Hospital of North Durham
- Darlington Memorial Hospital
- University Hospital of North Tees, Stockton
- Cumberland Infirmary, Carlisle
- West Cumberland Hospital, Whitehaven

Update on 2015 Royal College review

- In 2015 the Royal College of Paediatrics and Child Health (RCPCH) reviewed neonatal services across the region.
- Five recommendations were made and most are now complete.
- This included:
  - merger of both neonatal intensive care units in Teesside to create one NICU at James Cook and one SCBU at North Tees.
  - the development of a dedicated neonatal transport service (NNETs) to coordinate the movement of babies around the region.
  - the expansion of capacity at the RVI which is currently underway and ongoing.
- Overview and Scrutiny Committee members may recall previous engagement regarding this review in 2018.
- COVID-19 slowed down progress of the final recommendation which is still outstanding. This relates to changes at the NICU at Sunderland Royal Hospital

RCPCH 2015 summary of recommendations

Recommendation	Status
Re-designation of the Neonatal Intensive Care Unit at North Tees to a Special Care Units (SCU)	Complete
Increased capacity at South Tees to cater for the re-designation at North Tees	Complete
Development of a dedicated standalone neonatal transport service for the Northern Neonatal Network	Complete
Expansion of the Neonatal Intensive Care Unit at Royal Victoria Infirmary in Newcastle	Complete 4 Cots increased in 2018, a further 4 cots to be mobilised by July 2023
Changes to service provision in Neonatal Intensive Care in Sunderland (part of South Tyneside and Sunderland NHS FT)	In progress

What change is needed in Sunderland?

- At the moment, all three NICUs (Newcastle, Sunderland and Middlesbrough) look after babies from 22 weeks gestation
- The Royal College review recommends that the NICU in Sunderland looks after babies from 26 weeks gestation
- This means:
  - any babies born **below** 26 weeks gestation from across the region would be looked after in Newcastle and Middlesbrough
  - any babies born **from** 26 weeks gestation from the areas listed below will be looked after in Sunderland.
    - Carlisle
    - Durham
    - Gateshead
    - Northumbria (NSECH)

Why is this important?

- Sunderland is currently the smallest NICU in the whole country due to its low volume of activity.
- This means it currently does not meet important clinical standards on the volume of activity required for a neonatal intensive care unit to look after extremely small babies.
- There is good evidence that units with higher activity have better outcomes.
- Ultimately, this change will ensure the highest quality of care for extremely small babies across the region
- Although the Sunderland NICU will no longer provide intensive care of babies between 22-26 weeks gestation, the change will result in overall in increase in activity. This is because more babies from 26 week gestation will be cared for in Sunderland.

Where will pre-term babies be looked after?

The table below shows where babies born from 22 to 26 weeks will be looked after:

Northern Neonatal Network – NICU level 1 units		
Royal Victoria Infirmary, Newcastle	**Sunderland Royal Hospital**	**James Cook Hospital, Middlesbrough**
All Newcastle babies	South Tyneside and Sunderland babies above 26 weeks	All Middlesbrough babies
Northumbria babies below 26 weeks	Northumbria babies above 26 weeks *	All North Tees babies *
South Tyneside and Sunderland babies below 26 weeks	Gateshead babies above 26 weeks *	All Darlington babies *
Carlisle babies below 26 weeks	Durham babies above 26 weeks *	All Whitehaven babies *
All surgical babies across the Northern Neonatal Network	Carlisle babies above 26 weeks	

* Any babies born at 30 weeks and over will be cared for in their local SCBU

Indicates changes in patient flow due to the 26 week pathway change

What is the impact for families of very small pre-term babies?

Now

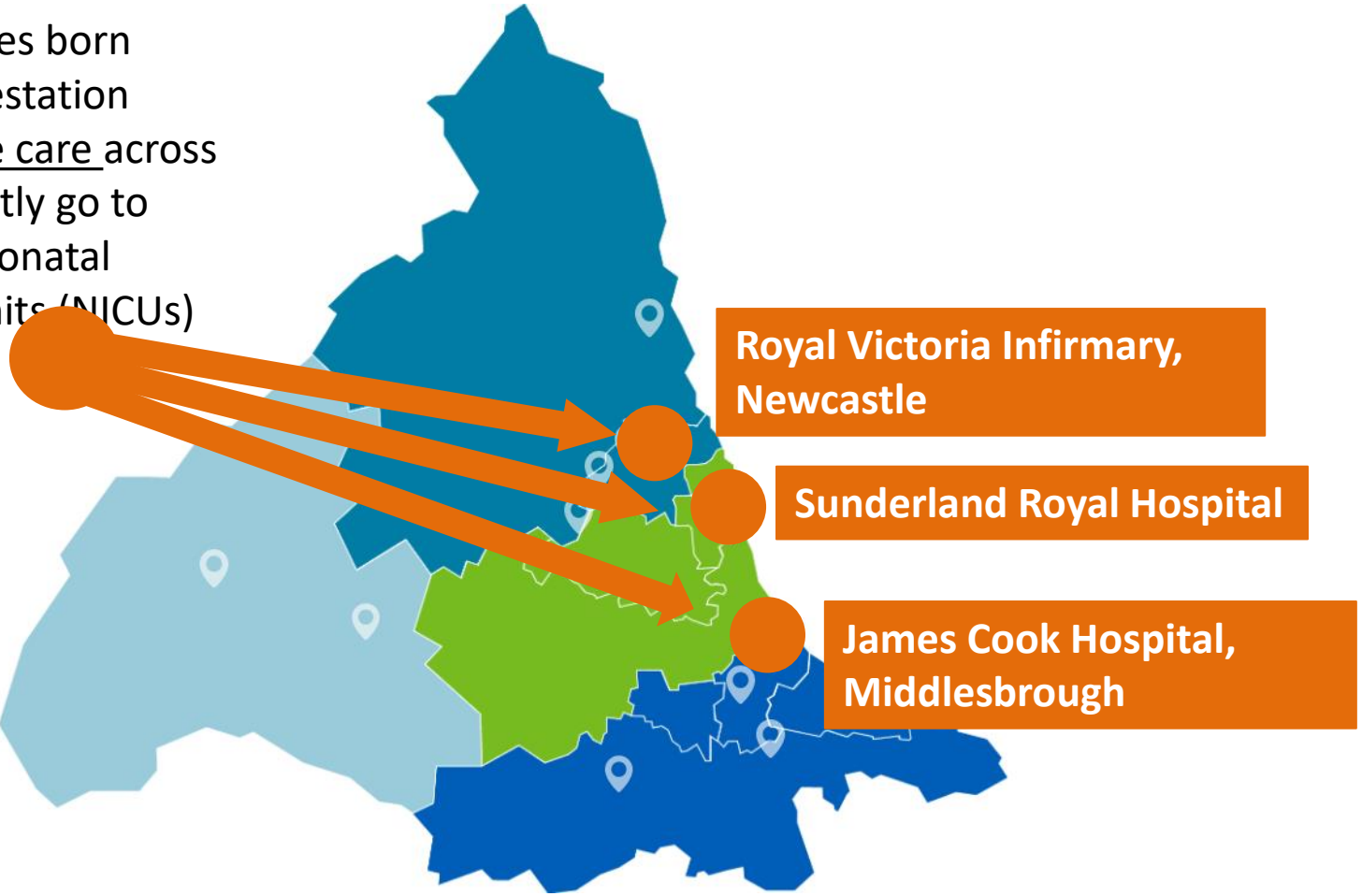
- All babies born from 22 weeks gestation are currently cared for in either Newcastle, Sunderland or Middlesbrough
- This means families from across the region already travel for this highly specialist care

After the 26 week pathway change

- Families will still need to travel to one of these three units, however, Sunderland will become the designated unit for 26 week babies from Durham, Carlisle, Gateshead and Northumbria
- All pre-term Newcastle and Middlesbrough babies will still be cared for locally.

Current patient flows

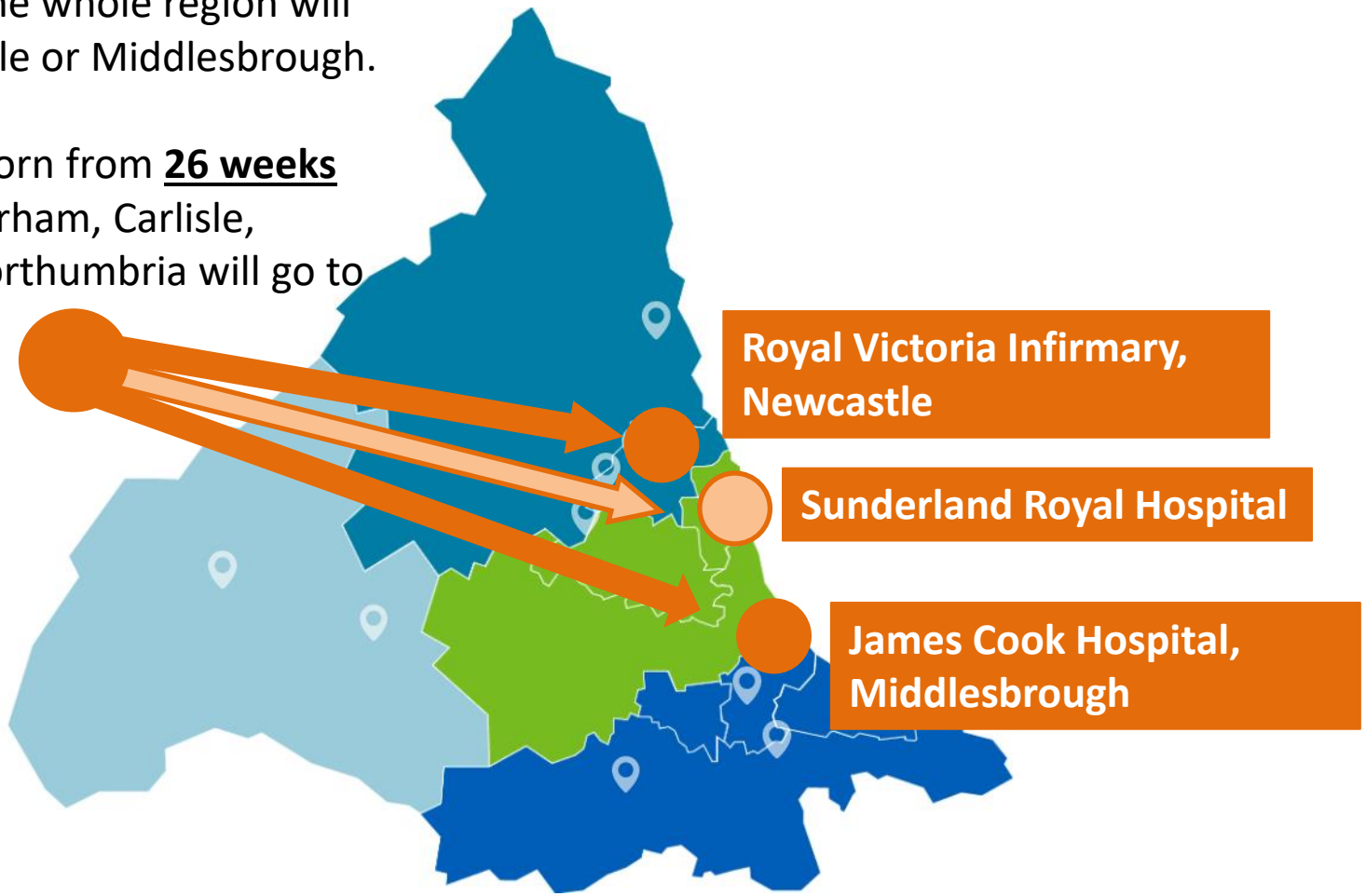
All pre-term babies born from 22 weeks gestation needing intensive care across the region currently go to one our three Neonatal Intensive Care Units (NICUs)



Patient flow after 26 week pathway change

Pre-term babies born from **22 weeks** gestation across the whole region will still go to Newcastle or Middlesbrough.

Pre-term babies born from **26 weeks** gestation from Durham, Carlisle, Gateshead and Northumbria will go to Sunderland



Activity in numbers

- Our neonatal intensive care units in the region look after approximately 1648 baby admissions every year.
- Of these 984 admissions are for pre-term babies (less than 37 weeks)
- Of the total number of babies born less than 26 weeks:
  - Newcastle looked after 128 admissions over 3 years
  - Middlesbrough looked after 97 admissions over 3 years
  - Sunderland looked after 37 admissions over 3 years

In one year, of the 12 Sunderland admissions, five were Sunderland 'booked' mothers.

- We expect the main impact of this 26 week pathway change will be for families in South Tyneside and Sunderland who would usually have gone to Sunderland Royal Hospital if their baby was born between 22-25 weeks gestation.

- This will affect approximately five families a year from Sunderland who will now go to Newcastle or Middlesbrough.

Information taken from data provided by the Northern Neonatal Network over a three year average between 2019-2022

Patient involvement

- Task and finish group in place which includes:
  - patient reps from across the region through a Parent Advisory Group
  - Care Co-ordinators from the Neonatal Network who have very close relationships with families

Key themes from discussions to date have focussed on clearer communication for families accessing neonatal services, specifically in relation to support services that might be available.

- Further focus groups are being held with families that have recently used neonatal services to review and update patient information that is provided to families.

Feedback from families so far

'Parents need to understand the reasons why they are being sent where they are being sent'

'There is only a small number impact, but what about the financial impact for these families'

'There is a need for support travelling to a non-local neonatal unit – more information should be made available about this.'

'There is a need to consider the mental health impact for Mums who are accessing neonatal services'

Commissioner and wider stakeholder support

The change to the 26 week pathway is fully supported by all system partners:

- Northern Neonatal Network and NHS Foundation Trust members
- The North East and North Cumbria Local Maternity and Neonatal System
- South Tyneside and Sunderland NHS Foundation Trust
- NHS England (North East and Yorkshire region)
- North East and North Cumbria Integrated Care Board (via its Joint Committee arrangements with Specialised Commissioning)

Summary

- The Northern Neonatal Network seeks support to progress with implementation of the 26 week pathway change. This is planned to take place on 1 August 2023

- This is the last recommendation from the 2015 Royal College review and seeks to make sure the best quality of care can be provided for pre-term babies across the region

- Further involvement and engagement with patients will take place over the summer as transition to the new pathway.

- Although the impact is small in terms of numbers, the impact of the change and on patient experience will be monitored closely

Next steps for neonatal care

- Since the Royal College review in 2015, a further national report has been published in 2019 called the Neonatal Critical Care Review (NCCR).
- This aims to facilitate the transformation of Neonatal Critical Care services even further by 2025 by:
  - *Aligning capacity*
  - *Developing the expert neonatal workforce*
  - *Enhancing the experience of families*

  Significant work has taken place for 'developing the workforce' theme including funding for neonatal nurses, allied health professionals and neonatal quality roles.
- For the 'enhancing the experience of families' theme, The Northern Neonatal Network established the first neonatal care coordination team in the UK in April 2021.
- No work has taken place in the region on the 'aligning capacity' theme yet. This is because we need to complete the recommendations from the 2015 Royal College review first. This will, however, help us towards meeting the NCCR ambition to 'align capacity' and importantly work towards meeting standards that improve the survival outcome for the baby.
- We would welcome the opportunity to come back to scrutiny once we understand more about the NCCR and what this means for the region.

Thank you and questions

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North East Ambulance Service NHS Foundation Trust

Inspection report

Ambulance Headquarters
Bernicia House, Goldcrest Way, Newburn Riverside
Newcastle Upon Tyne
NE15 8NY
Tel: 01914302000
www.neas.nhs.uk

Date of inspection visit: 26th - 28th July 2022 and 13th to 15th September 2022
Date of publication: 02/02/2023

Ratings

Overall trust quality rating	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Inadequate**

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Overall summary

What we found

Overall trust

The North East Ambulance Service NHS Foundation Trust (NEAS) provides an emergency ambulance service 24 hours a day, 365 days a year across the North East of England.

The trust provides an emergency and urgent care (999) service and the NHS 111 service across the region. The trust also has a Hazardous Area Response Team (HART) and provides a patient transport service (PTS).

The trust covers just over 3,200 square miles, which includes across rural, urban and coastal areas, and serves a population of 2.7 million people.

The trust has just under 3,500 staff and volunteers, 55 ambulance stations and has a fleet of over 600 vehicles. Every year trust staff answer over half a million 999 calls and almost 1 million 111 calls, and transport around 300,00 patients to hospital and completes more than 500,000 PTS journeys.

We carried out this unannounced inspection of North East Ambulance NHS Foundation Trust as part of our continual checks on the safety and quality of healthcare services.

We inspected Emergency and Urgent Care, the Emergency Operations Centre and the NHS 111 service. We also inspected the well-led key question for the trust overall. We did not inspect PTS or Resilience (HART) services at this inspection.

At our last inspection in 2018 we rated the trust overall as good.

Our rating of services went down. We rated them as requires improvement because:

- Overall, we rated safe and effective as requires improvement and caring and responsive as good. We rated well-led as inadequate.

Our findings

- We rated Emergency and Urgent Care as inadequate. We rated safe and well-led as inadequate. We rated effective and responsive as requires improvement and caring as good.
- We rated the Emergency Operations Centre as requires improvement. We rated safe, effective and well-led as requires improvement and rated caring and responsive as good.
- We rated NHS 111 as requires improvement. We rated safe, effective, responsive and well-led as requires improvement and rated caring as good. This report is published separately. The ratings are displayed in the ratings table in this report as 'Ambulance Headquarters, Bernicia House'.
- In rating the trust, we took into account the current ratings of the other core services that were not inspected this time.

What we found

- Leaders did not always understand or manage all of the priorities and issues the service faced and governance processes did not operate effectively across the organisation to ensure risk and performance issues were identified, escalated appropriately, managed and addressed promptly. We were not assured the board had sufficient oversight and focus on the operational risks or had effective systems to ensure incidents were consistently reported in line national patient safety reporting guidelines.
- Although staff were focused on the needs of patients receiving care, they did not always feel respected, supported and valued. Some staff told us they did not feel they could raise concerns without fear of blame or reprisal and the trust did not have effective systems to seek and act upon feedback from staff and other relevant persons.
- Although leaders actively and openly engaged with patients, equality groups, the public and local organisations to plan and manage services, engagement with staff was less robust.
- The portfolios for executive leaders were large and corporate services teams lacked capacity to be able to provide appropriate support. There were also limited succession plans to support staff to develop their skills and take on more senior roles.
- Services did not always have enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Although the trust had a workforce plan and had secured additional funding to increase the number of staff in patient facing roles, the Emergency Operations Centre did not have enough health advisors or clinical staff, and we were not assured advanced call-handler experts had received appropriate training or competency assessments.
- The trust monitored agreed response times to facilitate good outcomes for patients however, although the trust was one of the top performing ambulance services in the country for its response time to category one calls, performance did not meet the national target against this and other call category standards
- The trust aimed to provide the right care in a timely way and prioritised life-threatening responses, however people could not always access the service when they needed it, in line with national standards.
- Systems and processes for continually learning and improving services were not robust. Learning from complaints and incidents was not embedded across the trust and the pace of delivering improvement was slow.
- Following this inspection, we served the trust with a notice under Section 29A of the Health and Social Care Act 2008. We told the trust it needed to make the following significant improvements: (1) to ensure governance systems operated effectively; (2) in listening, responding, and acting upon feedback from staff and other relevant persons; (3) in incident reporting, investigating and monitoring of actions to prevent re-occurrence ensuring improvements are made as a result; (4) in medicines management to reduce risks to patients.

Our findings

However:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual cultural and religious needs. Staff provided emotional support to patients, families and carers to minimise their distress and supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.
- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.
- Staff promoted equality and diversity in daily work.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously and investigated them.

How we carried out the inspection

The team that carried out the well led inspection included two inspection managers, 13 inspectors, one assistant inspector and an inspection planner. In addition, there was an executive reviewer plus three specialist advisors experienced in executive leadership of NHS trusts, including the CQC national professional advisor for ambulance services. The inspection team was overseen by Sarah Dronsfield, Head of Hospital Inspection.

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Outstanding practice

We found the following outstanding practice:

- Trust safeguarding leads had been involved in a national task and finish group to review a standard for frequent callers aged under 18, and had implemented a local process for reviewing "frequently presented" children which included engaging with local partners to ensure appropriate information was shared and multiagency plans were developed.
- The trust had developed a communications support guide to enable staff to help triage people with learning disabilities and other communication needs. The trust had also undertaken significant work with people in BAME communities, promoting services and the support available, and had recruited community ambassadors to help deliver key messages and information.
- To improve ambulance handover times and reduce delays at hospitals in the region, the trust had worked collaboratively with local NHS trusts to develop effective processes and procedures.
- The trust had established a community paramedic scheme in a rural town in North Northumberland in which a small team of paramedics respond to calls in and around the area and work in partnership with local GPs supporting urgent home visits to patients, helping with the care plans for patients with long-term medical conditions. Since the launch, the trust had seen a reduction in category one waiting times due to more patients having been seen at home.

Our findings

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

We told the trust that it must take action to bring services into line with 17 legal requirements. This action related to all services.

Trust wide

- The trust must ensure there are sufficient quantities of medicines to ensure the safety of service users and to meet their needs. (Regulation 12 (2) (f)).
- The trust must ensure that systems and processes are in place to ensure the proper and safe management of medicines. (Regulation 12 (2) (g)).
- The trust must ensure that systems and processes are established and operated effectively to prevent abuse of service users. (Regulation 13 (2)).
- The trust must ensure it establishes and operates systems that enable the development and use of up to date, effective and relevant policies and procedures. (Regulation 17 (1)).
- The trust must ensure systems and processes are established and operated effectively to assess, monitor and improve the quality and safety of the services provided in the carrying on of regulated activities, in line with national guidance and frameworks. (Regulation 17 (1) (2) (a)).
- The trust must ensure systems and processes are established and operated effectively to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk (Regulation 17 (1) (2) (b)).
- The trust must ensure it encourages the identification, reporting and investigation of incidents and risks in a timely fashion and shares learning to improve safety and quality of the service. (Regulation 17 (2) (b)).
- The trust must ensure they have sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in all services to make sure that they can meet people's care and treatment needs. (Regulation 18 (1)).
- The trust must ensure it establishes and operates systems that enable safe working environments for staff and acts upon outcomes of staff feedback and surveys. (Regulation 18 (1)).
- The trust must ensure it fully complies with the Duty of Candour requirement. (Regulation 20 (1) (2) (3) (4) (5) (6) (7) (8) (9)).

Emergency Operations Centre:

- The service must ensure all premises used by the service provider are suitable for the purpose for which they are being used and properly maintained (Regulation 15 (1) (c) (e)).

Our findings

- The service must ensure clinical staff receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. (Regulation 18 (2) (a)).

Emergency and Urgent Care:

- The service must ensure that premises and equipment used for providing care and treatment are safe for their intended purpose and used in a safe way. (Regulation 12 (1) (2) (d) (e)).
- The service must prevent, detect and control the spread of infections, including those that are health care associated, through the application of effective infection prevention and control policies and procedures. (Regulation 12 (1) (2) (h)).
- The service must ensure all premises and equipment used by the service provider are clean, secure, suitable for the purpose for which they are being used, properly used and properly maintained (Regulation 15 (1) (2) (a) (b) (c) (d) (e)).
- The service must ensure people can access the service when they need it, and that response times for calls are in line with national standards. (Regulation 17 (1) (2) (a)).
- The service must ensure staff receive appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. (Regulation 18 (2) (a)).

Action the trust SHOULD take to improve:

Trust wide

- The trust should ensure that incidents are discussed, and learning shared at service level meetings.
- The trust should ensure that business continuity policies and procedures are up to date and reflect current business process.
- The trust should ensure there is a dedicated medication safety officer and the controlled drug accountable officer role is further developed to ensure that risks are proactively identified and actioned in a timely manner.

Emergency Operations Centre (EOC):

- The service should improve compliance with safeguarding training targets to meet the trust's own target.
- The service should improve response times in line with the Ambulance Response Programme.
- The service should consider providing mental health and Mental Capacity Act training to all frontline EOC staff to support patients who contact the service.
- The service should ensure that fire evacuation plans are tested and recorded regularly.
- The service should ensure health and safety inspection checklists are up to date and reflect trust wide processes.
- The service should ensure that up to date health and safety checks are completed at all EOC sites.
- The service should ensure that scheduled governance meetings are held at an appropriate frequency in line with the trust's terms of reference.

Emergency and Urgent Care:

- The service should ensure all staff attend regular meetings or have access to information discussed at meetings.

Our findings

- The service should ensure all station cleaning records are completed in a timely manner.

Is this organisation well-led?

Our rating of well-led went down. We rated it as inadequate.

Leadership

Although leaders had the skills and abilities to run the service, they did not always understand or manage all of the priorities and issues the service faced. There were limited succession plans to support staff to develop their skills and take on more senior roles.

At the time of inspection, there were six executive and six non-executive directors in post, plus an associate non-executive director and the chair of the board. Most of the executive directors had been in post for three years or less, and for the majority, it was their first executive post. The medical director who joined the trust in 2017 was the only executive board member of the current team in post at the time of our last inspection in October 2018. Following our inspection, we learned that three of the executive directors had plans to leave the trust and had been appointed into new roles in other organisations in the region. Although the trust had a recruitment plan, we were concerned about the stability of the executive leadership at the trust.

Executive leaders described a collective responsibility to owning and managing issues and risks, with each director demonstrating an understanding of their own accountabilities. However, the portfolios for executive directors were large and the corporate services tier lacked capacity to provide adequate support, which meant executive directors were also very operational. Members of the board also described working in 'silos' to deliver on their portfolios and there were inconsistencies in how they worked together to address issues that might not be their direct responsibility.

Corporate services managers described high workloads and small teams and expressed concern over the impact this had on operational delivery. We found there was a lack of roles and people within some teams to ensure functions were delivered effectively. For example, at the time of our inspection, we heard the patient experience team had 105 open complaints of which 40 required a response letter which the team did not have capacity to write. In addition, the chief pharmacist provided a significant amount of operational support due to a period of staffing pressures, this meant that their role in strategic and service development had been paused. Although this risk sat on the team's risk register there was minimal access to the board for escalation of risk and as such momentum for improvement had stalled. The pharmacy department had a clear work plan however due to capacity issues the work plan had stalled.

The medicines team had been through a period of significant staff shortages, although key medicines roles had recently been filled, crucial roles such as the medication safety officer were embedded into these existing roles giving very little time for the roles to be developed to their full potential. The trust controlled drugs accountable officer was in place however there was a lack of direction and oversight for this role and its responsibilities. This was evidenced by the lack of oversight of issues experienced by front-line staff regarding CD management, lack of responsiveness to risks and oversight and leadership to mitigate risks.

Leaders described their aim to move away from the traditional ambulance 'command and control' leadership model to a transformational style of leadership, with less reliance on a 'top-down' hierarchical approach. Leaders acknowledged the significant amount of work required to introduce such changes but clearly recognised the positive impact it would have on people and performance. Although the trust had developed a plan, it did not include specific timeframes for delivery.

Our findings

Some staff described a disconnect between executive and senior service leaders and frontline workers, who described not feeling fully engaged, however they felt the chief executive maintained a visible presence. Most executive leaders we spoke with recognised this as a concern, recognised the need for change and improvement and had plans to manage this. The trust had recently completed a restructure across services, resulting in management changes.

The trust provided leadership and development training for managers at all levels in the organisation. The programme was suspended during the pandemic and had recently restarted, and this included further plans for board development, which had also been limited during this period. However, we heard about a lack of succession planning and clinical leadership development to support staff to transition to more senior roles in the organisation. The trust told us of plans to improve and strengthen senior clinical leadership by recruiting a director of paramedicine, who will be in attendance at board meetings.

There is a requirement for providers to ensure that directors are fit and proper to carry out their role. This included checks on their character, health, qualifications, skills, and experience. During the inspection we carried out checks to determine if the trust was compliant with the requirements of the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014).

We found the FPPR Procedure was fit for purpose and the files complied with the requirements of the regulation. We reviewed five executive and non-executive director files in total. Our review included checks for the newest executive and non-executive appointments. There was a robust annual process in place to continuously monitor fitness to practice.

Vision and Strategy

The trust had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. To support the delivery of its 'unmatched quality of care' vision, the trust had nine plans each with a series of strategic objectives, however the pace of delivering the actions was slow and plans lacked specific timescales for completion.

The trust's current strategy (2021-2026) set out its vision, values and four ambitions - people; partner; performance, and quality and safety. The strategy initially included 21 priority objectives underpinned by nine plans, each with its own assurance framework, and was updated by the board in May 2022. We heard work was in progress to further streamline the overall framework as inconsistencies had been identified from audits, resulting in concerns of silo working across sectors. Non-executive directors had requested the trust revert to a single board assurance framework (BAF), which was agreed in January 2022. The updated document was presented to the board in September 2022.

The trust had a detailed objectives plan for 2021-22, setting out the objectives to support the delivery of the nine plans. This included over 200 actions but just over 50% of these had been delivered within the timeframe. The plan noted these actions had been carried forward to this current year, 2022-23. The trust had developed a dashboard to display this plan and included sections for future objectives plans over successive years. However, there was no plan included in the section for this current year, 2022-23 therefore we were unable to find evidence of progress or delivery of those actions carried over. Following our inspection, the trust submitted evidence of a plan for 2022-23. We found not all actions carried over from the previous year included a progress update and no actions in the current or previous year's plan included a specific delivery date. The 2022-23 plan did not include any timeframe for delivery at all.

There was a lack of a trust wide medicines optimisation strategy – the current medicines strategy, which mirrored the trust strategy was passed its review by date and although was still relevant was not available to staff for reference. This meant there was a lack of trust wide focus vision and strategic direction regarding medicines optimisation.

Our findings

The trust had a strategic improvement plan (2019-2024) for meeting the needs and improving outcomes for patients living with a mental health condition or diagnosis, however this document was in draft form therefore we were not assured it had been ratified. We reviewed the trust's mental health action log which included an action raised in June 2019 to write a mental health strategy in line with national drivers. The action log showed this action had not been delivered by the target date of September 2019 and remained incomplete at the time of our inspection. The log included 11 additional actions with target dates ranging from April 2019 to August 2022. Only three actions had been completed at the time of inspection.

The trust had developed robust financial plans for NHS England in line with national requirements, and these were aligned to the overall strategy priorities for the organisation. The trust also had a strong recent track record of delivering on its financial plans, managing cash, capital and revenue effectively, however recognised that it had an underlying deficit that it needed to work with system partners to address going forward.

Culture

Although staff were focused on the needs of patients receiving care, they did not always feel respected, supported and valued. Some staff told us they did not feel they could raise concerns without fear of blame or reprisal. The trust did not have effective systems to seek and act upon feedback from staff and other relevant persons. The service promoted equality and diversity in daily work.

At previous CQC inspections in 2016 and 2018, we found staff were positive and proud to work for the organisation and felt valued. However, at this inspection staff opinion was more mixed.

During this inspection, we invited clinical and non-clinical staff from all services to complete a survey and we received 481 responses. Of these, 70% of respondents were from Urgent and Emergency Care Services, 26% were from the Emergency Operations Centre and 4% were from the Patient Transport Service. The majority of responses (70%) were from clinical staff, 18% of respondents were non-clinical, 7% identified as management and 5% preferred not to say.

The results showed over 50% of staff did not feel safe to report concerns without fear of what would happen as a result and did not believe that the organisation would take appropriate action. Although 43% of staff felt the trust did encourage staff to be open and honest with service users and staff when things went wrong, 35% disagreed.

Over 75% of staff felt that communication between senior staff and staff was ineffective and 76% felt that the organisation did not value them or provide them with effective support to do their job.

52% of staff felt unable to meet the conflicting demands on their time at work and 83% told us they did not meet regularly with their team to discuss the team's effectiveness. Just less than 50% were not satisfied with the support they received from their immediate manager.

Although over 80% of staff had experienced bullying, harassment or abuse at work from managers or colleagues less than two times in the last 12 months, nearly 50% of those surveyed felt the organisation did not treat people with respect and did not take action to reduce bullying and harassment.

We also read accounts from staff who described a 'toxic' culture across the organisation and low morale. Despite staff feeling proud of the work they do, they felt less proud of working for the organisation itself.

Some of the comments in our survey from staff were:

Our findings

- “We are encouraged to report incidents, near misses etc, but I feel there is a blame culture. If there is a management failure then nothing will be done, but if an employee is deemed to be at fault, I feel they would be blamed rather than supported.”
- “There is a significant blame culture that makes staff scared to report incidents of any nature, a fear to ask for help out of worry of being deemed incompetent and when things do go wrong very little support in response- often times met with instead of support to avoid future incidents and promote learning to instead blame the individual and frankly “string them over the coals” to avoid NEAS affiliation with the incident even when very minor.”
- “Staff are used as scapegoats for incidents which go wrong.”

The trust’s own incident investigations had evidenced staff being reticent to report incidents. A SI report stated, “Due to culture, the crew were fearful to report this incident as they felt they might be punished.” This same incident was presented to the board in July 2022 as a patient experience story. Information about the delay in reporting, and the reason why the staff were fearful to report, was shared as part of this report which also stated “Work is required across the Trust to ensure that staff understand why they need to report accidents and incidents, and that this is not a punitive process, but a learning one.” The report further stated, “both crew members are now undergoing disciplinary processes which may have been avoided if they had reported the incident at the time.”

Results from the latest NHS staff survey (2021) indicated the trust was on par with other trusts or just below the average national score in relation to overall themes. However, In the last six months CQC has received 11 whistleblowing concerns from staff at the trust raising concerns about patient safety and clinical practice, the culture within the organisation and leadership and management support to staff.

In response to the survey, the trust organised a series of focus groups, roadshows, pulse surveys with staff to corroborate feedback. From this, the trust established a set of nine ‘people promises’ aligned to three risks: leadership and progression opportunities; inability to recruit and retain people with the required skills and values and low staff morale and engagement. Updates were reported to the board through the people committee however leaders acknowledged that the delivery of some actions took time, such as developing a new process for annual leave, which involved the introduction of new system software, and improving the current relief system. The annual leave process for unscheduled care staff was agreed in 2018. Issues with the external supplier followed by the pandemic delayed the delivery and the project resumed in January 2020.

Senior leaders we spoke with recognised the need to do more to improve staff satisfaction and wellbeing at work. They understood the areas that mattered most to their workforce and had taken steps to address them however staff we spoke with expressed their frustration with the pace and delivery of those priority objectives.

Freedom to speak up

The trust employed two freedom to speak up guardians, both had other substantive roles, however neither was allocated any time at all to their freedom to speak up role. This was not in line with guidance produced by the national guardian’s office which states guardians ‘should be provided with ring-fenced time for the role’.

The numbers of people speaking up were low, and there were no freedom to speak up champions in the organisation. We heard there were delays in the guardians being able to respond to even the low numbers of people speaking up due to the pressures of their substantive roles, despite taking calls at evenings and weekends in their own time, and that the lack of resource had been raised at a trust subcommittee. The trust had not fully considered guidance from the national guardian’s office when determining how freedom to speak up had been operationalised within the organisation.

Our findings

Freedom to speak up was part of the trust's statutory and mandatory training, and training levels were good, however, guardians had neither the time, nor sufficient training to be able to support those wishing to raise concerns and it was clear from the numbers of people speaking up, when compared to both the number of employees and the results from CQC's staff survey, that the majority of staff did not wish to use this avenue.

Executive and non-executive leaders had considered FTSU capacity at a recent board meeting. Minutes from the private session of the June 2022 board meeting confirmed leaders had discussed this and were exploring possibilities such as sharing the resource across the region or sector.

Despite the issues flagged in the staff survey, including recent concerns raised in the media, the trust had not given enough priority or placed enough importance on this role within the organisation or listening to concerns raised by staff. Following this inspection, we served the trust with a notice under Section 29A of the Health and Social Care Act 2008. We told the trust it needed to make significant improvement in listening, responding, and acting upon feedback from staff and other relevant persons.

Equality and diversity

The trust had an equality, diversity and inclusion (EDI) policy and a current EDI plan (2020-2023), outlining a set of aims and objectives. The trust's EDI lead was supported by two members of staff and over 90 community ambassadors across the region, extending the EDI agenda to include patients alongside staff. The trust had a range of tools to support compliance with the accessible information standard. This included a pictorial guide for front line staff to help triage people with learning disabilities and other communication needs.

The trust had won three national BAME awards in 2022: Clinical Champion of the Year; Digital Champion of the Year and Community Initiative of the Year. The trust was also shortlisted for an Inclusive Culture Initiative award for a ceremony due to be held in Autumn 2022.

There were three established staff networks; Together (ethnicity and faith), Able (disability); Proud (LGBTQ+) and a new fourth network, Empower (women). Each network had an executive and non-executive lead representative.

The Workforce Race Equality Standard (WRES) became mandatory for all NHS trusts in 2015/16 and trusts are required to show progress against nine workforce indicators. The latest data identified the trust as one of the top 10 NHS organisations in three out of the nine indicators and demonstrating improvement in the remaining six.

Governance

Governance processes did not operate effectively across the organisation to ensure risk and performance issues were identified, escalated appropriately, managed and addressed promptly.

The trust's governance structure included six committees reporting to the board: audit and risk; nomination and renumeration; people and development; performance and finance, and quality and technology. Each committee was chaired by a non-executive director and included additional non-executive and executive representation For example, four executive directors were members of the quality and people committees, with two and one non-executive directors respectively at each.

The executive team met informally twice a week to discuss performance, issues and challenges. There was also a formal weekly executive meeting however this was attended by deputy and assistant directors and various other attendees

depending upon the agenda. The structure of this meeting was revised in April 2022 to create a space for focused discussions. However, the agenda was not standard and varied week by week, with a rolling five-week schedule of key focus areas. It was difficult to determine from the minutes what the key focus was of that week's meeting. The trust acknowledged the meeting required further review and had plans to address this. We heard the other weekly executive director meetings were not documented plus, non-executive directors participated in a weekly call with the chief executive however this was also informal and undocumented, and outside the formal governance structure. Following the inspection, the trust told us these meetings were intended to support and maintain regular operational oversight.

In May 2020, CQC had been contacted by whistle-blowers sharing concerns about the coronial process in the organisation dating back to 2019. We reviewed the concerns and asked the trust to provide information which included a review into the concerns, information shared with the coroner and action plans to address the areas of improvement needed which included a more robust system and process. CQC also spoke with other key stakeholders such as the coroner and NHSE in relation to these concerns.

Following further whistleblowing concerns in 2021, we asked for additional updates which showed that the actions were still in progress. Although there had been improvements made, this had been identified through external audits. In June 2022, following some media attention in relation to the coronial process we found the trust still had not delivered all the actions to ensure the systems and processes were embedded and were consistently operating effectively. The trust had not ensured they had worked with pace to ensure these actions were delivered two years after the concerns had first been raised.

Assurance reports were produced and presented at committee and board meetings, highlighting specific areas of focus. However, not all leaders could provide examples of assurances they had received. The board was not sighted on the patient safety concerns identified by CQC relating to medicines management and, where patient safety concerns had been identified, the trust was slow to act or failed to recognise the significance of the concern. We were also not assured the trust had full oversight of other areas of concern identified through incidents.

In July 2022, the board completed a well-led self-assessment exercise in which it positively reported that all levels of governance and management functioned effectively and interacted with each appropriately. The trust also commissioned an external review of its governance arrangements at this time. However, through our monitoring and from our inspection findings we found significant concerns in how the trust operated effective systems and processes to assess, monitor and improve the quality and safety of services. We were concerned that the board did not have enough insight and awareness into how their systems functioned and the gaps in governance and assurance.

Where concerns had been identified, the pace of delivery was slow, and we were not assured the board and respective committees had an effective system to monitor this. For example, we reviewed the trust's 'learning from deaths' process and noted there was a significant number of outstanding actions from associated audits and re-audits, several of which dated back to 2020. It was not clear this had been identified and actions put in place to address this.

The trust had participated in 25 national clinical audit projects and eight clinical outcome quality indicators in 2020/2021. The trust submitted 100% of their eligible cases for the national ambulance clinical quality indicators and two eligible national clinical audit projects.

We heard each executive director was permitted to request two audits on the internal audit plan The executive leadership team collectively agreed the audit plan however we were not assured audit was embedded across the trust or that the clinical audit team had sufficient capacity to deliver or monitor outcomes.

Our findings

The trust used the clinical audit module on its trust-wide reporting system however we noted not all audits were included, such as end of life care or service-level audits, and there was no effective close out mechanism for outstanding audit actions. This meant there was no systemic integrated approach to audit across the organisation which limited the board's ability to maintain effective governance and oversight of key concerns, actions and outcomes and use the results as a means to improve the quality and safety of services.

Some policies and procedures were out of date across services, such as the risk management policy and the mental health policy (no revisions since 2018). The trust's clinical guidance action plan noted 36 clinical guidelines needed updating. There was only one entry which contained a date, and it was last updated in March 2020. It was unclear how the trust was monitoring the progress against this action plan and we were not assured that action was being taken and that all clinical guidelines were reviewed and updated in a timely way.

A council of governors held the non-executive directors (individually and collectively) to account for the performance of the board of directors. There were 35 posts on the council, covering elected, appointed and staff governors. Although the council met four times a year, some governors felt was not frequent enough. The lead governor met with the chair every month however we heard updates and outcomes from these meetings were not always shared with the other governors.

The trust's risk management strategy stated the trust will review its risk appetite annually. We heard this was last completed in 2020. We were not assured this, and other governance processes, were embedded at senior level within the trust.

The trust had recently introduced an integrated quality and performance report which was presented at every board meeting. The report included a performance dashboard plus updates on quality and safety, clinical, operational, people and financial performance.

The chief executive acknowledged governance had not been robust during the pandemic, in response to a national directive to operate a 'stepped down' approach. They recognised the impact of this and referenced the board assurance framework specifically. They explained the board had a timeline for governance recovery with the expectation improvements would be in place by April 2023. However, with the patient safety and quality concerns we have identified we were concerned about the pace of this.

Budget management processes were in place throughout the organisation to enable stable financial management.

Management of risk, issues and performance

Leaders and teams did not always use systems to manage performance effectively. We were not assured the board had sufficient oversight and focus on the operational risks or had effective systems to ensure incidents were consistently reported in line national patient safety reporting guidelines. The trust did not always identify or escalate relevant risks and issues or identify actions to reduce their impact. The trust had plans to cope with unexpected events.

The board's well-led self-assessment reported the trust had processes to manage current and future performance and had a systematic programme of clinical and internal audit to monitor quality, operational and financial processes. The report also concluded improvements were required to identify, record and manage risks, issues and mitigating actions.

Our findings

Although some leaders we spoke with told us the trust had a strong risk management culture, we found executive and service leaders did not have a robust grip and oversight of the board assurance frameworks (BAF) and organisational risk register. The BAF was separated into a high level BAF, which identified key strategic risks, plus a BAF for each of the nine plans supporting delivery of the strategic goals. Leaders acknowledged the current BAF was not fully aligned to organisational objectives, and we were unclear where and when risks were reviewed by the board.

The trust had plans to review the BAF and risk register. The decision to revert to a single BAF was agreed in January 2022 and the new document was presented to the board in September 2022.

The internal audit annual report (2021-22) concluded there was 'reasonable assurance' the trust had a 'sound system of internal control, governance and risk management' however the controls were not 'applied in a consistent manner'. The report identified the incident reporting system had a 'significant number of blank fields' which included 'progress, responsibility and associated action'.

Minutes from an executive management group meeting in July 2022 noted that risks had become 'normalised', despite the high level of some of the risks. At this meeting, leaders were asked to review the risk register with a view to updating their risks. It was also noted that 98% of risks on the risk dashboard were overdue for review and some had been on the register 'for long time without resolution'. Queries were also raised in relation to the appropriateness of risk scores.

We were not assured service-level risks were always assessed, monitored or mitigated effectively. For example, the emergency operations centre risk register had four risk entries that were incomplete, and it was unclear how long the other risks had been on the divisional risk registers awaiting review.

The trust had a major incident plan based on the joint emergency services interoperability principals (JESIP) of co-locate, communicate, co-ordinate, jointly understand risk and shared situational awareness. Although the trust had tested this and other business continuity plans, we found actions had not been completed within the required timeframe.

There was a non-executive director and a strategic lead for emergency preparedness, resilience and response (EPRR). The team comprised of 15 whole time equivalent (WTE) staff. The hazard area response team (HART) operated with six staff on duty 24/7 and there were 42 paramedics trained in total. However, a recent report from the national ambulance resilience unit (NARU) highlighted some issues relating to staff shortages, training, testing and systems and the oversight of this. For example, one HART team had not completed physical competencies and not all 42 paramedics had completed training, due to constraints on training provision during the pandemic. The trust also used several systems to record information including asset management and log books. We were told this was identified as an issue in the NARU report and the contractors who used these systems did not always keep them updated. The trust was reviewing its assurance process to comply with national standards however we were concerned the trust, whilst aware of the issues, was not acting with enough pace to address the concerns. This meant the trust may not be able to respond and meet their national responsibilities when responding to incidents that required mutual aid, an out of area or national response or the expertise of these teams.

Following concerns raised in May 2020 in relation to safeguarding and staff working in the organisation, CQC reviewed information from the trust and were concerned there were not robust systems and processes in place to manage concerns about staff. In August 2020, we served the trust with a notice under Section 29A of the Health and Social Care Act 2008 which required the trust to make significant improvements in quality of health care. This was in relation to concerns raised about staff including safeguarding concerns, their conduct and managing positive disclosures on DBS checks.

Our findings

The trust was given a timescale to make the improvements and we reviewed and followed this up through our monitoring and found the trust had put in systems and processes to manage this.

Incident reporting and oversight of incidents

We reviewed nine incidents and tracked the investigation and learning from these. Incident reports varied in the amount of detail supplied, and some lacked key information. Only those files where a formal complaint had been raised showed evidence that patients and their families had been consulted and feedback sought around the incident investigation process. The time taken to report incidents varied, with four reported the same day, and the remaining five reported up to five months later. All files indicated that Duty of Candour (a legal requirement for trusts to say sorry when things have gone wrong) had been discussed with the patient or their family, although evidence for this was stored separately on another part of the system.

Incidents were submitted electronically. Staff and whistleblowers told us they did not always report incidents, either because it was difficult to do so, or because they didn't see the point as there was no learning or they felt singled out or blamed. To report incidents, staff working in ambulances had to wait until they returned to a base with a computer (often not until the end of their shift) to complete an incident form. Once submitted, incidents were reviewed by managers in the area where the incident occurred, and any graded as potentially moderate harm or above were sent to the trust's clinical review panel, which took place twice a week. This was attended by clinical team leaders and representatives from the patient safety teams. Any incidents which, following review, remained at this level, were escalated to a weekly executive safety panel, for executive leaders' oversight and input.

Staff told us the incident, risk, complaints and legal systems were not as joined up as they could be. We found safeguarding incidents were submitted on a separate system unlinked to incident management although both were discussed weekly at executive safety panel, which was a relatively new addition to the trust's incident review process. Work was ongoing to refine the trust incident management process and align this more closely to complaints and legal processes, however we heard that there was more to do, and that previous business cases put to board offering solutions had been turned down.

In April 2022, CQC raised concerns with NEAS about their perceived low reporting of incidents. The trust confirmed they had had a total of six serious incidents in the previous 12 months, in comparison to 43 for their nearest neighbours. Since raising concerns about the potentially low numbers of serious incidents, a further 19 have been sent to CQC. We were therefore not assured that the trust had been accurately reporting incidents in the period prior to our inspection.

Whistleblowers and patients' families told us of examples of incidents they had reported that had not been followed up, or they felt had not been fully investigated. We found that, where these had been taken to executive safety panel, they had been accompanied by information and some analysis which included a presentation of the situation, background, assessment and recommendations. However, we found many had been downgraded to no or low harm and closed with no further action, even though there were clear opportunities for learning, and not all relevant information was available at the time of the decision. We were therefore not assured the trust was fully compliant with the Duty of Candour requirement for incident investigations.

For example, one incident involved a patient who had been given clinical care outside of national guidance which had the potential to have caused harm. The cause of death had not yet been identified; however, the panel closed the incident with no further action.

Our findings

Another incident related to a technical failure, which could have recurred at any time, at several locations, between the incident (over two years ago) and the time the incident came to executive safety panel. No learning had yet been identified and the timescale for completion of a key action to prevent recurrence was November 2022.

In a third incident, we found a learning from deaths review had been delayed and while learning had been identified, this had not been shared with all involved, nor was this (reminding crews of national guidance) likely to lessen the chance of recurrence.

We had significant concerns about the numbers of incidents which had been recommended as moderate harm and above, only to be downgraded at panel by members of the executive team to low risk, or no harm. Following the meeting, CQC requested documentation from the meeting. We only received the agenda and weekly briefing document from the meeting and no documentation of any decision made during the meeting. This was a concern as this had been an issue raised from high profile whistleblowing concerns and the trust had reported they had systems to ensure meetings and decisions were documented and this now took place.

We are concerned leaders are not thoroughly investigating incidents and are making decisions based on limited information, reducing the ability to identify learning and actions to prevent reoccurrence and mitigate risks to patients

We could not see evidence of incidents having been discussed at an incident review learning meeting in those files we looked at. Learning was not considered where it had been deemed that there was no harm attributable to the trust, even when it was clear that there was still an opportunity for this to take place.

We found multiple occasions over the previous year where learning from incidents was limited to training, reminders or retraining for staff directly involved in incidents, with less evidence of wider learning. Learning bulletins were circulated but senior leaders could not be assured these were read and the contents digested. For example, we found a complaints response to a family's relative who had been conveyed to an ambulance in an undignified and unsafe way, causing them injury. The learning shared with the family was that staff would receive refresher training.

In response to CQC raising concerns about medicines management, the trust's response to the review of the 19 incidents was that, for eight of them, reminding staff of policy medication recording would be sufficient to reduce the risk of recurrence.

Staff responding to our staff survey told us that frequently, when they had reported incidents, they felt learning came with 'a subtle undertone of it was your fault anyway' and a culture of 'blame the individual'. One person told us that they had identified a system issue, and reported this as a wider risk, expressly asking that the individual concerned was not singled out as in their view it wasn't an individual issue. They were disappointed to receive feedback that the only action was that the individual had been spoken to and given feedback, which was exactly what they had hoped to avoid. Another felt that staff were used as scapegoats for incidents, removing learning and placing blame. Several felt that incidents were either not fully investigated, or worse, covered up, with the emphasis on individual retraining or reminders rather than system-wide scrutiny. We were therefore not assured that the trust was correctly triaging, reporting and managing incidents, nor that actions were taken in a timely way to prevent recurrence.

Following this inspection, we served the trust with a notice under Section 29A of the Health and Social Care Act 2008. We told the trust it needed to make significant improvements in incident reporting, investigating and monitoring of actions to prevent reoccurrence, and ensure improvements are made as a result.

Duty of Candour

Our findings

The trust did not have a standalone Duty of Candour or Speaking Up policy at the time of our inspection, but we were provided with a draft document for a separate policy which was in the process of being written. We found evidence of some long delays or absence of the full implementation of duty of candour, and evidence that this was not always appropriately applied. For example, in one case, an apology in writing to a family was not issued until several months after the first opportunity to do so. In another example, we viewed minutes of an executive safety panel meeting which showed the trust did not understand its responsibilities under the act and had chosen not to enact duty of candour despite deciding on a moderate level of harm. We were not assured the trust was fully compliant with this requirement.

Medicines management

Prior to our inspection, we noted the trust had reported very few medicines incidents on national reporting systems, which was unusual compared to other ambulance trusts. During this inspection, we asked for a list of all medicines incidents from the previous six months, which the trust provided. We found these had not been shared with pharmacy colleagues when they had occurred, and that there was a backlog of over 115 incidents awaiting review. We heard that this was due to an element of the trust's reporting system having been turned off. It was not clear why this had been done.

Although staff told us about their own governance processes for medicines, in particular controlled drugs, there was a lack of clear lines of accountability within operational leadership for medicines oversight. This included responsibility for audit of medicines to ensure staff had access to what they needed. This lack of direction meant there was no consistent trust wide approach in place to promote safe medicines optimisation and highlight everyone's role and responsibility in this process.

There was no robust process for medicines audit and oversight of these processes was minimal due to a lack of medicines staffing to undertake these roles but also a lack of operational oversight due to recent changes in role and a lack of direction on who's role this was. Although most of the risks we identified sat on the medicines team risk register and were discussed as part of the medicines optimisation group there was minimal board level insight into these issues. In addition, medicines related policies and procedures required updating to account for changes in roles and responsibilities.

Medicines optimisation processes in the trust did not ensure that front line staff always had the correct medicines needed to complete their role. The medicines team had identified risks within the service however there was a lack of oversight at a more senior and board level. This meant that there was not an adequate focus on medicines so that wider understanding of the risks and a proactive focus was not in place to mitigate those risks. Following the core service inspection, we wrote a letter of intent notifying the trust of possible enforcement action. The trust provided an action plan which aimed to review medicines management, oversight, audit and governance processes within the trust. At the well led inspection, we reviewed aspects of the action plan including those that had been marked as completed and found that actions were not completed to a level that ensured front line staff had access to what they needed. We also noted the trust has seen an increase of over 100% in medicines incident reporting and we issued a second letter of intent following these findings and the trust submitted a revised action plan.

Due to our ongoing significant concerns, we served the trust with a notice under Section 29A of the Health and Social Care Act 2008 in October 2022. We told the trust it needed to make significant improvements in medicines management to reduce risks to patients.

Finance

Our findings

NHS England reported that financial performance had been consistent in recent years, with cash and revenue plans being delivered in line with plans and national requirements. Review meeting discussions with NHS England demonstrated that financial risks had been identified and mitigated by the trust and in association with system partners. Managing capital outturn had been flagged as a risk by the trust, who cited global supply chain challenges with regards to securing vehicles in a timely manner.

Information Management

Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure however, not all systems were utilised effectively.

The trust had a digital strategy, approved by the board in February 2022, which set out its key focus areas and work plan. Information management and technology (IM&T) governance arrangements were in place and the key IM&T leads worked collaboratively across the respective groups and committees.

Systems were integrated and secure, preventing unauthorised access to information. The trust operated a fully integrated 111, 999 and ePRF service maximising efficiency and resilience to the services they provided. Systems were used to record and share patient sensitive data with emergency departments during handovers and there were clear processes to ensure compliance with access protocols.

The trust used performance figures and data captured electronically to monitor and manage performance. This included dashboards to review activity in the emergency operations centres.

The trust reported the use of internal audit to provide independent assurance over IM&T processes and controls. The IM&T team had increased its focus in the technology assurance domain of the internal audit plan as part of the wider governance changes, for example, the introduction of the technology committee, to strengthen focus on this area of the organisation.

The trust had comprehensive financial information stored and reported from appropriate financial ledger systems. Financial information provided to NHS England had been consistent and reliable and accurately reflected the organisation.

However, the trust did not always utilise electronic systems effectively to ensure enough oversight of medicines risks were in place. For example, the incident reporting system had at the core service inspection been identified as having the medicines review button switched off. This meant that medicines risks were not actively screened, and themes and trends were therefore not identified or mitigated. In addition, systems did not always correlate, and we found examples identified in complaints and incidents where this had led to delays in investigation and learning.

Medicines audit processes and oversight was not robust – we asked for EVDI records (records which were made at the start of each shift to record vehicle compliance). We were initially told that there were too many to send. We asked for specific dates and when these were provided, and we were not assured that the trust had a process to effectively review these given the volume, format and complexity of the documents. We could therefore not be assured that the systems in place enabled the trust to have the oversight and assurance that front line staff had access to what they needed for their shift.

Our findings

Leaders and staff described the reporting system as 'clunky' and not robust. The trust had plans to invest in new interactive digital visualisation software but acknowledged there was a need for an increase in staff resources to facilitate the implementation.

Engagement

Although leaders actively and openly engaged with patients, equality groups, the public and local organisations to plan and manage services, engagement with staff was less robust. They collaborated with partner organisations to help improve services for patients.

Although the trust had a communications and engagement strategy, the document showed no evidence of review since 2018, however leaders could describe the different ways in which they engaged with their workforce, patients and partners and we found evidence of this.

The trust engaged with staff through social media, including Facebook, Twitter and Instagram. Internal communications are also shared using Siren, including newsletters and service updates. The 'Workplace' application (app) was reported as being well utilised by staff, with 75% having an account as of February 2022; they could use this tool to provide feedback, ask questions and engage with the executive team and senior leaders.

Leaders we spoke with described the challenges of engaging with frontline staff across a geographically diverse region and told us they felt engagement could be improved. Some executive leaders had utilised the 'welfare car' to visit and engage with frontline staff.

Not all staff felt engaged or listened to and some of the comments in our survey from staff were:

- "We are treated like numbers and there is very little engagement. Communications are done via the beacon and occasionally email – which is great if you have time to read it – which we don't."
- "Senior management seem hesitant to involve individuals…leading to changes that could have been delivered more quickly, effectively and efficiently if they had just engaged."
- "Some junior managers do engage with staff…The senior managers in my experience don't even acknowledge me."

Patient information was published on the trust's website and included a range of guidance and advice. There was a 'learning disability zone', which included easy-read downloads, videos and pictures, plus information and guidance videos which were subtitled and with British Sign Language interpretation. The website also enabled patients to leave feedback and make a complaint.

Following the NHS staff survey (2021), the trust recognised more work was required to improve engagement with staff to understand their concerns and take appropriate action to address them. Task and finish groups were established with staff to support delivery of actions however the outcomes were not always delivered timely.

However, communication, engagement and scrutiny from the executive and management level on medicines related topics was not sufficiently in place to ensure risks were shared challenged and responded to in a timely manner.

The trust had increased the number of engagement events in person, and virtually with local health providers, Healthwatch organisations, local authorities and commissioners over the last twelve months. Executive and non-executive leaders described their positive progress in developing collaborative working relationships through engagement with local NHS trusts, the North East and North Cumbria Integrated Care Board and other key partners.

Our findings

The trust collected patient experience feedback from patients and the public. The trust's annual patient experience report reported data and themes. Data from 2021/22 indicated an overall positive satisfaction rate of 88% (out of 9,239 responses). The three main positive themes were 'professional and competent' staff who provided 'emotional and physical' support and who showed 'compassion'. The three main negative themes were 'waiting', 'emotional and physical support' and ambulance transport'.

The chief pharmacist was part of local and national medicines safety groups and ambulance pharmacist networks. They worked collaboratively with local trusts and was part of the North East North Cumbria regional managers meetings.

The trust finance department was engaged with regional HFMA and One NHS Finance for staff development and best practice across a range of measures.

Learning, continuous improvement and innovation

Systems and processes for continually learning and improving services were not robust. Learning from complaints and incidents was not embedded across the trust and the pace of delivering improvement was slow.

During the pandemic, the trust demonstrated flexibility and adaptability to sustain its services. For example, the trust effectively utilised its patient transport service (PTS) to support ambulance handovers at acute hospitals, to free emergency vehicles to respond to acutely unwell patients.

Following the pandemic, the trust identified a need to better understand the health inequalities exposed by the pandemic and had a plan to engage a public health registrar from 2022-2024 to support the trust's work on health inequalities.

The trust had developed a transformation programme, comprising of five key workstreams, to ensure people received the right care at the right time, focusing on operational processes, people and culture to improve delivery and performance.

However, we heard reports from some staff that continuous quality improvement was not fully embedded across the trust and previous executive leaders had different opinions about transformation. One leader cited previously known medicines management issues as an example and the associated challenges to improve the system.

Some staff told us although they had the opportunity to contribute to continuous improvement initiatives, they expressed concerns about the slow pace of delivery. We heard that some projects never achieved an outcome or were ongoing for a long period of time although we also heard reports where the trust had taken timely action to improve operational downtime and improve handover times.

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement ➔➔ Feb 2023	Requires Improvement ➔➔ Feb 2023	Good ➔➔ Feb 2023	Good ➔➔ Feb 2023	Inadequate ➔➔ Feb 2023	Requires Improvement ➔➔ Feb 2023

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Ambulance Headquarters, Bernicia House	Requires improvement Feb 2023	Requires improvement Feb 2023	Good Feb 2023	Requires improvement Feb 2023	Requires improvement Feb 2023	Requires improvement Feb 2023
Overall trust	Requires Improvement ➔➔ Feb 2023	Requires Improvement ➔➔ Feb 2023	Good ➔➔ Feb 2023	Good ➔➔ Feb 2023	Inadequate ➔➔ Feb 2023	Requires Improvement ➔➔ Feb 2023

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for Ambulance Headquarters, Bernicia House

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Requires improvement Feb 2023	Requires improvement Feb 2023	Good Feb 2023	Requires improvement Feb 2023	Requires improvement Feb 2023	Requires improvement Feb 2023

Rating for ambulance services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency operations centre (EOC)	Requires Improvement ➔➔ Feb 2023	Requires Improvement ➔➔ Feb 2023	Good ➔➔ Feb 2023	Good ➔➔ Feb 2023	Requires Improvement ➔➔ Feb 2023	Requires Improvement ➔➔ Feb 2023
Resilience	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
Patient transport services	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
Emergency and urgent care	Inadequate ➔➔ Feb 2023	Requires Improvement ➔➔ Feb 2023	Good ➔➔ Feb 2023	Requires Improvement ➔➔ Feb 2023	Inadequate ➔➔ Feb 2023	Inadequate ➔➔ Feb 2023

Overall ratings for ambulance services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Emergency operations centre (EOC)

Requires Improvement ➔➔

Is the service safe?

Requires Improvement ➔➔

Our rating of safe went down. We rated it as requires improvement.

Mandatory training

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

All staff received and kept up-to-date with their mandatory training. The trust target for mandatory training was 85%; average compliance for staff in the emergency operations centre (EOC) was 92%. Staff we spoke with told us they had time offline to be able to complete training, and the demand management team allocated this based on projected and actual times of lower demand.

The mandatory training was comprehensive and met the needs of patients and staff. We found that there were appropriate mandatory training modules in place, including dementia awareness, level one resuscitation and business continuity management which was service specific.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Mental capacity act training was completed as part of the mandatory training

Managers monitored mandatory training and alerted staff when they needed to update their training. The service had a plan in place to ensure all staff had opportunities to complete training and completion rates were monitored monthly. They planned for all staff to have completed mandatory training modules by 30 September 2022.

Staff mandatory training was done electronically. Staff told us they were given time to complete the training at times of the shift where there was less demand.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. However, systems and processes were not robust and we found gaps in the safeguarding policy.

Staff received training specific for their role on how to recognise and report abuse. The trust target for safeguarding training was 85%; average compliance across all staff groups in the EOC was 84% which was just below the trust target. Three staff groups had not met the safeguarding training target; administrative and clerical staff compliance was 82%, nursing and midwifery staff compliance was 76% and medical and dental staff compliance was 50% (however the number of staff in this group was low). The service had a plan in place to ensure they met the trust target of required mandatory training by 30 September 2022, which included safeguarding training. Despite organisational pressures in 2021/22, the service ensured clinical staff in the EOC received face to face safeguarding training and face to face and eLearning training was available to all other EOC staff to ensure they received appropriate training in safeguarding.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm.

We reviewed the trusts safeguarding adult's policy; it was version controlled, however it was passed the review date which was due in May 2022. We found gaps in the process in place. The policy stated that where an ambulance disposition was made, EOC staff should note possible safeguarding with a brief description of their concern on the electronic system to notify the attending ambulance crew. However, there was no clear process referenced to provide assurance that safeguarding concerns were followed up if an ambulance was cancelled, and a referral was made, if appropriate. The trust provided a draft version that would replace the one in circulation at the time of the inspection, which addressed the gaps identified in the safeguarding process, requiring EOC staff to make a referral if they had a concern. The table of revisions indicated the new policy had been updated in March 2022, however the service did not provide a timescale for the updated policy to be approved or implemented.

We found that a guidance note for cancellation of ambulances had been issued in June 2022 which required EOC staff to escalate a cancellation request to a clinician if there was an electronic message relating to possible safeguarding. This was not reflected in the updated safeguarding policy that was in draft form. This meant that safeguarding policies were not always aligned with other relevant policies, at the time of the inspection.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff we spoke with could describe how to make a safeguarding referral and when to do so. However, they told us safeguarding referrals were not made if an ambulance was dispatched during the call and they did not describe a process to make a referral if this changed. During the inspection, ambulance staff told us that they did not always get enough information from the EOC to adequately follow up a safeguarding query.

We asked managers about the process and what mechanisms were in place to ensure safeguarding was not missed, and they were not clear on the processes being followed in the EOC, so we asked for more information after the inspection. We did not receive a response.

The trust had a safeguarding children's policy in place at the time of the inspection, it was version controlled, and was due for review eight days before our inspection began. The trust also provided an amended safeguarding children's policy which was due to be ratified and approved three weeks after the version in use was due for review. We did not see the same gaps in the safeguarding children's policy that we found in the adult's policy. However, when we spoke to staff during the inspection, they did not describe a difference in the process they would follow for children and adults, so we were not assured that safeguarding referrals were always made by staff in the EOC when they had a concern about a child.

Trust safeguarding leads had been involved in a national task and finish group to review a standard for frequent callers aged under 18, and had implemented a local process for reviewing "frequently presented" children which included engaging with local partners to ensure appropriate information was shared and multiagency plans were developed.

The trust safeguarding leads had identified that safeguarding supervision was routinely offered to clinicians, however it was not offered to other roles. The service implemented safeguarding supervision for EOC staff to support them around safeguarding children's incidents and feedback from staff who had accessed supervision was positive.

Emergency operations centre (EOC)

We reviewed the annual safeguarding children and adults report for 2021/22 and saw that the EOC was included under a number of headings, which included; safeguarding resource to support referrals on the logistics desk, NHS pathway risks around bruising in immobile children and themes from cases over the 12 month period. This meant the service contributed to safeguarding reports to board, and there was a mechanism in place to escalate risks and issues relating to safeguarding.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. This included people at risk of female genital mutilation and child sexual exploitation. Although staff had not experienced patients suffering this type of abuse, they were able to explain what they would do if they suspected it.

Inside working hours there was a specialist safeguarding team who could provide advice and support to staff, and outside of office hours there was support from clinical team leaders.

There was a logistics desk that made all referrals for road staff. However, the logistics desk staff had not received any additional training to support them in this role, and this was often an expectation of ambulance staff. Staff told us there was often a long wait for ambulance crews to reach the logistics desk because it took up to 20 minutes for them to make a safeguarding referral, and the desk was manned by one person. Leaders told us they were reviewing the logistics desk function as part of a wider service review, which included changes to the safeguarding referral process via the use of technology.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. However, documentation used to review the environment and equipment was not always up to date, and action plans relating to improvements were not up to date.

The service had a fire evacuation plan for the main EOC site at Bernicia House. It was in date and due for review in July 2023. There were fire evacuation plans for the site which included location of fire exits and fire extinguishers. We asked for details of the last fire safety and evacuation test, however the trust did not provide them.

The service had contingency and business continuity plans in place for various events, including loss of power, loss of service and weather events. We reviewed a selection of the plans and documentation provided by the service and found that there were plans in place in the event of a failure in any of the three EOCs, and business continuity plans to address total failures. However, we found that not all documentation was up to date and recommendations were not always actioned to reduce the impact.

We reviewed a recent exercise which was completed in May 2022 to test the response and recovery to a power loss at Russell House. There was an action plan and we found that eight observations were made; five had been allocated corrective actions, action owners and target dates for completion. All five actions were past the target date for completion and remained open. Three of that five related to updates required to the power loss procedure. We reviewed the power loss procedure and saw it had not been updated since February 2020, and although review was not due until February 2023, the exercise identified a number of areas that were incorrect or out of date. A further three observations were identified on the action plan, however no corrective actions, action owners or timescales had been added to address the observations. We found the service leaders had identified plans were not always up to date and this was on the business continuity team risk register.

Emergency operations centre (EOC)

Following the inspection, we served a section 29A warning notice because we were not assured the trust had effective governance systems in place to ensure risks and performance issues were identified, escalated appropriately, managed and addressed promptly. We asked the trust to make significant improvements.

The service had arrangements in place to accommodate equipment failure such as communication and computerised systems. In the event of a system failure, including complete loss of service, dispatch would be operated from one site, to ensure that appropriate monitoring and support could be implemented. This included clinicians 'floor walking' to support call handlers and health advisors within the service. Paper based records would be started.

In the event of telephony failure, mobile phones kept within the service would be used.
Planned interruption of service such as an update of the electronic systems were pre-planned and included the systems running parallel to each other to ensure revalidation was carried out in line with national requirements.

The service had a Workplace Health and Safety Inspection Checklist; it was version controlled. We reviewed the checklist for each of the three EOC locations and found that one out of three inspections had used an old version of the checklist which contained different checks. Version 04 was effective from 01 November 2019, however one EOC site had been checked against version 01, effective from 16 March 2016. This meant that the most recent health and safety inspection of the main EOC site used an out of date checklist; we checked both versions and version 04 identified different checks to version 01.

The service had an ongoing equipment replacement programme in the EOC that began in 2020 and was planned to be completed in 2022. There were plans in place with the trust's supplier for next business day support and the trust held a supply of IT equipment for immediate replacement. This was important due to the nature of the service which meant IT equipment was required 24 hours a day to provide a safe service.

The service had records of equipment maintenance; equipment in two of the three EOCs was last checked in February 2021, the third site had only been operational for two months at the time of the inspection and so equipment had not required maintenance checks.

Live electronic chats with information technology teams as well as relevant managers meant that all relevant stakeholders were kept informed of changes and could also quickly escalate any unplanned events. Debriefs were held following equipment changes and recommendations put in place to support learning for unplanned incidents.

The service had fire extinguishers located on each floor, these were clearly labelled, in date and easily accessible to all staff.

Confidential waste bins were located on each floor meaning that confidential details were disposed of securely and not left lying around.

Nut allergy posters were clearly displayed in relevant areas of the control room alerting staff not to bring nuts into the area.

Noise levels at all three sites were at a manageable level and did not distract staff whilst on telephone calls to patients.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Emergency operations centre (EOC)

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Clinical staff in the EOC used nationally approved tools to make triage decisions; they received training and competency-based assessments to utilise NHS Pathways and the Manchester Triage System (MTS). Clinicians had access to an emergency advice chart, which included 53 presentations and had easy links to screening and assessment tools to support clinical staff. Each presentation had an algorithm which indicated the emergency ambulance response required, depending on the answers given about the patient's condition.

Staff completed risk assessments for each patient, using a recognised tool. Clinicians reviewed patients waiting for an ambulance (where a category two, three or four response was required) and checked the disposition was correct, they completed call backs to monitor patients waiting for an ambulance response, check for deterioration and if appropriate amend the priority of the disposition or allocate an alternative mode of transport. These calls were prioritised by risk. This meant that all patients waiting for non-urgent responses were reviewed by a clinician. For example, where a category two disposition (serious but not life threatening) was reached, patients were called back within 18 minutes of the initial telephone call for help by a clinician who revalidated the call making sure the patient had not deteriorated and that the correct category had been selected to determine the correct and most appropriate response. We found this reflected in the policies we reviewed.

The service also had registered medical professionals and advanced practitioners who validated ambulance responses using their advanced clinical assessment skills.

Clinical staff were allocated to monitor specific presentations that could be high risk for category two and three ambulance dispositions, including falls, overdoses and urgent transfers. They reviewed these patients using pathways and the MTS. Clinical staff highlighted patients they were clinically concerned about to clinical team leaders and could request specialist dispatch if appropriate.

There were plans in place to maintain a safe clinical service when the EOC was busy. This included clear allocation of tasks to different staff roles. This meant the service could increase capacity to respond to emergencies, reduce demand on the service and reduce clinical risks to patients using the service. The plan included a structure for clinical call backs to check if patients had deteriorated and revalidating calls with differing categories for dispatch. The plan also gave specific actions to take when the ambulance service was under significant pressure and less urgent responses would not receive an ambulance response; this was reflected in the service's procedure for not sending ambulances. The actions were clear, and outcome driven.

Staff knew about and dealt with any specific risk issues which were recorded as 'special notes' within the electronic dispatching systems. This included information about do not attempt cardiopulmonary resuscitation (DNACPR) and advanced care plans and directives. These special notes were turned red which meant they were visible to staff and could not be easily missed. Where a patient had multiple flags or special notes, they were all listed within the patient notes so that they could not be missed.

The service had a guidance note for the management of callers with suicidal intent; it was version controlled, in date and due for review in September 2023. The guidance provided actions staff should take to ensure the appropriate clinical advice was secured for patients, including allocating a priority category when the EOC was unable to provide a clinical call. This meant that patients who needed priority risk assessment were identified for a crew to be dispatched.

Staff shared key information to keep patients safe when handing over their care to others. The service had a policy for the management of urgent ambulance responses by clinicians; it was version controlled, however it was past its review date which was September 2021. The policy outlined the process for patients who had an urgent ambulance response

from a health care professional. For example, if a patient attended a GP surgery and required an urgent ambulance, a healthcare professional would call the ambulance service to arrange an appropriate ambulance by transfer, once arranged, a clinician would call back to check that the response category was correct. This meant that the response requested was validated and the patient was reviewed.

Shift changes and handovers included all necessary key information to keep patients safe.

The service had an appropriate procedure for the management of long lying falls; it was version controlled and was next due for review in November 2023. Patients who had fallen, were unable to get up and waiting for an ambulance to be dispatched were prioritised for a clinical call back due to the risks associated with long lies.

The service had a procedure to manage long waiting patients; it was version controlled however the review was due in April 2022 and we did not see evidence this had happened. The trust told us this policy was replaced in August 2022, however the policy that replaced it had no effective from or review by dates documented.

The policy identified patient groups that were at high risk, including certain age ranges, environments and communication barriers, that may require upgrading to a faster ambulance response. The trust had a weekly report for long waiting patients and these cases were audited against the required validation time scales; there was an audit tool that was used if a patient's wait breached the national standard.

999 calls were prioritised by risk. For example, category two (serious but not life threatening) calls were called back within 18 minutes of the initial telephone call for help by a clinician who revalidated the call making sure the patient had not deteriorated and that the correct category had been selected to determine the correct and most appropriate response.

Staffing

The service did not have enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

The service accurately calculated and reviewed the number of staff needed for each shift in accordance with national guidance, however they were routinely unable to allocate enough staff to meet the demand in the service.

The service did not have enough health advisors in post to meet the forecasted demand or the service level agreement. We reviewed the staffing levels for week commencing 11 July and 18 July 2022 and saw the staffing variance was negative on every day; this meant there weren't enough staff available to answer the forecasted number of calls to the service.

The service did not always have enough clinical staff. We reviewed two weeks of rotas and there were not enough clinicians to meet the forecasted demand on nine out of 14 days; the service particularly struggled on Friday, Saturday and Sunday shifts, where we found gaps of up to 45% of the required clinical workforce. The trust told us managers met regularly during times of high demand to flex the workforce between 999 and 111. The service continued to find recruitment of clinical staffing a challenge, which was a national issue.

The service did not have enough staff in dispatcher roles to meet the requirement; we reviewed two weeks of staffing information and saw there were not enough staff on 10 out of 14 day shifts, and 11 out of 14 night shifts; this varied between one and two staff short of the planned numbers. The service had a process in place to ensure the main dispatch desks were covered in times of low staffing and managers helped to cover breaks when there were not enough staff on duty.

The service had a 'look forward' report that was updated weekly and identified staffing requirements for the six weeks ahead. We found that the service did not have enough staff at any time during that period to meet the projected demand.

Managers reviewed staffing requirement forecasts to identify any gaps which they could fill through use of overtime or agency staff. Despite this process we found significant gaps remained unfilled. This could be broken down by hour, so additional staff could be allocated to the busiest times. The service used the clinical safety plan during times of staff shortages which was monitored by leaders to mitigate the risk when there weren't enough staff to answer calls or provide clinical cover.

The service had a recruitment programme in place which had been commissioned and was in progress to significantly increase health advisor staffing, and the wrap around roles to support the increase in this area of the work force, for example team leaders, call audit team and senior health advisors. The plan was being rolled out and was due to be completed in the summer of 2023. The increase in staffing would support the service to meet the demand of the service.

The service had high sickness rates across varying roles; we found there was an ambition to reduce the sickness target from 10% in the current year, to 6.5% by 2025/2026.

Sickness rates for clinicians was 8% out of approximately 75 whole time equivalent (WTE) staff.

Managers told us about secondment opportunities for clinicians to come into the control room over previous winter periods which had been successful and were being reviewed at the time of our inspection for the upcoming winter period.

Recruitment via social media had been explored by the trust and was underway as an open advert at the time of our inspection. Managers told us this had generated more interest and applications in progress than other previous recruitment drives.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Records were stored securely. The service used electronic systems to record patient information. We observed staff across the EOC using systems to record information from people calling the service, update records and clinical information, dispatch resources and make referrals. Records were stored securely and staff routinely locked their computers if they left their work station.

Patient notes were comprehensive and all staff in the EOC could access them easily.

When patients transferred to a new team, there were no delays in staff accessing their records. For example, clinicians could access the record of a patient who was still providing information to the call handler. Although the clinician could not alter the record that the call handler was in at that time they were able to add additional notes onto the record. This meant that any calls requiring urgent clinical assessment could be access in a timely way.

Medicines

Staff gave advice on medicines in line with national guidance. However, there were ineffective processes in place to ensure ambulance staff dispatched had time to complete medicines checks.

Staff completed medicines records accurately and kept them up-to-date.

Staff gave advice on medicines in line with national guidance. Health advisors and clinicians gave advice to patients who may be able to use medicines they were already prescribed to manage their condition before help arrived.

During the inspection, ambulance crews told us they were not always given sufficient time to complete checks on their vehicles including checking their medicines were correct and available. We asked the EOC service to provide information on their dispatch processes and how the trust was assured that staff on the road were given sufficient time to complete these vital checks. The information provided did not reference medicines checks. We found that crews who had not completed their vehicle checks were highlighted on the electronic dispatch system, however we did not see evidence of a system or process to ensure these checks were completed, and the trust did not provide information to evidence how they were assured staff were given the time to complete these vital checks before they were dispatched. This was a concern as we found incidents where staff had arrived at calls without the appropriate medicines to treat the patient's condition and meant staff did not always have the right medicines. Following the inspection, the trust confirmed EOC staff now recorded whether a crew had their drugs as part of their sign on procedures at the commencement of their shift.

We asked the service how many times in the last six months an additional crew had been dispatched because the responding crew did not have the correct medicines or equipment available, and to provide any actions they had taken to address this issue. The trust did not provide a response.

During the core service inspection, we issued the trust with a section 31 letter of intent because road staff did not always have access to medicines they needed to treat patients, medicines were not stored or stock checked appropriately and oversight of medicines was not robust. We found that EOC systems and processes did not ensure staff had time to complete vital medicines checks before they were dispatched, and there was limited oversight of these checks in the EOC to ensure they were completed at a later time during the shift. We reviewed this during our second on site inspection, where we looked at how well led the trust was and found ongoing issues with the availability of medicines and systems to manage medicines. We issued the trust with a further section 31 letter of intent, and we were not assured by their response, so we served a section 29A warning notice, which required the trust to make significant improvements to the management of medicines.

When we returned to the service for the well led inspection, we found that although some mitigating actions had been put in place, road staff continued to attend to patients with incorrect medicines, without medicines, or with medicines that had not been checked in line with guidance.

Following this inspection, we served the trust with a notice under Section 29A of the Health and

Social Care Act 2008. We told the trust it needed to make significant improvements in medicines management to reduce risks to patients.

Incidents

The service did not manage patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately, however investigation reports were not in line with national guidance, and learning was not shared in a systematic way with staff. When things went wrong, staff apologised and gave patients honest information and suitable support. Staff did not think learning from incidents was implemented across the organisation.

Staff knew what incidents to report and how to report them. Staff understood how to report incidents and told us there was a no blame culture in the EOC. Clinicians were encouraged to report near misses. Staff received feedback from incidents they raised which was shared during monthly one to one meetings. Staff told us about changes to processes in the EOC as a result of learning from recent incidents and staff were aware of the duty of candour and being open and honest.

Staff did not report serious incidents clearly and in line with trust policy. We found incidents were investigated; however this was not always timely. We reviewed two incidents in full and saw that one incident occurred in October 2021 and was not reported or investigated as a serious incident until April 2022; this was a delay of six months. The action plans had target timescales, but it was unclear how long the timescales for each action were. There were no start dates, and we found there were timescales as much as one year later than the time we reviewed the information, due in July 2023. This meant the pace of delivery and completion of actions, mitigating risks and sharing learning was slow.

The serious incident reports we reviewed did not reflect the national serious incident framework as they did not include key information, including lead investigator, date of sign off or completion of the investigation, executive summary, contents page or index, or any root causes determined by the investigation. It was unclear who was accountable and how the report and action plans were escalated to board. We were not assured there was sufficient senior oversight of incident reports, as per national guidance, or that outcomes to ensure learning and improvements were made across the organisation in a systematic way.

We did not see evidence that incidents were discussed in regular meetings held by staff groups from the meeting minutes we found, however they were discussed by managers.

There was a system in place for incidents rated as moderate and above to be reviewed at a twice weekly clinical review panel, where there was input from all areas of the EOC; information from these meetings was reported at a trust wide executive safety panel. The EOC had a monthly serious incident review group in place to monitor the progress of incidents.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. The two serious incidents reports we reviewed had a cross directorate approach; the EOC were involved in investigations where they were not involved in the outcome of the incident, to check initial contact with the patient had been in line with policies and procedures.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. We reviewed two duty of candour response letters and saw they were in line with regulations.

Emergency operations centre (EOC)

We looked at the trust's integrated performance report from June 2022 that was reported to the trust's board in July 2022. We found that the rate of patient safety incidents per 1000 calls was above the threshold and had increased since the previous report to 2.5%.

In July 2022, the trust reported two of the top three patient safety incidents themes related to the EOC. There were 64 (19.5%) attributable to triage issues with 'Delay in Assistance' and 'Incorrect Disposition too Low' as the dominant themes and 46 (14%) attributable to ambulance delays. In response to this, the EOC senior management team had commenced weekly meetings to review higher acuity incidents with the patient safety team, and staff had been seconded to the patient safety team to assist in the investigation of incidents.

Following this inspection, we served the trust with a notice under Section 29A of the Health and Social Care Act 2008. We told the trust it needed to make significant improvements in incident reporting, investigating and monitoring of actions to prevent reoccurrence, and ensure improvements are made as a result.

Is the service effective?

Requires Improvement 

Our rating of effective went down. We rated it as requires improvement.

Evidence-based care and treatment

The service did not always provide care and treatment based on national guidance and evidence-based practice. Managers did not always check to make sure staff followed guidance. We found policies throughout the inspection that were past their review date. However, the trust had contributed to national best practice databases.

Staff followed policies to plan and deliver high quality care according to best practice and national guidance, however we found several policies during the inspection were past their review date.

For example, the service had a mental health policy; it was version controlled, however it was passed its review date which was due in July 2021. The policy had no revisions made since it was circulated in October 2018. Three out of four appendices were missing from the document we received and there was no specific guidance for EOC staff to follow contained in the policy. This contradicted the way the trust policy said effectiveness was monitored, which included "production of reports on compliance with core outcomes (i.e. response times for s136 detentions)" which was not covered in the main body of the policy, nor cited in the linked policies, therefore it was unclear how the trust were using this measure to monitor effectiveness.

We reviewed a document provided by a national NHS organisation which provided more detailed information on pathways to support EOC staff when they assessed patients presenting with self-harm. We could see the document had been copyrighted in 2016, however there was no other information included to evidence if the guidance note had been reviewed. We saw reference to the management of active suicidal intent guidance had been circulated to staff in November 2018, but we did not see evidence of recent review or circulation of the guidance, however the trust told us it had been updated on five occasions since January 2021.

We found the trust had shared national clinical guidelines with staff which related to extreme heat during the summer heatwaves in 2022. It included best practice guidance to provide to patients with heat related illnesses.

Emergency operations centre (EOC)

The trust monitored relevant national guidelines and we found commentary from staff which considered how changes impacted on the trust's guidance. We found updates had been made regularly. However, we reviewed the trust's clinical guidance action plan which noted 36 clinical guidelines which needed updating. There was only one entry which contained a date, and it was last updated in March 2020. It was unclear how the trust was monitoring the progress against this action plan and we were not assured all clinical guidelines were reviewed and updated in a timely way.

Clinical staff in the EOC had access to Joint Royal Colleges Ambulance Liaison Committee (JRCALC) and used nationally recognised triage tools and service specific national pathways. They were based on nationally recognised guidance.

The trust contributed to a national repository of examples of good practice for safely reducing ambulance conveyance to emergency departments; the last submission relevant to the EOC was in April 2021, where the trust had piloted a dedicated mental health response car which could be dispatched to patients with a mental health crisis awaiting a category three response. We did not see that this initiative was in place at the time of the inspection.

The trust took part in 25 national clinical audit projects and 8 clinical outcome quality indicators in 2020/2021. The trust submitted 100% of their eligible cases for the national ambulance clinical quality indicators and two eligible national clinical audit projects.

We found the trust also had an internal audit programme in place, which included EOC call and clinical call audits for the current financial year. The service was required to maintain its licence to use NHS Pathways, which included meeting a minimum call audit requirement. During the inspection we spoke with the call audit teams who told us they had maintained compliance throughout the COVID-19 pandemic, and in 2022 they had re-introduced a targeted approach to call auditing, which meant they could identify themes, trends and improvements.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief advice in a timely way.

Staff assessed patients' pain by looking at the functionality of the patient and how the pain had affected them. For example, what the patient was not able to do because of the pain they were experiencing.

Health advisors recorded pain described by patients and callers as prompted by the electronic Pathways system. They also advised patients who were waiting for an emergency ambulance to gather any regular medicines in case they needed to go to hospital. This ensured that patients had a supply of any regular pain medicine if they needed it.

Pain relief was not administered by the clinicians within the service; advice was given on what medicines to take whilst waiting for help to arrive. These were over the counter medicines that included non-steroidal medicines and paracetamol. Alternatives to pain relieve medicines such as heat and ice packs were also suggested.

Referrals to general practitioners took place for patients who were under an existing pain management plan and clinicians within the service could refer patients to speak to community pharmacists between the hours of 6pm and 10pm Monday to Friday and also 8am to 6pm at weekends.

Response times

The service monitored, agreed response times so that they could facilitate good outcomes for patients, but they did not meet the national targets. They used the findings to facilitate changes.

Emergency operations centre (EOC)

The service monitored but did not always meet agreed response times.

The trust monitored nationally measured NHS Ambulance Quality Indicators (AQI) for a range of indicators including call answer rates. Calls to EOCs should be answered within a maximum of ten seconds on average. In June 2022, the trusts average call answering time was 27 seconds, which did not meet the target.

The EOC was measured and benchmarked against other ambulance service trusts for its performance against the 99th centile time to answer calls. This measure shows the time to answer 99% (99 out of 100) of 999 calls. This is defined as the time in seconds between call connect and call answer. This measure identifies the longest waits to have calls answered. In June 2022, the trust's performance against the 99th centile was 198 seconds. This was better than the England average, which was 256 seconds.

We looked at the service's response time performance over a three-year period and found the following between 2019 and 2022:

- There was a considerable increase in mean 999 call answering time in late 2021, peaking at 66 seconds in October, and followed by rapid reduction to 23 seconds in April 2022. This reflected the overall England trend, but did not meet the target.
- The trust's 95th percentile call answer time peaked at four minutes and six seconds in October 2021, before reducing to one minute and 33 seconds in April 2022.
- The service dispatched resources efficiently, activating and then subsequently standing down fewer resources per response than the national average.

In addition to responding to their own call demand, the service supported other ambulance services if the EOC exceeded its capacity. This is known as mutual aid and occurs nationally. Leaders we spoke with told us they regularly provided mutual aid to other ambulance services which could negatively impact their own response times performance.

In June 2022, the call abandonment rate was 4.4% on the 999 and urgent call handling time. For only 999 emergency calls, the abandonment rate was 2.6%. There was no national target.

The service measured average call back times from clinical staff in line with the trust's internal target; there was a target for call backs required within 20 minutes, and a target for call backs within 60 minutes. In June 2022, the service's average did not meet the target for 20-minute call backs, or 60 minute call backs. The performance for call backs made within timeframe was 67%. This meant it took longer than the trust's target for clinicians to contact patients who were waiting for an ambulance response.

The AQI also measured the time it took for NHS ambulance services to respond to patients requiring an ambulance. Each category of call had a target average response time, and a target for the 90th percentile (which shows the time to respond to 90% of patients).

In May and June 2022, the trust's response to category one (life threatening) calls met the standard in both the seven-minute average and 90th percentile targets.

The service monitored response times in line with the national targets, however they remained a challenge across all areas of the service. The service was not meeting the key performance indicators relating to category two and three responses.

Emergency operations centre (EOC)

Category two responses consistently failed to meet the standard, however the service performed better than the national average. There was no national standard for response to category three calls, however the trust's response times were reflective of the national average.

We spoke with the performance team who interrogated the response time and call handling data. They described initiatives to make improvements to the category two response times, including work to understand pressure points and impact of different areas of the service on ambulance response times. This involved reviewing staffing, training, forecasted demand and road crew data. We heard about changes the service had made to vehicle cleaning regimes to reduce down time of ambulance crews with the aim of increasing category to response performance; the service had seen a reduction in ambulances unavailable in peak times due to this work.

Patient outcomes

The service monitored the effectiveness of care and treatment. They used the findings to make improvements. However, national performance was not always in line with targets and staff did not always follow pathways to reach to correct outcome for patients.

Hear and treat rates were incidents resolved by staff over the telephone and therefore not requiring an ambulance to be dispatched. This was a nationally measured Ambulance Quality Indicator (AQI) standard for which the trust was benchmarked against other NHS ambulance services in England. The service achieved a hear and treat rate of 9.8% in June 2022 which was lower than the national average of 12.9%. This was the third lowest rate of the 11 NHS ambulance trusts in England. This meant that more ambulances were dispatched to patients than other services, and we heard from ambulance crews that they were sometimes sent to inappropriate patients who did not need conveying to hospital or seeing by an emergency ambulance response. This meant that there were missed opportunities for patients to be managed outside of the emergency ambulance response category.

The trust measured re-contact rates; in July 2022 6% of patients re-contacted the service within 24 hours. The service collected data about the geographic areas of patients who re-contacted the service which included the initial impression (reason for the call, for example muscle pain, fall), and initial outcome disposition (hear and treat, see and treat, see and convey). This was no longer a nationally required performance measurement; however, the service used this data to support oversight of patient outcomes across geographical areas.

The call auditing team completed the required audits of staff calls, in line with licencing agreements, which checked that pathways had been correctly followed by health advisors. In June 2022, 251 health advisors were audited, and compliance was 75.7%; 61 health advisors failed two or more call audits in June 2022 and 32 of those staff members had reoccurring non-compliance with the audits in the last three months.

Performance management plans were triggered for 68 staff in June 2022 for managers to review errors in audit and support staff to make improvements. Not all staff in the EOC were meeting the required audit results to evidence competence in their role. Managers we spoke with told us that a risk for the service was high turnover of experienced staff into more senior roles due to the recruitment programme that was ongoing. This meant that not all patients who contacted the service were correctly triaged, and the ambulance response was not always correct to the condition of the patient.

The service also completed a targeted audit in June 2022 of urgent calls (healthcare providers requesting an ambulance response) and compliance with the audit was 68.5%. To achieve a pass rating, 86% compliance is required by NHS pathways. Targeted audits were also completed on chest pain calls, and staff met the target with compliance at 94% for

applicable 999 calls; highlighted areas of concern related to appropriate probing of information. This meant that although some pathways were not correctly followed, patients with life threatening presentation were managed in line with guidance. Managers told us they used the audit results to support staff to make improvements in their performance.

The service had a trust wide group that monitored performance; we looked at meeting minutes from June 2022 and saw they provided a monthly update on new pathway opportunities, as well as existing pathways and alternative care pathways. This meant that the service gave patients up to date information on pathways available to them.

Competent staff

The service did not always make sure staff were competent for their roles. Managers appraised work performance to provide support and development, however the appraisal compliance rate for clinical staff did not meet the trust target. Managers did not hold regular supervision meetings with clinical staff.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Overall, the EOC achieved 85% of appraisals completed, which was in line with the trust target of 85%. Health advisor and dispatch officer compliance was above the trust target at 88% and 100%, senior health advisors were below the target at 79%.

However, clinical staff appraisals did not meet the trust target of 85%. The trust provided a range of clinical staff compliance rates for appraisals, we looked at the average of clinical advisory job roles and saw that appraisal rate compliance was below the trust target at 65%. Only one clinical staff group met the trust's target; advanced practitioner nurses appraisal compliance was 95%. Three clinical staff groups which represented the majority of clinical staff achieved a compliance of between 73% and 79%. One staff group had not completed any appraisals, however there were low staff numbers in this group of only two staff.

The service had a clinical call audit programme and there was a monthly dashboard which reported performance. The dashboard for June 2022 showed that improvements had been made in the audit results for clinicians that used NHS Pathways and MTS. The target was 86% and NEAS clinicians and agency clinicians scored an average of 95% from April to June 2022.

The service audited bank clinicians' calls; in April 2022 they audited 44 calls and the average score was 94%; four calls failed the audit. This meant the trust had systems in place to check bank and agency staff had appropriate review and support in place.

We asked the trust for their most recent clinical call audit performance reports for substantive staff, including themes and trends and any related action plans. We did not receive any.

Managers gave all new staff a full induction tailored to their role before they started work. The service had created and implemented a framework for new clinicians, which included how consolidators, who were experienced clinical staff, supported the clinician to achieve the required competencies. This meant that the induction process for clinical staff was structured and identified key competencies to be achieved.

Managers supported staff to develop through regular, constructive clinical supervision of their work. Staff in all areas told us one to ones were only cancelled when the service was in high demand, but most staff had regular one to ones and an annual appraisal where they discussed performance and development. However, clinical staff did not have routine constructive clinical supervision in place; they told us they could access support as and when it was needed, but we did not see a mechanism in place for regular, constructive clinical supervision.

The service did not hold team meetings for staff to attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. We found the audit team dashboard provided information to managers on themes and trends for failed audits. Managers we spoke with during the inspection told us they used the reports to support staff in their teams and identify any system or process issues that needed to be reviewed. Senior Health Advisors had additional training to be competent for their role. They had specific guidelines and criteria to follow to make appropriate decisions.

Staff taking 999 calls were able to contact designated Advanced Call-handler Experts (ACE) for advice. There was a speed dial option on the telephony system to contact an ACE. ACEs were health advisors who had 999/111 experience and had undertaken additional training to advise colleagues when they needed help to navigate clinical pathways and provided support to deal with calls.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff told us they had regular one to ones with their managers and performance was discussed routinely, including training that was available to staff.

Managers did not always make sure staff received specialist training for their role. We asked the trust to provide the guidance in place for staff support patients in a mental health crisis, however they did not provide a response.

Managers identified poor staff performance promptly and supported staff to improve. Call audit results and clinical call audit results were shared with managers and there was a system in place to ensure feedback was given quickly and plans put in place to make improvements where required.

Multidisciplinary working

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.

The staff in the EOC did their best to deliver coordinated safe care; we observed the internal multidisciplinary team working between emergency call takers, dispatchers, clinical advisors, and frontline crews to manage and direct care and treatment for callers.

Managers were working on new care pathways with local acute trusts, including making improvements to handovers in emergency departments.

Most health advisors in the service were dual trained and could follow pathways for either 999 emergency care or 111 advice, depending on the reason for their call. Calls were automatically routed to the correct telephone line, and health advisors who were dual trained could follow the correct pathway without the need to transfer the call to a different line.

Health Promotion

Staff gave patients practical support and advice to lead healthier lives.

There were pathways available for staff to refer callers to other services when they were not calling with a medical emergency or there was a more appropriate service in their local area that could meet their needs. The clinical advisors accessed a web-based information system to find relevant services to refer patients to care and support other than an ambulance response when this was appropriate.

Emergency operations centre (EOC)

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. Senior clinical staff completed training on the Mental Capacity Act and mental health, however there was no specialist training for other staff.

EOC staff were not expected to conduct mental capacity assessments over the telephone. If a staff member had concerns about a patient's capacity, they would note it on the electronic system for dispatcher and crews to see and raise this with a clinical manager if appropriate.

All staff in the EOCs were expected to follow the principle of the Mental Capacity Act 2005 in assuming that all patients had capacity unless they found evidence to suggest otherwise. Where possible, staff would speak to the patient directly. Staff told us that special patient notes were used if there was a known power of attorney in place.

Clinical staff in the EOC that we spoke with understood and could articulate the relevant consent and decision making requirements of the Mental Capacity Act (MCA) 2005. Training on capacity and the Mental Capacity Act 2005 was provided as part of the safeguarding adults training package.

Staff did not have access to specialist mental health support; although some clinical staff had a background in mental health, this was not a routine skill set available at all times.

Advanced practitioners completed mandatory training on MCA and a specific mental health module developed by NEAS every three years; 44 advanced clinical staff in the EOC completed this training and we found they exceeded the target of 85% in both modules across all staff groups. There was no specific training on mental health or the MCA for other roles in the EOC; staff told us MCA training was part of the safeguarding training module. This meant staff taking calls did not always have access to specialist training to support them in managing patients in crisis or distress. However, the trust had been involved in national conversations which recognised the need following the COVID-19 pandemic for increased training for staff and had implemented additionally training in November 2022 for existing staff; this was also added to the induction package for new staff in the service.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed several calls during the course of our inspection and found them all to be dealt with in a calm and compassionate manner. All staff said thank you and were courteous.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. We listened to mental health calls and observed staff showing empathy with a patient who expressed suicidal thoughts. We listened to a caller who had an alcohol problem; the health advisor showed no judgement and took time to obtain demographic details and uncover the call reason despite some communication difficulties.

Staff could be nominated to be a headset hero. These staff often sported 'Headset Hero' badges having been recognised as going above and beyond to help someone. One staff member was nominated after dealing with someone who planned to jump from a bridge and they supported and reassured them to maintain their safety while the ambulance was on its way.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff provided as much emotional support and reassurance as possible over the phone during emotionally challenging calls.

Staff were given the opportunity following a difficult or distressing call to have time away to reflect or debrief and offered counselling through the trauma risk management (TRiM) programme. We spoke with a staff member trained to deliver TRiM who felt it was a service that needed expanding given the increase in mental health calls, incidents and staff wellbeing a work.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment.

Staff talked to patients in a way they could understand.

The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether patients were happy with the service provided, or where improvements are needed. The service had received positive FFT scores (good or very good) in 89% of their feedback for 999 see and convey (where patients were taken to hospital) and 92% of their feedback of 999 see and treat (where patients were not taken to hospital).

The service had completed analysis on the results received in quarter four 2021/22 across both areas; the three main positive statement themes related to staff being professional and competent, compassionate and in emotional and physical support. The top three negative themes related to waiting, emotional and physical support and politeness. The survey results took into account the patient's experience across the whole 999 service, and so this included road staff.

We found positive comments in the 999 FFT responses in June 2022, including "the operator who took the call was polite and efficient" and "your operator was calm and collected which helped me stay calm". Most negative comments we found related to long waits for an ambulance response and delays in calls being answered. This was in line with the overall analysis of themes identified in quarter four 2021/22. We asked the trust for action plans in response to patient survey results, however we did not receive any.

Emergency operations centre (EOC)

Is the service responsive?

Good 

Our rating of responsive stayed the same. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the needs of the local population. Leaders in the service told us they worked with all local commissioners across the patch and had secured an investment in collaboration with commissioners to make substantial improvements to the staffing of the EOC to meet the increasing demands for service provision since the COVID-19 pandemic.

Senior leaders in the EOC had links to senior leaders in other national ambulance trusts and local acute hospitals, and there were regular conversations between organisations.

There were system and regional networks that senior managers contributed to and the service had completed work with local hospitals to make improvements to flow across different local areas. There were also links in place with primary care services, and leaders worked to identify system issues and make improvements in their scope.

The service held a rapid process improvement workshop to problem solve two key issues for the EOC; long lead time (time between the call taken and arrival of care), and patient's not always receiving the right care (resources providing care over and above what is required, impacting on patients waiting for an ambulance response). The service developed five programme workstreams to work towards the future EOC, and included involving patients, acute hospitals, primary medical services, and integrated care boards as stakeholder groups. They planned for stakeholder groups to be members of the project board. This meant when changes were designed in the EOC, there was evidence that leaders considered and included stakeholders in planning and delivery of service changes.

The service had systems to help care for patients in need of additional support or specialist intervention. The trust had specialist vehicles and access to specialist transport organisations, such as a local independent ambulance service for those with Jewish faith. There was a specialist evacuation team that the EOC could dispatch to provide specialist risk assessments to move patients from their home to an ambulance where there were challenges.

Staff told us the trust had a proactive equality, diversity and inclusion team who spent time in communities working to understand their needs and educating on how to access the services. Outreach groups has been undertaken including local Asian communities and providing local cardiopulmonary resuscitation (CPR) training.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

The service had access to translation through an international telephone translation service. Managers we spoke with told us they had long standing issues with the availability of some languages and had worked with the contracted organisation to increase access to the organisations global translators. This meant it was quicker to access translators of less common languages. There were also text message and British Sign Language (BSL) relay services available to support people to access the 999 service.

The trusts website contained a learning disability zone with easy read information and leaflets, including information about when to ring 999.

Staff told us they had awareness of religious fasting times to support clinicians to provide appropriate advice to patients of different faiths.

The service had multidisciplinary meetings to support frequent callers to the service; measures and plans were put in place for these patients, and one clinician was allocated per shift to manage any frequent caller contacts to support continuity and manage expectations.

Clinicians could access local crisis teams to refer patients with mental health needs.

Access and flow

People could not always access the service when they needed it, in line with national standards, however the service aimed to provide the right care in a timely way and prioritised life-threatening responses.

Managers monitored waiting times and made sure patients with life threatening concerns could access emergency services when needed, but other categories of responses were not always provided within agreed timeframes and national targets.

The EOC frequently struggled to match ambulance and staffing resources to call volume and they were not meeting key performance indicators, however there were plans in place to make improvements,

The service had an ongoing recruitment plan to significantly increase the capacity of the EOC to meet the rising call demand. The aim of this was to support improvements to call answering times, reduce the time patients waited to access the service and improve patient experience.

There were national targets for ambulance response times, where NHS ambulance trusts should respond to 90% of all incidents within a target time frame. We reviewed the trust's response times for dispatching an ambulance in June 2022. Response times for category one calls was 12 minutes, 55 seconds, against a target of 15 minutes. Response times for category two calls was 1 hour, 32 minutes and 45 seconds, against a target of 40 minutes. Response times for category three calls was five hours, 51 minutes and 57 seconds, against a target of two hours. Response times for category four call was three hours, 58 minutes and 30 seconds, against a target of three hours.

The service was meeting response times to category one calls but did not meet the agreed timeframe and national targets for category two or three responses. This meant that patients did not always have access to the service in a timely way.

To mitigate risk to patients waiting to be seen, the service had processes in place to re-contact patients at the highest risk, or those with the longest waits who were more likely to deteriorate, or where alternative help could be sourced.

Senior Health Advisors (SHA) dealt with complex calls that did not need a clinician's input. For example, they could send taxis to patients who did not necessarily need an ambulance crew to get them to hospital, but the patient had no other way of attending an emergency department. The SHAs also gave advice to health advisors over the telephone. They had oversight of the stack which was a safety net to ensure patients waiting for a response had been triaged appropriately and had the correct call categorisation.

Clinicians contacted patients waiting for a category three or four response to understand if an ambulance was the correct response; where appropriate they could offer home advice, or support patients to access services independently.

Patients received welfare calls if the ambulance response to their calls had exceeded the target time. Patients were called back and asked if any of their symptoms had changed or worsened. A new triage would be completed if answering positively to either of those questions. However, we found evidence that welfare calls were often made outside of the target time and patients could wait several hours before receiving a call.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. Staff gave details of the complaints procedure over the phone, or signposted patients to the trust's website for further details.

The service clearly displayed information about how to raise a concern on their website.

Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes.

In June 2022, the service received 10 new complaints and they completed 100% of their outstanding complaints in the agreed timescale.

The service had one complaint referred to the ombudsman, and this was closed with no further action taken in August 2021.

The top three themes of complaints received in the three months prior to the inspection related to delayed category three (12 complaints) and two (12 complaints) ambulance responses, patients who disagreed with the disposition for children (14 complaints) and callers who self-conveyed to hospital rather than waiting for an ambulance (nine complaints).

The trust agreed timescales to respond to complaints on an individual basis, with an informal aim of three months; over the last 12 months, on average complaints were responded to by the EOC in 33.75 days which was in line with the trust's aim. In the last 12 months, one complaint exceeded this aim, and was responded to in 102 days, however the complaint required an investigation and an extension to the timescale was agreed.

We reviewed the response letter to the two most recent complaints the EOC had received from patients who contacted the service in April 2022; they provided information on how the service works, a sincere apology and findings and learning identified during the complaint investigation.

Emergency operations centre (EOC)

Is the service well-led?

Requires Improvement 

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Leaders in the EOC had the abilities and skills to lead the service; they recognised the challenges the service faced and had plans in place to tackle them. Leaders understood the key performance issues; they told us about the challenges in the EOC and what actions they were taking to make positive improvements, some of which were a national challenge.

The leadership team described how they were supporting staff to develop their own skills to become future leaders, and the recruitment programme had provided significant opportunities for staff in lower grade roles to progress into senior health advisor and team leader roles. Leaders acknowledged that there was a gap in progression opportunities at higher grades, and they planned to introduce more roles and opportunities at that level as part of the departmental restructure.

There was a newly created clinical team leader (CTL) role in place after a year-long transformation process. This role was part operational out 'on the road' in a response car, responding to jobs and part EOC based. This was a band 7 post and staff employed had advanced skills and when a CTL was based in the EOC, they monitored the queue of patients waiting and crews. They were able to give advice to staff, liaise with crews who had been on a scene for a long time, and they permitted crews to leave scene when they were not able to make judgements themselves (for example a double crewed ambulance with no paramedic who did not need to convey a patient). This was an additional layer of clinical oversight, queue management and an extra response when deemed appropriate.

Leaders were visible in the main EOC and made an effort to attend all EOC sites regularly, although they acknowledged this was not always easy due to the nature of the business and the geography of the patch and the agile working of clinicians. In order to address this, senior leaders had held live events on electronic communication platforms to provide opportunities for staff based across sites to attend, and videos had been recorded and shared with staff when new members of the leadership team had joined the EOC.

Staff felt supported by their immediate line managers though often were unable to tell us who was in the trust's executive team.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

Emergency operations centre (EOC)

There was a trust strategy for 2021-2026 which referenced overarching plans for the trust, including the EOC. It included a mission statement, vision and values which were about safe, effective, responsive and quality of care. The overarching strategy had been developed with consideration of local system partners and the ambitions of the trust were described in four key areas, with patients at the centre; people, partners, performance, and quality and safety. There were nine underpinning delivery plans to turn the strategy into action. We found that updates had been given to the board about the nine delivery plans in June 2022 and operational plans had been developed for 2022-2023.

The EOC had an improvement proposal to make improvements to the delivery of its purpose; to ensure the right care is given at the right time for patients. The proposal was in draft, and had not been fully completed, however it had considered the impact of operational issues such as processes, structure and people and culture. The service had planned to hold a workshop in September 2022 to complete a deep dive into the improvements required to help determine and define the areas of improvement required in the next six to 12 months.

Staff told us there was a trust event when the values and behaviours were reviewed and health advisors, clinicians and operational staff were involved.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear. However, staff told us about cultural issues in bullying and harassment.

During the inspection, staff told us morale was generally good across the EOC. Many staff had been in post for a number of years and told us that they enjoyed their job. They appreciated that services were busy but saw this as a failing of the national system rather than their employer.

Managers listened and understood. Staff said that they could give feedback to managers and were able to share ideas at one to one meetings. One individual told us that “work had been brilliant when they needed time off for studies”.

We found examples of equality, diversity and inclusion promoted in the EOC; there was a noticeboard with a Ramadan calendar, a Pride poster displayed in the lift and a vision and well being board. TRiM assessment posters were displayed.

Staff knew who the freedom to speak up guardian was and how to access them. They told us they felt supported if something went wrong and in response, the EOC felt open and transparent. There was a culture of peer support.

The service had not held all staff meetings in person, however they held online live events for staff in the EOC in October 2021 and June 2022; we found an overview of the content and saw that staff were given the opportunity to ask questions to senior leaders and that responses were recorded and shared with staff who were unable to attend. The events addressed concerns from staff specific to the EOC including processes, staff rotas, and system related queries.

We looked at the most recent clinical team meeting minutes; they discussed a variety of areas including operational issues, training, and processes, however there was no clear agenda and the minutes noted poor attendance.

EOC staff spoke of a disconnect between themselves and staff ‘on the road’. Some EOC staff had requested to go out with operational ambulance crew and had done so in their own time. They felt this gave them a real understanding of the work they did. EOC staff wanted crews to visit the call centre so they could similarly get a view of the pressures that they faced. Senior leaders were aware of this challenge, but we did not see specific plans to make improvements in this area.

However, as part of the inspection CQC conducted a survey for staff in NEAS in August 2022. There were 481 responses, 23% were from the EOC. We received comments about a toxic culture and bullying in the EOC, which included inappropriate behaviours displayed by managers, poor communication, low morale and lack of support from managers and senior managers in the service. Some staff felt that the visibility of senior leaders was poor due to high levels of home working following the COVID-19 pandemic. Some staff felt like they could not raise concerns because of the toxic behaviours displayed by managers, including favouritism and an “if your face fits” attitude.

Following this inspection, we served the trust with a notice under Section 29A of the Health and Social Care Act 2008. We told the trust it needed to make significant improvement in listening, responding, and acting upon feedback from staff and other relevant persons.

Governance

Leaders did not operate effective governance processes. Staff at all levels were clear about their roles and accountabilities. They had opportunities to meet, discuss and learn from the performance of the service, however meetings were not always held at their required frequency and there were no staff meetings for non-clinical staff.

The service had a meeting structure in place which meant that senior leaders and managers had regular opportunities to discuss operational issues and they were clear on the links to trust wide groups and committees for escalation.

There were opportunities for managers to meet with the senior management team on a weekly basis, and key areas including performance, staffing and incidents were discussed in these meetings.

We asked to see the most recent meetings where audit performance was discussed in the service; we found the senior management team (SMT) for the EOC had weekly meetings in May 2022, where performance was discussed, however the next meeting minutes were from July 2022. We did not see meeting minutes between these dates and the trust did not provide any narrative to explain the gaps in SMT meetings. We reviewed the action log from the SMT meetings and saw the log contained action owners, updates and timescales. It had been updated on a regular basis until the end of May 2022. However, in line with the gap in SMT meetings, no actions had been added to the register since May 2022. We did not see evidence of an alternative mechanism to monitor and act on performance and risk.

We reviewed minutes from four EOC governance meetings that took place between May and July 2022. We found that there was appropriate representation and items for discussion were in line with the trust's governance structures. However, meetings were not always held in line with their planned frequency, for example, the EOC change approval board was monthly meeting and was held in May and the July 2022. We were not assured that all meetings to support the development and delivery of the service were held at appropriate times to ensure timely review and escalation of issues and improvements.

We reviewed the action plan for the service's investment implementation group and saw that regular updates had been made to open actions, they had been reviewed for progress in July 2022, and new actions had been added.

Due to the nature of the EOC, some managers worked shift patterns, and relevant meetings were held as online meetings and recorded for managers to watch back.

There were no regular staff meetings held for call taking staff and clinicians told us their staff meetings had poor attendance and the frequency was inconsistent and variable.

Emergency operations centre (EOC)

Following the inspection, we served a section 29A warning notice because we were not assured the trust had effective governance systems in place to ensure risks and performance issues were identified, escalated appropriately, managed and addressed promptly. We asked the trust to make significant improvements.

Management of risk, issues and performance

Leaders and teams had systems to manage performance, but they were not used effectively. They identified and escalated relevant risks and issues but did not always identify actions to reduce their impact. Actions were not monitored and managed well. There were plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The service had seven separate risk registers that related to different operational areas of the EOC. We reviewed the registers and saw that across all seven, there were two risks rated as high relating to sufficient numbers of clinical staffing, and loss of service at the main EOC location impacting capacity of the service to run safely; when we spoke to service leaders, these were the top risks they described.

Leaders we spoke with told us they reviewed and managed risks monthly and in a timely way, however we found four risk entries across the seven risk registers we reviewed that were incomplete. The entries did not have a reference number, owner, date of entry, mitigations in place, current risk score or target risk score; there was commentary on one of the risks from May 2022, but it was unclear how long the other risks had been on the register awaiting review. None of the risks, mitigations or actions on the risk register had target dates for completion or target dates for risk reduction, so it was unclear how leaders could monitor the timeliness of actions taken. This meant that we were not assured risks were always assessed, monitored or mitigated effectively, in line with trust guidance and national best practice.

The senior managers had a weekly meeting to monitor performance and risk, with an accompanying action plan, however no meetings had taken place between 18 May and 13 July 2022.

The service had dashboards in place which supported managers to monitor team performance. This included individual and whole team performance against KPIs and was broken down by team and team manager. The EOC performance was reviewed on a weekly basis and broken down by the performance team into highlights and key messages. This was shared with the senior management team of the EOC.

During the inspection, the service had connectivity issues at one of the EOC sites; we observed how this was escalated and that quick action was taken to mitigate the risk and make decisions to make required improvements. This included requiring financial approval. We found that the safety of patients was the highest priority and that escalation meetings were attended by appropriate senior managers, both in the EOC service, and other areas of the business.

The trust had a major incident plan in place; it was version controlled and due for review in December 2022. The major incident plan was based on the joint emergency services interoperability principals (JESIP) of co-locate, communicate, co-ordinate, jointly understand risk and shared situational awareness. There was a testing exercise plan that was in line with national guidance and included communication exercises, table-top exercises and live exercises. We found there had been a communication exercise in May 2022; this was in line with the major incident plan to be tested every six months. However, the action plan following the exercise had not been completed and there was limited evidence of monitoring.

The trust had tested the communication exercise of their major incident plan in May 2022, in line with national guidelines. We reviewed the recommendations and action plan relating to this exercise and found that it had not been completed. There were five recommendations identified, two were completed in timescale, however two actions had a

target date for completion in May 2022 and remained open with no evidence of updates or monitoring, and one recommendation had been added to the action plan, but no other fields had been completed; there was no evidence action had been taken in line with the recommendation. We were not assured that action was taken in a timely way following trust assurance processes to identify issues with their own processes.

We also reviewed an exercise carried out in May 2022 to validate the business continuity arrangements for communication between the EOC dispatch team and operational unscheduled care vehicles. The trust checked the availability of mobile phones on 172 unscheduled care vehicles. There were three issues found; 22 vehicles did not have a mobile phone on the vehicle, 34 vehicles had no charger or there were issues with the mobile phone, and various vehicle mobile phone numbers were incorrect on the trust's electronic system. Actions were put in place for the first two findings, however both had target dates for completion in May 2022 and remained open in July 2022. There was no action identified to resolve the incorrectly recorded telephone numbers. This meant we were not assured that there were systems in place to ensure action was taken in a timely way to resolve identified risks and issues.

We looked at two recent sets of minutes and saw that the EOC senior management team met weekly and discussed areas such as performance, incidents, risks and actions.

We reviewed documentation relating to the trust's most recent practical and desk top exercises to test their business continuity plans in the event of a loss of service to the main EOC site. One exercise was completed in November 2021, however the debrief and identification of issues was not completed until nine weeks later in January 2022. There were 23 recommendations identified, however only two had actions identified. The remaining 21 recommendations had not been allocated an action, action owner, timescale for improvement or resolution or priority. The two actions identified had timescales for completion in January and March 2022 and remained open with no identified updates documented in July 2022.

Following the inspection, we served a section 29A warning notice because we were not assured the trust had effective governance systems in place to ensure risks and performance issues were identified, escalated appropriately, managed and addressed promptly. We asked the trust to make significant improvements.

We found there was a risk on the business continuity risk register that the EOC evacuation plan was not fit for purpose. This risk was raised one month before the inspection and we found there was mitigation and ongoing actions in place to reduce the risk.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

The service used performance figures and data captured electronically to monitor and manage performance. There was a call handling performance dashboard that gave managers and leaders the information they needed to monitor KPIs and performance, both over time and broken down by team. This meant they could identify trends in data and monitor this based on individual team performance.

When we reviewed meeting minutes and trackers, we found that managers had access to recent performance data and information.

Emergency operations centre (EOC)

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The trust had developed videos and information about the 999 service; they engaged with a stakeholder group, learning disabilities group and an ambulance forum with Healthwatch to develop the materials.

We asked the trust about examples of engagement with the public and patients to make improvements to the EOC and they did not tell us about any.

Learning, continuous improvement and innovation

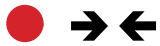
All staff were committed to continually learning and improving services.

Staff at the service were committed to making improvements. Throughout the COVID-19 pandemic, ambulance performance had been a challenge nationally. The trust had worked with system partners and local emergency departments to reduce ambulance wait times and improve handovers. This included a dedicated resource at emergency departments to support implementing improvements. For example, the service had held a model handover day at one hospital looking at patient safety and reducing harm through performance issues within the system. The service involved local stakeholders including patient safety experts. The service also collected observations from 55 patients and NEAS resources and mapped their journey through the emergency department which was used to create an emergency department handover process.

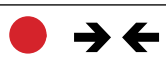
The service also gave examples of current and ongoing quality improvement initiatives including improving operational downtime, a survey to engage emergency department staff relating to safe and efficient handovers, work streams with identified acute services to improve handover times.

The service had implemented a trial dispatch clinical risk procedure which continued into normal practice. There was an improvement in outcomes for patients. A new competency framework was developed and rolled out for new clinical staff to provide a consistent approach to induction.

Emergency and urgent care

Inadequate 

Is the service safe?

Inadequate 

Our rating of safe went down. We rated it as inadequate.

Mandatory training

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

All staff received and kept up-to-date with their mandatory training. The trust target for completion of mandatory training was 85%; information provided showed the current (July 2022) compliance rate for ambulance staff was 95.3% and for additional clinical services staff was 94.9%. At the time of inspection there were four drivers scheduled for a driving course (0.2%) and all apprentices had their portfolios marked.

The mandatory training was comprehensive. Staff accessed mandatory training through a combination of online courses and face-to-face modules. Modules included dementia awareness, health and safety and welfare, equality, diversity and human rights, fire safety, moving and handling, conflict resolution, infection prevention and control, and Mental Capacity Act training. However, some staff said safeguarding training did not equip them with the skills or level of understanding to identify and escalate incidents.

In the staff survey as part of this inspection, a member of staff said *'…training has been very thorough, support has always been amazing'.*

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Safeguarding

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.Staff completed 'Preventing Radicalisation – Prevent Awareness' training. Although at the time of inspection the compliance rate for advanced paramedics was 80%, it was 100% by the end of September 2022, above the trust target of 85%.

Staff knew how to identify adults and children at risk of, or suffering, significant harm. We spoke with staff who explained how they had identified the care support needs for a patient when they had transported the patient from their home to hospital. Staff spoken with were confident they would recognise safeguarding issues.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. However, the referral process was not always robust as staff reported safeguarding concerns to a single point of contact based within the operations

centre. We observed two crews attempting to make a safeguarding referral to the safeguarding desk, one crew waited more than 40 minutes for a response and the other more than 20 minutes. This delay meant staff were unable to clear their current job with the operations centre and return to active calls and also meant there were delays in referring vulnerable patients to local authorities.

The trust had named professionals for Safeguarding Vulnerable Adults and also Vulnerable Children trained to Safeguarding of Adults and Children level 5 in place. The director of quality and patient safety was the executive lead for safeguarding.

We reviewed the trust's safeguarding adult's policy; this was version controlled but past the date for review (May 2022). The policy stated that where an ambulance disposition was made, emergency operations centre (EOC) staff should note possible safeguarding with a brief description of their concern on the electronic system to notify the attending ambulance crew. The trust provided a draft version that would replace the one in circulation at the time of the inspection. The table of revisions indicated the new policy had been updated in March 2022, however the service did not provide a timescale for the updated policy to be ratified or implemented.

Although this policy stated health advisors, based in the EOC, will '…add "POSS SG" in the crew notes with a brief explanation of their concerns in the call notes to give the crew an understanding', this was not always completed. On occasions this meant crews attended calls without full prior information and unprepared for actions they may have to take. This had not been identified as an issue by managers within the trust.

Disclosure and Barring Service (DBS) checks were in place and the trust provided evidence of completion for the last twelve months. Staff were informed when an update was due.

Staff followed safe procedures for children being conveyed and had child appropriate seating, and harnesses. Parents or carers accompanied children when being transported. We were told by staff that there were shortages of paediatric oxygen face masks and thermometers.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment, vehicles and the premises visibly clean.

Most station areas were clean and had suitable furnishings which were clean and well-maintained. We inspected 23 stations which were mostly clean with rest facilities and seating within crew rooms allowing socially distanced meal breaks. However, at some stations we found incomplete 'one-hour' cleaning schedules, excess dirt in common areas and garage floors, and waste left in inappropriate areas. We found substances hazardous to health were not always stored and locked away appropriately.

The service generally performed well for cleanliness. Vehicles had been cleaned by crews to appropriate standards including floors, all touch point surfaces, equipment carried out by ambulance crew, clinical waste disposed and deep cleans after transportation of patients with a health care associated infection. Trust audits (2021-2022) showed '…excellent overall cleanliness compliance' for unscheduled care vehicles of 97%, advanced practitioner vehicles of 90% and rapid response vehicles of 95%. Trust vehicles were deep cleaned by North East Ambulance Service Unified Solutions (NEASUS) at six, 12 and 24-week intervals.

The trust had undertaken a 'make ready' trial in Sunderland servicing vehicles from 51 stations and supported by a vehicle driving to hospital emergency departments ('make ready' centres involve a system which sees ambulances prepared by a dedicated team of specialists in a purpose built or converted building, who clean, restock and check the equipment on ambulances before the beginning and at the end of every shift).

Most staff usually followed infection control principles including the use of personal protective equipment (PPE). Managerial observational audits (2021-2022) showed 89% of staff were fully compliant with hand hygiene, alcohol gel use, aseptic non-touch technique (ANTT), bare below elbow, glove and apron use. However, during our inspection, we observed some staff did not consistently adhere to 'bare below the elbows', wearing of jewellery and painted fingernails guidelines.

The director of infection prevention and control (DIPC) confirmed the management of donning and doffing PPE remained with locality managers and relied on them ensuring compliance. The trust 'Infection Prevention and Control Policy' provided by the trust was effective from April 2019 and had been due for revision in April 2022.

Staff cleaned equipment after patient contact. Staff consistently cleaned equipment inside vehicles between patients. Staff disposed of clinical waste safely in secure clinical waste bins, they maintained their own uniforms; staff uniforms were clean.

Environment and equipment

The design, maintenance and use of facilities, premises, vehicles and equipment did not always keep people safe. Staff were trained to use them. Staff managed clinical waste well.

The design of the environment followed national guidance. There was a range of station sizes throughout the service. All were well designed and large enough for the staff and vehicles allocated to each station inspected. All stations had staff break areas, toilet and shower facilities and stock storage. However, we did see instances of rusty pipes, and also an expired electrical box inspection date (Morpeth).

Staff carried out daily safety checks of specialist equipment. We found daily vehicle inspections were consistently undertaken by staff before their shifts. Staff had checklists to complete, and we observed these were fully completed. Staff told us the service had enough suitable equipment to help them to safely care for patients, although some staff said there was a shortage of paediatric oxygen masks and paediatric thermometers. Equipment in vehicles reviewed, including carry chairs, scoops and patient monitoring equipment, were in good condition and had in date safety checks.

However, we did see instances of ripped seats, broken locks on cupboards and trauma wall slides, and air conditioning units not working. Staff told us there was a process for reporting faults, but they were not made aware of progress and repairs took a long time.

All vehicles inspected had harnesses, chairs and trollies available for the safe transportation of patients, this included equipment for the safe transportation of children.

Staff disposed of clinical waste safely. Each ambulance had a clinical waste bin and a sharps bin which was labelled; we did see instances where sharps bins were over-filled. Staff disposed of clinical waste in the secure clinical waste compound when returning the vehicle to the station.

Emergency and urgent care

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. We observed staff who completed and updated risk assessments for each patient and managed risks identified.

Staff completed risk assessments for each patient, using a recognised tool, and reviewed this regularly, including after any incident. Staff monitored each patient using the National Early Warning Score (NEWS2), applying standards defined by national guidelines (Joint Royal College Ambulance Liaison Committee) and recorded outcomes on an electronic patient care record system.

Staff knew about and dealt with any specific risk issues. The electronic patient care record was used to identify care pathways for patients with specific needs, for example, head injuries. This system was also used to refer patients to other agencies. NEWS2 and sepsis care processes and clinical guidance were displayed on staff notice boards at locations we visited.

Although the service had 24-hour access to mental health support and advice, staff told us specific support relating to a patient from local crisis teams was not easily accessible.

Staff shared key information to keep patients safe when handing over their care to others. We found staff shared key information during handovers in emergency departments in a concise and professional manner. Electronic notes were uploaded to hospital systems and copies filed in each patients' notes. Each emergency department visited had liaison officers identified to ensure complete and timely handovers

Staffing

The service had plans to ensure there were enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Managers accurately calculated and reviewed the number and skill mix of staff needed for each shift in accordance with predicted call levels. Managers adjusted staffing levels daily according to the needs of the service. Staffing levels were reviewed each day and adjustments made to staffing in the event of sickness, late finishers impacting on staff start times (average 2327 each month since April 2022), delays and operational needs. Managers ensured double staffed ambulance crews included one qualified staff.

We reviewed the trust's workforce plan and in April 2022 the base establishment was 609 WTE paramedics. The total establishment was 652.79 and there were 591.26 paramedics in post. In May 2022, the base establishment was the same, the total establishment increased to 665.84 and the total number of paramedics in post was 618.52. In June 2022, the base establishment was 603 WTE, the total establishment dropped to 655.89 and the number of paramedics in post dropped slightly to 615.14. In July 2022, the baseline remained the same, the total establishment increased to 668.94 and the total number of paramedics in post was 631.25. The plan included current vacancies, which had improved from 61.53 WTE in April 2022 to 37.69 in July 2022, demonstrating the trust's upward trajectory, however it was unclear why the figures for the total establishment changed on a monthly basis.

The trust had secured non recurrent funding to improve staffing which would, overall, result in a 33% increase in patient facing roles. However, although the trust explained how this additional funding was included in the total establishment figures, it was difficult to understand the trust's current position and whether the trust had enough staff within the service.

The service had decreasing sickness rates. Absence rates for paramedics between April and June 2022 was 9.1% compared to 10% for the previous three months; for ACAs the absence rate was 10% between April and June 2022 compared to 12.1% for the previous three months.

The trust had a relief allocation procedure (December 2019) in place which identified the process for allocating relief shifts to staff. Some staff told us they were allocated to shifts away from their base station and did not always have the opportunity to ensure they had the required medicines available.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. Patient notes were recorded on handheld electronic devices. The electronic system had all relevant protocols and pathways available for the staff to access. Some issues were raised by staff about the reliability of the system.

When patients transferred to a new team, there were no delays in staff accessing their records. The electronic patient record system automatically downloaded onto the hospital servers, allowing hospital staff to access the record.

Records were stored securely. Handheld electronic devices had secure log-in access to the device and patient care records.

Medicines

The service did not always use systems and processes to ensure the proper and safe management of medicines, including the effective storage and management of medicines, exposing patients to the risk of harm.

During our subsequent well led inspection of the trust we also found that systems in place to ensure the proper and safe management of medicines, including the storage and management of medicines remained ineffective, which exposed patients to the risk of harm.

Staff did not always have access to critical and other medicines they needed to treat patients or have time to complete vehicle medicine checks, resulting in delays in treatment due to the lack of systems and processes in place. Staff told us they frequently responded to emergencies without the medicines they needed to treat common or life-threatening conditions. We reviewed incidents provided by the trust and enquiries received by CQC which highlighted a lack of availability of life saving medicines, discrepancies in the number of medicines, missing medicines and incorrectly tagged medicines bags, which corroborated the concerns we identified during the inspection.

For example:

- a crew responded to a bleeding wound and tranexamic acid (a blood clotting medicine) was not present in the drugs bag, however the drugs stock sheet indicated it should be available;

- the first crew on scene at a road traffic collision arrived and the paramedic did not have access to morphine. The paramedic stated they were on a relief shift the week before and were not able to get back to their ambulance base to replenish their stock of pain relief prior to the response, so did not have any morphine available. A second crew was allocated and arrived eleven minutes later, with the appropriate medicine however there was a delay in the patient receiving pain relief when it was first indicated they needed this;
- an incident was reported where a crew was unable to treat a patient with life threatening asthma as the required adrenaline was missing. The drugs stock sheet indicated it should be available, however a whole box was missing;
- an incident was reported where a crew responded to a patient with known angina and glyceryl trinitrate (GTN) was missing from the drugs bag. The crew decided to use the patient's own GTN which was out of date;
- there were numerous incidents reported of missing medicines not accounted for on the drug register.

Following our well led inspection, we found that systems remained ineffective, which exposed patients to the risk of harm. Staff continued to not always have access to critical and other medicines they needed to treat patients, this increased the risk to patients of experiencing poorer outcomes and increased the risk of harm due to delays in treatment as a result of the lack of systems and processes in place, for example:

- road crew responded to a patient and dextrose gel was required. The drug bag was orange tagged rather than red tagged in line with trust policy, due to only one tube being present. The reporter stated, "patient would have benefitted from a second tube, but this was not an option";
- road crew attended a patient with chest pain. When the pharmacy green tagged blue drugs bag was opened, glyceryl trinitrate (GTN) was missing, also contained one extra furosemide (used to treat high blood pressure);
- road crew stated '…no syntometrine (used during and immediately after delivery of a baby to help the birth and to prevent or treat excessive bleeding) on ambulance;
- road crew responded to a category one cardiac arrest immediately on start of shift. On arrival vehicle had no red drug bag (cardiac arrest drug bag) on the vehicle. In addition, the blue, yellow and black drug bags all had items below the minimum level and required changing. The reporter does not state the impact on patient care or next steps taken given the lack of red drug bag when attending a cardiac arrest. No evidence of subsequent down time to complete checks;
- road crew identified yellow drugs bag discrepancies – one additional ondansetron (used to prevent nausea and vomiting caused by cancer medicines or radiation therapy) and two missing glucogel (used to treat low blood sugar levels); and
- road crew attended a cardiac arrest. All drugs checked prior to administration. After the event it was noted that the red drugs bag was out of date on 30 August 2022 with one syringe of adrenaline being out of date. The drug bag was 17 days out of date.

Staff told us they continued to respond to emergencies without the medicines they needed to treat common or life-threatening conditions, for example:

- there continued to be varied systems in place to access controlled drugs when staff provided relief cover at a station other than their own. Crews did not always have time to go to their own base to pick personal issue medicines between responses, so they responded to patients without the required medicines which meant patients could experience delays in receiving treatment for their condition;
- there continued to be unavailability of relief lockers meaning staff attended for relief shifts without their controlled drugs; and

- staff highlighted concerns that due to poor audit systems being in place and drugs bags not always being tagged, there was a risk of medicines either being missing from medicines bags or being out of date.

Medicines continued to not always be audited to ensure staff had access to medicines stock when needed and appropriate tagging and records were not always made. This increased the risk of patients experiencing poorer outcomes and increased risk of harm due to staff not having access to necessary treatments in a timely manner.

Incidents provided to us on 22 September 2022 from the trust showed that medicines bag stock control audit sheets continued to not reflect the quantity of medicines in the bags when checked. This posed a risk of harm to patients and poorer outcomes due to staff not having access to the medicines needed for treatment.

We continued to see on 13 September 2022 that there was not a robust system and process in place on vehicles for the safe storage of medicines.

We reviewed fridge temperature sheets provided for August 2022 and found gaps in the recording of temperatures. We were not assured that actions marked as completed had been completed, records showed there is ongoing risk to patients that medicines requiring refrigeration continue to not be stored in line with guidance and that these medicines were fit for purpose.

Paramedic personal lockers for controlled drugs were located at their base station. Crews told us there was no system or process in place to access controlled drugs when staff provided relief cover at a station other than their own. Crews were not always given time to go to their own base to pick them up between responses, so they responded to patients without the required medicines. This meant patients experienced delays in receiving treatment for their condition.

Crews told us they frequently responded to incidents without morphine and attended patients experiencing fits without first line medicines to treat seizures.

Staff did not always store and manage medicines safely. Medicines were not always stored securely on vehicles, and audit processes were not in place to ensure medicines stock was checked appropriately. Medicines bags were not always checked or audited in line with the trust process. We looked at medicines in five ambulances and two cars. We found gaps in medicines bag checks in three out of five ambulances we reviewed during the inspection. Nine out of 12 medicines bags on those three ambulances were not tagged in line with trust processes. Medicines bag audits were not always completed at the start of each shift. We found evidence of audit sheets that did not reflect the quantity of medicines in the bags we checked. This posed a risk to patients from crews attending without the necessary medicines.

Fridge temperatures were not always checked and there was no robust process in place to ensure this task was completed in line with trust policy. There was uncertainty amongst staff whose responsibility it was to check the fridges and as such records we looked at showed a lack of assurance that these medicines were fit for use.

Following our well led inspection, the action plan received from the trust confirmed the implementation of daily fridge temperature monitoring was complete. However, we reviewed fridge temperature sheets provided for August 2022 and found gaps in the recording of temperatures. We were not assured that actions marked as completed had been completed, records showed there was an ongoing risk to patients that medicines requiring refrigeration continue to not be stored in line with guidance. These medicines were not fit for purpose.

Although We found self-audit of controlled drugs were completed by paramedics, governance processes to enable board and senior leader level oversight and assurance for controlled drugs were not always recorded as completed. Some staff were unclear whose responsibility it was to complete manager audits. The provider's policy did not clarify this.

Staff followed systems and processes to prescribe and administer medicines safely however the medicines management policy and accompanying standard operating procedures (SOPs) were out of date. National guidelines for the administration of medicines were available to staff through handheld devices. Appropriate staff followed 'Patient Group Directions' (PGDs) and access was managed centrally. PGDs are written protocols that enable staff to administer or supply medicines to a specific group of people without a prescriber. Medicines policies and SOPs we looked at did not always ensure that staff knew who's role and responsibility task related to safe management and oversight of medicines were.

Staff did not learn from safety alerts and incidents to improve practice. Staff told us feedback from incidents was not always received. Not all medicines incidents were recorded due to lack of capacity in the working day. Learning from recent medicines incidents was not shared as reviews from the appropriate staff were not taking place.

Following this inspection, we served the trust with a notice under Section 29A of the Health and

Social Care Act 2008. We told the trust it needed to make significant improvements in medicines management within urgent and emergency care services to reduce risks to patients.

Incidents

The service did not manage patient safety incidents well. Staff recognised but did not always report incidents and near misses appropriately. Managers investigated incidents but did not always share lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report but they did not always report them.Staff did not always raise concerns and report incidents and near misses in line with trust policy. Although staff knew what incidents to report and how to report them, some staff said they did not always complete a report. Reasons given for this were that staff did not have the time to complete the necessary paperwork and they did not receive feedback or learning from incidents that had been previously reported.

In the staff survey as part of this inspection, 47% of staff felt that, although encouraged to report incidents, they did not hear about incidents that happened in their part of the organisation or the learning from them. Further, only 28% of staff believed that when errors were reported the organisation took action to ensure that they did not happen again. A member of staff said they had '…*put in NEAS 07s* (incident reporting form) *which I believe have been covered up*.'

We raised this with managers of the service who told us not every incident reported required a response direct to the reporter, as the outcome and/or learning did not apply to the individual who had made the report. However, managers told us every incident was thoroughly investigated, feedback given to the appropriate and relevant member of staff, learning identified, and actions taken where necessary.

Other staff told us how they had reported incidents and gave us examples of feedback and learning from incidents. Incidents were reported onto an electronic system that all staff had access to and were familiar with. Feedback was given in several forms such as in one to one conversation, in newsletters and displayed on staff noticeboards. Following inspection, the trust provided information relating to three serious incidents which had been declared in the last twelve months. Two of these related to sub-optimal care of the deteriorating patient and one to slips, trips and falls.

We reviewed 19 incident reports from April 2022 to date, some were historical incidents that had not been reported at the time. A number of themes were identified within these, such as:

- Sub-optimal care provided in relation to cardiopulmonary resuscitation (CPR);
- Two incidents where either the defibrillator or medicines administered were at incorrect intervals which may have impacted upon the patient.
- Delays reaching patients and incorrect categorisation of calls;
- Crews could take up to double the standard target time to reach patients, mostly these were category 2 calls. There was a specific incident of a patient bleeding after kicking a glass door and dying, two examples of patients suffering from a stroke and who have experienced life changing harm, potentially due to length of delay receiving help'.
- A category 4 incident where the patient was described as '…non-responsive and cold to the touch' which potentially should have been categorised as a category 1, or the Emergency Operations Centre should have advised to commence CPR.
- A further incident was initially recorded as category 3 assigned to a patient who was conscious but non-responsive. This was subsequently upgraded to category 2, 23 minutes later and then re-prioritised as a category 1 when the patient went into cardiac arrest. The crew arrived 90 minutes later however the patient subsequently died.
- Medicines;
- Multiple concerns regarding medicines not being audited and tagged correctly, incorrect medicine counts and missing from drugs bags, and crews not having sufficient time to complete checks.
- A crew attended a road traffic collision without morphine available on the ambulance.

During our inspection, we found that the trust's definition of a serious incident appeared to be subjective, and that the executive safety panel was not consistently making judgements in line with national patient safety reporting guidelines. We were concerned incidents with a recommended harm rating of moderate or above were often downgraded.

For example, we were made aware of the following:

- One incident was not classed as a serious incident until two years later and related to an ambulance delay in responding to a patient due to a power cut meaning it could not leave the ambulance station. A second ambulance was deployed to the patient but stopped on route to re-fuel the vehicle and when they arrived, they found the patient had died.

This was presented at an executive safety panel on 27 July 2022 and a decision was made to downgrade the incident to no harm, as harm *'…could not be directly attributable to the delay'.*

Initial actions identified at the time of the incident included to notify staff of how to override the gates of all ambulance stations in the event of a power cut, but this had not yet been completed and were scheduled for completion by November 2022, over 2 years later.

This did not give assurance that wider learning and actions were taking in a timely way to reduce risks to patients.

- An incident where a patient had been allowed by staff to engage in unwise and unsafe behaviour, which was against trust policy and caused the patient injury.

The trust's safeguarding team were not aware of the incident until September 2022. Although the team referred the trust to the local authority for investigation about concerns relating to neglect/ organisational abuse, there was a four month delay due to the lack of joined up systems.

We were concerned the trust was not thoroughly investigating incidents and was making decisions based on limited information, reducing the ability to identify learning and actions to prevent reoccurrence and mitigation of risks to patients.

Incidents were recorded on one part of the trust's reporting system, with no link to the other sections. This had been identified on the board assurance framework (BAF- WL27), however the associated actions only related to closing incidents on time, and delivery of services.

There were no actions specifically addressing the uniformity of reporting, or that the organisation did not have sufficient oversight of themes and trends from incidents, complaints, claims and safeguarding and the correlation between these.

In the information supplied by the trust to CQC alongside the final incident report for the complaint cited above, the safeguarding team noted that *'…we need to stop looking at these in isolation – during any investigative process we need to ensure that staff consider other frameworks and don't simply focus on a complaint or an SI, etc.'*

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong.Staff were aware of the duty of candour regulation and had access to and were familiar with trust guidance within the serious incident policy.

Following this inspection, we served the trust with a notice under Section 29A of the Health and Social Care Act 2008. We told the trust it needed to make significant improvements in incident reporting, investigating and monitoring of actions to prevent reoccurrence, and ensure improvements are made as a result.

Is the service effective?

Requires Improvement 

Our rating of effective stayed the same. We rated it as requires improvement.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Handheld devices held current care pathways and plans, flow charts and policies for patient care and treatment, however we reviewed incidents where it was reported staff did not follow policies and processes. Most policies reviewed

after inspection were comprehensive, in date and version controlled. Staff had access to the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines and were able to demonstrate how they could access them on their mobile devices. Where necessary further guidance had been developed by the trust, for example a sepsis recognition tool had been developed.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools. Although staff assessed and monitored regularly to see if patients were in pain, patients did not always receive pain relief soon after requesting it.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff recorded pain scores as part of the patient record on handheld devices. The staff used a zero to 10 numerical pain scale to assess pain levels.

Patients did not always receive pain relief soon after it was identified they needed it, or if they requested it. Staff did not always have access to critical and other medicines they needed to treat patients or have time to complete vehicle medicine checks, resulting in delays in treatment. We received a report of a crew arriving at the scene of a road traffic collision without access to morphine, resulting in a delay of treatment to the injured patient until a second crew arrived eleven minutes later, with the appropriate medicines.

During this inspection we observed staff ask patients to assess and re-assess their pain levels and pain relief was given in response, when needed.

Staff prescribed, administered and recorded pain relief accurately. Staff usually had access to pain relief in the form of compressed gases such as Entonox and medicines such as paracetamol. All medicines were documented on the electronic patient record.

Response times

The service monitored but was not able to meet agreed response times so that they could facilitate good outcomes for patients.

For 2021/2022 the mean ambulance response times were seven minutes and 15 seconds for category one calls (life threatening injuries and illnesses), and 36 minutes and 48 seconds for category two calls (emergency).

Trust performance during 2021/2022 for responding to 90% of category three calls (urgent) was 7:25:34 (national standard two hours) and category four calls (non-urgent) was 5:23:24 (national standard three hours).

Although the trust was one of the top performing ambulance services in the country for its response times to category one calls, current performance data (July 2022) showed the trust had been performing worse than the national standard. The trust mean response time for category one calls was eight minutes and five seconds against a national standard of seven minutes. However, nine out of ten (90%) category one calls were at the scene within 14 minutes and 22 seconds of dispatch (target 15 minutes).

Performance with other call categories was worse than the national standard. This means patients were often waiting significantly longer than national standards.

For example, the trust mean response time for category two calls was 48 minutes and 35 seconds against a national standard of 18 minutes, and 90% of calls were responded to in 1:41:32 against a national standard of two hours. We were provided with evidence by the trust that a patient had died following the downgrading of a category one call to a category two call; this subsequently took 45 minutes to arrive.

Trust performance for responding to 90% of category three calls (urgent) was 7:25:34 (national standard two hours) and category four calls (non-urgent) was 5:23:24 (national standard three hours).

Contributory factors to these were delays at accident and emergency departments, staff vacancy and sickness rates impacting on the number of vehicles available and increased service user demand. We were also told of occasions where a second crew had to be dispatched as the first crew did not have appropriate medicines to treat the patient.

To mitigate these the trust had developed plans with commissioners to increase paramedic and clinical care assistant establishments, along with increased number of vehicles and an increased use of third-party provision. Further, the trust was working with primary care providers and care homes to review category 2 requests for transport and dispatch clinical validation of 111 category 3 and 4 cases. The trust was also trialling the use of a handover data pack, developing new technology to support transfer of patient information and reduce time for booking in patients at emergency departments and maintaining improvements in handover to clear times through clinical team leaders as part of new operational structures.

Absence and well-being plans have been developed to guide how staff can be best supported. A staff psychological advisor and two wellbeing facilitators had been appointed within the trust and flexible workforce options made available, such as step-down opportunities. Additional work was being undertaken to improve allocation of annual leave and relief, to support improved availability of crews

The trust received 520,999 calls to the 999 service and 675,912 calls to the 111 service in 2021/2022. Of these calls 412,068 patients were taken to hospital, 115,319 patients were treated and discharged at home ('see and treat'), and 48,054 patients were treated and discharged over the telephone ('hear and treat').

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients

The service participated in relevant national clinical audits. The service participated in relevant national clinical audits. The service identified key clinical areas to improve the clinical care given to patients. Ambulance quality indicators (AQIs) and national quality indicators (NQIs) measured the effectiveness of the service and each care bundle.

AQIs included stroke (when the supply of blood to the brain is reduced or blocked completely), sepsis and ST-Segment Elevation Myocardial Infarction (STEMI, a type of heart attack) and post return of spontaneous circulation (ROSC) following cardiopulmonary resuscitation from cardiac arrest . NQIs included care of patients with asthma, trauma patients with limb fracture, older people and paediatric patients with febrile convulsions under five years.

NQI outcomes for patients were positive and met expectations, such as national standards. For example (2021/2022), 98.5% of patients who presented with a stroke received the appropriate stroke package of care. Further, 84.9% of patients with suspected sepsis received the care bundle, 83.7% received the STEMI care bundle and 78.4% received the post ROSC care bundle.

Managers and staff used the results to improve patients' outcomes.The service participated in national and local clinical audits and highlighted actions taken to improve services within their annual quality account.

Managers used information from the audits to improve care and treatment. The trust had agreed actions to improve care and treatment. For example, the development of a new clinical audit tool, direct referrals from the electronic patient care record (ePCR) to other services and training for clinical team leaders to undertake audits and reviews.

Managers shared information from the audits. Improvement was checked and monitored by repeat audit at regular intervals. Audits had resulted in reminders to staff to use the age, time of onset, medical complaint/injury, investigation, signs and treatment (AMIST) structure for calls to pre-alert a receiving hospital for a patient handover.

Other audit outcomes had resulted in further work to clarify the national early warning score scales (NEWS2) and education to improve the recognition of COPD exacerbations. Another outcome had been communication to staff to ensure alternative diagnoses and early assessments are considered for the exclusion of life-threatening presentations in hyperventilation.

Competent staff

The service made sure staff were competent for their roles. Although, managers appraised staff's work performance and held supervision meetings, not all staff agreed these were effective.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Although the service had processes in place to ensure staff had the right skills and competences, further assurance of compliance was needed as a number of incidents had been reported which had resulted from staff not adhering to professional responsibilities, for example the administration of medicines.

Professional updates and clinical skills updates were consistently completed. The trust complemented this with access to additional clinical advice for staff, available 24 hours a day, seven days a week. However, in the staff survey as part of this inspection, a member of staff said *'…it's non-clinical staff making clinical decisions or deciding if you can speak to a clinician. They don't work between 3am and 7am meaning access to clinical advice is limited at this time'.*

Managers gave all new staff a full induction tailored to their role before they started work.

Managers supported staff to develop through yearly appraisals of their work. Appraisal compliance for the trust overall was 89%, and was 88% for ambulance services staff, both were better the trust target of 85%. However, some staff said they had not yet received an annual appraisal and others did not agree they had an effective appraisal.

The clinical educators supported the learning and development needs of staff. There were 14 WTE clinical educators and three WTE clinical education leads in post with support from a wider training, apprenticeship, administrative and driver training team. These numbers are reviewed by the assistant director of people development to ensure training plans are supported with the appropriate number of staff to deliver.

The Office for Standards in Education, Children's Services and Skills (Ofsted) reported the trust had the correct number of clinical educators in post and further assurance was confirmed through monthly workforce metrics reports showing compliance with quality indicators. Ofsted further reported clinical educators were well-qualified operational front-line

ambulance staff with substantial experience as paramedics or patient transport drivers; educators maintained their practice and skills by completing a range of training and qualifications, such as the postgraduate certificate in education and courses covering conflict management. An annual education report is presented to the trust People and Development committee including qualitative and quantitative survey outcomes from students.

Managers did not ensure staff attended team meetings or had access to full notes when they could not attend. We were not assured team meetings were held and staff had access to notes. Staff at a number of stations told us they did not have regular team meetings, and others told us notes were not available following meetings when they did take place. Although, we asked to see notes from team meetings within stations, these were not available.

In the staff survey conducted as part of this inspection, staff said they felt under pressure and did not feel as though they have enough support to conduct their work and 83% of staff said they did not meet regularly with their team to discuss the team's effectiveness.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. However, some staff told us it was difficult to access training and courses for professional and career development due to pressures on the service.

Managers identified poor staff performance promptly and supported staff to improve. Locality managers confirmed, they and local managers had responsibility for identifying and improving poor staff performance. This involved giving direct staff support and actions required to improve staff performance including training needs or management of behaviours.

Multidisciplinary working

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We observed staff handing over effectively to hospital staff. The exchange of patient information was comprehensive.

Staff worked across health care disciplines and with other agencies when required to care for patients. Both ambulance and hospital staff told us team working between was good. All staff worked together to prioritise access for high acuity patients and deliver the best care possible to their patients. Managers attended daily calls where an overview was given of current system risks.

Health Promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on vehicles. Although staff told us they would not give unsolicited advice to patients, they were uniquely placed to assess the home environment and asked if patients needed help accessing services, for example smoking cessation.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Although staff followed national guidance to gain patients' consent, not all staff felt sufficiently trained to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Not all staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Although the trust provided training on mental capacity and support and advice was available to staff, some staff told us their mandatory training did not provide them with the skills necessary to assess patient capacity, and they did not feel there were sufficient support mechanisms in place.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Capacity to consent was a mandatory field on the electronic patient record and staff were not able to complete the record without this.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions.

Staff made sure patients consented to treatment based on all the information available. Consent was clearly recorded in patient records. Care plans and flow charts on the handheld devices enabled staff to give patients clear information on which to base consent.

Staff applied consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004. Some staff said they were unsure how to access support for advice if needed.

Mental health training was provided on induction to the trust and was refreshed in the mandatory training and professional update programme.

All training completion rates for advanced practitioner paramedics exceeded the trust target of 85%; Mental Capacity Act (86.7%), Mental Health – level 2 (93.33%), Conflict Resolution (100%), Safeguarding Adults (93.33%), Safeguarding Children (93.33%).

Is the service caring?

Good

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed staff interact with patients in a way that ensured patients maintained their dignity throughout their journey and also when being transferred to hospital staff. We observed staff assisting patients with personal care in private, maintaining the dignity of the patient.

Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. All patients told us staff treated them well, with kindness and respect; all patients we spoke with praised the total experience with the service and staff.

The trust collated 4703 patient survey responses, 91.2% rated the 999 service as very good and good.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff supported patients who became distressed in an open environment, and helped them maintain their privacy and dignity. We found staff treated patients in the vehicle when appropriate to maintain dignity.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. We observed all staff talking to patients and providing reassurance. Staff told us they often gained insights into a patient's ongoing needs when picking them up, around safeguarding, emotional and physical needs.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Staff told us patients had treatment options explained to them, and care pathways and information were available for both the patients and staff.

Staff talked to patients in a way they could understand, using communication aids where necessary. We observed staff talking and interacting with patients. Staff explained situations, care and treatment well and ensured patients understood what was happening to them. Staff told us translation services were available.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The trust engagement, diversity and inclusion team worked closely with community groups, attended public events and hosted community events enabling patients, families and carers to give feedback.

Staff supported patients to make informed decisions about their care. Staff explained how patients were always involved in care decisions, for example, patients were involved in non-conveyance decisions.

Emergency and urgent care

Is the service responsive?

Requires Improvement 

Our rating of responsive went down. We rated it as requires improvement.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the needs of the local population. Managers attended daily and weekly capacity meetings which reviewed each sector day and night cover.

In 2021/2022 the trust did not meet the national target that handovers must take place within 15 minutes. To address this, the trust was working with partners to improve effectiveness across all parts of the service, review and refine risk management and escalation arrangements during times of high demand. In response the trust had introduced an initiative of a community paramedic assisting general practitioners with category one emergencies; this was reported as working well.

The trust was in the process of undertaking a thematic analysis of handover delays and a review of procedures in place with each hospital emergency department, designed to understand the impact on the overall patient experience of patients waiting in ambulances and the impact of handover delays on trust staff. Locality managers had a clear view of which emergency departments had the longest delays.

The trust participated in the 'Avoidable Conveyance Programme' designed to ensure ambulance staff convey patients to an emergency department only if this is clinically appropriate for the patient's needs, or where no alternative exists for the patient's safe ongoing treatment and care. This includes putting in place timely responses so patients can be treated by skilled clinicians at home or in the most appropriate setting outside hospital whenever it is safe to do so. The trust gave treatment to 27% of patients through 'see and treat' within their own home in 2021; this does not compare well to the highest performing ambulance trust (39%) or the England average (32%). The trust continued to give treatment to 27% of patients through 'see and treat' within their own home in 2022.

The trust had completed a demand and capacity review to determine the resources needed by hour of day at each geographical location to meet response times and complemented this with software to sense check and model increases in demand to understand where there was a need to increase or decrease resource levels; planned cover was checked against these levels daily. Based on research into the different needs within each ambulance division the trust adjusted resources aimed at improving and managing conveyance rates, time at hospital, demand levels and rostering.

Staff could not always access emergency mental health support for patients with mental health problems, learning disabilities and dementia. Although, staff understood how to support patients with specific needs such as those with mental health difficulties and those living with dementia, they told us it was not always possible to access mental health advice or support. Although staff said they were equipped to deal with violent or aggressive patients, some told us it was not always possible to access police support when attending patients with histories of violence.

Emergency and urgent care

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. The service made reasonable adjustments to help patients access services.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet their needs. Staff understood how to support patients with specific needs such as those with mental health difficulties and those living with dementia. Mandatory training included equality, diversity and human rights as well as dementia awareness, conflict resolution and Mental Capacity Act training. Staff were able to discuss how they would manage the transfer of a bariatric patient using specialist equipment, and also how they would calmly explain and inform patients with a dementia, their options.

The service had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff had access to a translation service on handheld devices.

Access and flow

People could not always access the service when they needed it, in line with national standards, and receive the right care in a timely way.

Staff supported patients when they were transferred between services. We observed staff supporting patients when they were transferred between services and handed over to hospital emergency department staff. Each hospital location had liaison officers enabling triage, assessment, monitoring and care to be delivered until handover is complete. Liaison officers within hospital departments provided a first link between ambulance crews and emergency department staff.

Handover delays

Handover start time is defined as the time the ambulance arrives at the emergency department, with the end time defined as the time the patient is handed over to the care of departmental staff. National ambulance standards indicate handover must take place within 15 minutes, with none taking more than 30 minutes.

In 2021/2022 the average handover time between ambulance and hospital emergency departments was 22 minutes and 16 seconds, seven minutes over national target.

The trust provided handover data for the two weeks before inspection (11 July 2022 to 24 July 2022); 5899 handovers where the time was recorded and 2307 where the handover time was not recorded, a total of 8206 handovers. Of the total number, 2184 handovers were recorded less than 15 minutes (26.6%), and 2385 handovers recorded between 15 and 30 minutes (29.1%).

Of the remaining recorded handovers, 10.1% were completed within 30-60 minutes, 3.9% within 60-120 minutes and 1.2% greater than 120 minutes. The time for the remaining handovers (28%) was not recorded.

This means a significant number of patients were waiting for handover to hospital emergency departments longer than national standards, and there is a significant impact on the access and flow within the emergency department and hospital wards.

We did not observe ambulances waiting to offload their patients at hospital locations visited during our inspection.

Also, we did not observe 'cohorting' patients during our inspection (cohorting patients happens when departmental staff are unable to take over the care of patients and the care of these patients is overseen by ambulance service staff). However, when handover delays have been significant staff told us they have had to cohort and oversee patients until the delays eased.

To improve ambulance handover times and reduce delays at hospitals in the region, the trust was working collaboratively with local NHS trusts to develop effective processes and procedures.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously and investigated them.

Patients, relatives and carers knew how to complain or raise concerns.The service clearly displayed information about how to raise a concern. Complaints information was available online and displayed within vehicles.

Staff understood the policy on complaints and knew how to handle them.Complainants were provided with the opportunity to feedback on complaint handling through a web link for in formal response letters.

Managers investigated complaints and identified themes. Complaint outcomes and learning were shared with relevant staff. Managers were aware of ongoing complaints and themes over the last twelve months; 575 complaints had been received in the last twelve months, the most frequent referring to quality of care (281), timeliness of response (126), staff attitude (90) and quality of communication (58).

Lessons learned from investigations were shared at individual, team and divisional meetings and with the trust board and commissioners of services through the Quality and Safety Quarterly Report.

Over the same period the service received 883 'appreciations'; 842 related to the quality of care.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Managers shared feedback from complaints with staff and learning was used to improve the service.The trust had identified 'Involve our patients and communities to improve care' as a quality priority for 2022/23 to improve complaint handling.

Is the service well-led?

Inadequate 

Our rating of well-led went down. We rated it as inadequate.

Leadership

Leaders understood the priorities and issues the service faced. However, they were not always visible and approachable in the service for staff.

Emergency and urgent care

Local leaders understood and had oversight of the challenges to quality and sustainability within the service. The service had recently restructured management responsibilities and staff were becoming familiar with these new arrangements at the time of inspection.

We met with team leaders, duty officers and locality managers who told us they were available and supportive, and they felt able to escalate concerns. All managers felt well supported within the service. There were opportunities for staff to develop their skills and take on more senior roles.

However, staff described a disconnect between senior leadership and local leadership. Staff told us there was limited visibility of the executive team except for the chief executive officer.

Staff told us managers at all levels were not visible throughout the service and some staff were unsure of the responsibilities of each management level, for example, responsibility for undertaking medicines audits.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

The trust had a clear vision, strategy and values. The overarching mission for the trust was to ensure 'Safe, effective and responsive care for all' and this was underpinned by the trust vision to provide 'Unmatched quality of care, every time we touch lives'.

The trust had identified the following values to deliver its vision:

- Compassion;
- Accountable and responsible;
- Respect;
- Excellence and innovation;

The majority of staff were aware of the trust values and we found these were displayed on some staff notice boards.

In its delivery strategy the trust acknowledged the need to support colleagues in a safe work environment '…where they can thrive and provide the best support to our patients'.

Culture

Staff did not feel respected, supported and valued however they were focused on the needs of patients receiving care.

Most staff felt positive and proud to work in the organisation, although some staff told us capacity issues within emergency departments impacted their ability to support patients in the community.

Delays meant staff sometimes finished late and missed meal breaks. The trust did not hold missed meal break data by month as staff only missed their breaks in extreme circumstances. As soon as staff were out of break banding time they were stood down; breaks taken out of banding time were reviewed on a shift by shift basis and the information included in the shift handover report.

Staff reported difficulties with booking annual leave due to the allocation system used. This meant it was difficult to co-ordinate time off with the needs of individual family commitments.

We observed staff were committed to delivering the best care possible to their patients and demonstrated trust values in all patient and hospital interactions.

We sent out a survey to all staff within the trust at the time of our inspection and received 337 responses from urgent and emergency care staff.

Findings from this survey showed:

- staff were encouraged to report incidents but did not feel that those reported would be dealt with (47% of staff said they did not receive feedback from incidents reported and only 28% agreed action was taken to prevent recurrence);
- staff felt under pressure and did not feel as though they have enough support to conduct their work (76% of staff did not agree they had enough effective support to do their job to the best of their ability and 83% of staff did not agree they had regular team meetings);
- some staff had experienced bullying and/or harassment in the last twelve months (44% from managers and also 37% from colleagues) however, the majority of staff did not feel comfortable coming forward if they had done so.

Comments received included *'…the organization fails to listen to respected members of staff when questioning issues, as once it sets its agenda, the organization always needs to be right'*, *'…has a senior management bullying culture and all flows to workers who are guilty until proven innocent'* and *'…low staff morale, now unable to choose when we have our holidays which makes home life difficult. Stressful trying to get shift swaps. Never look forward to coming in for a shift'.*

Although managers we interviewed said they encouraged, openness and honesty at all levels some staff told us they did not always feel safe to raise concerns (57% of staff said they did not feel safe to report concerns and 48% of staff said they were not satisfied with the level of managerial support). Staff did confirm they were encouraged to be open and honest with service users.

Staff did not feel that the organisation supported them effectively within their work life and 52% of staff felt unable to meet the conflicting demands of their work. Just less than 50% of staff were not satisfied with the support they get from their immediate manager.

Over 75% of staff believed communication between senior management and staff was ineffective and more than 50% of staff did not feel safe to report concerns without fear of what will happen as a result and believed the organisation would not take appropriate action.

Locality managers told us they and other managers were committed to addressing behaviour and performance that was inconsistent with the values of the organisation, for example bullying and harassment, non-adherence to infection prevention and control.

In the staff survey as part of this inspection, over 19% of staff said they had experienced harassment, bullying or abuse at work from managers or colleagues more than three times in the last twelve months. Nearly 50% of staff felt that the organisation does not treat people with respect and doesn't take action to reduce bullying and harassment. Not all staff (41%) reported the last time they experienced harassment, bullying or abuse.

We were concerned the service did not have effective systems or processes to seek and act upon feedback from staff and other relevant persons for the purposes of continually evaluating and improving services. For example, the trust's own incident investigations have evidenced staff being reticent to report incidents. SI report (2022/8986) stated:

- *'Due to culture, the crew were fearful to report this incident as they felt they might be punished.'* This same incident was presented to the board in July 2022 as a patient experience story. Information about the delay in reporting, and the reason why the staff were fearful to report, was shared as part of this report which also stated *'Work is required across the Trust to ensure that staff understand why they need to report accidents and incidents, and that this is not a punitive process, but a learning one.'*

Respondents to the CQC staff survey told us they were concerned about blame when reporting incidents. These included but were not limited to:

- *'There is a significant blame culture that makes staff scared to report incidents of any nature, a fear to ask for help out of worry of being deemed incompetent and when things do go wrong very little support in response- often times met with instead of support to avoid future incidents and promote learning to instead blame the individual and frankly "string them over the coals" to avoid NEAS affiliation with the incident even when very minor.'*
- *'We are encouraged to report incidents, near misses etc, but I feel there is a blame culture. If there is a management failure then nothing will be done, but if an employee is deemed to be at fault, I feel they would be blamed rather than supported.'*
- *'The staff involved were threatened to stop incident reporting these incidents, this was backed up by risk department instructing staff to stop reporting incidents.'*

In the last six months CQC received 11 whistleblowing concerns from staff at the trust raising concerns about patient safety and clinical concerns, the culture within the organisation and leadership and management support to staff. These included but were not limited to: medicines management and storage; incident reporting, investigation and learning; trust leadership and management and culture in the organisation.

Following this inspection, we served the trust with a notice under Section 29A of the Health and Social Care Act 2008. We told the trust it needed to make significant improvement in listening,responding, and acting upon feedback from staff and other relevant persons.

Governance

Governance processes were not always operated effectively in the service to ensure risk and performance issues were identified, escalated appropriately, managed and addressed promptly

Although, there were structures and systems of accountability in place to support the delivery of the service, the service had recently restructured management arrangements and not all staff were clear on individual responsibilities.

The trust-wide governance structure included meetings of the Council of Governors, Public Board of Directors, Nomination and Renumeration Committee, Audit and Risk Committee, People and Development Committee, Performance and Finance Committee, Quality Committee and the Technology Committee. These were complemented by internal strategic meetings, operational meetings and also meetings with external organisations.

We found limited evidence of local governance meetings and there was no clear process to escalate service-level risks and concerns to the board. During this inspection we queried the low number of incidents being reported around medicines, this resulted in more than one hundred incidents identified which had not been registered on relevant systems. This demonstrated that although systems were in place, they weren't always used appropriately to mitigate risks

Managers understood how teams were performing against key performance indicators such as compliance with mandatory training, professional updates and appraisals, and incident and complaint themes.

The service used measures for operational performance providing oversight of response times and operational productivity, key performance indicators (for example, numbers of journeys undertaken and numbers of cancelled calls out), quality issues (for example, complaints and appreciations and safeguarding data), and workforce data.

Management of risk, issues and performance

Although leaders and teams used systems to manage performance, they did not identify and escalate relevant risks and issues and identify actions to reduce their impact.

Although there were processes in place for identifying, recording and managing risks we found that incident reporting and medicine management were not managed well within the service. For example, we found a lack of identifying specific risks associated with medicines management, incident reporting, staffing, infection prevention and control and culture that were not being actioned and mitigated. Further we were unable to identify clear plans for continuous improvement and learning in response to these identifiable risks.

Staff knew what incidents to report and how to report them, but some staff said they did not always complete a report because they did not receive feedback or learning from incidents that had been previously reported. This meant some incidents were going unreported. Further, staff did not always have access to critical and other medicines they needed to treat patients or have time to complete vehicle medicine checks, resulting in delays in treatment.

Although these were known risks within the trust, there was no evidence of these being managed and their impact being mitigated.

There was also a known risk of loss of radio communications throughout emergency care which had been identified some years earlier and not yet resolved. This had been raised by staff during interviews.

The trust participated in national clinical audit projects (for example, Cardiac arrest: survival to 30 days, Stroke, Sepsis) and clinical outcome quality indicators (for example, Adult seizures, Delayed hospital handover, Hyperventilation).

Managers used information from these audits to improve care and treatment. Where improvements were identified there were processes in place for learning and improvement. For example, the hyperventilation quality indicator had led to communication to staff to ensure alternative diagnoses are considered and early assessments to exclude life-threatening presentations.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

We found information systems were integrated and secure, to prevent unauthorised access of information. Systems were used to record and share patient sensitive data with emergency departments during handovers and there were clear processes to ensure compliance with access protocols.

There were clear and robust service performance measures, which were reported and monitored. Performance measures were shared internally and with external stakeholders.

Managers understood performance targets including quality and data from clinical and internal audits. The trust participated in national clinical audit projects and clinical outcome quality indicators.

Engagement

Leaders and staff actively and openly engaged with patients, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The trust increased the number of engagement events in person, and virtually with local health providers, Healthwatch organisations, local authorities and commissioners over the last twelve months.

Outcomes from this engagement included the recruitment of over 90 community ambassador volunteers working in ethnic minority communities. This had resulted in more than 1300 community members in service awareness and access, and more than 1000 community members trained in lifesaving skills including CPR and defibrillators.

Online engagement spaces had been developed for adults, young people, people with learning disabilities and British Sign Language users with content tailored to the needs of each group and delivered in accessible communication formats.

Individual videos had been developed to help patients and the public obtain more information about services including an interactive ambulance 360 tour and service awareness and information videos.

The trust enabled patient, carer, and family engagement through email, Microsoft Teams conference calling technology and face to face meetings where possible to help understand concerns and feedback.

The trust had developed a team of local volunteers as ambassadors to seek patient feedback and involvement in service change, service delivery and design.

In the staff survey as part of this inspection, 43% of staff believed the organisation encouraged staff to be open and honest with service users and staff when things go wrong.

Information was shared with staff by email and newsletters. Although most staff said they were well-informed, others said there were limited opportunities to feedback to managers.

The trust engaged with staff and gathered feedback through the annual NHS staff survey, quarterly ‘People Pulse Survey’ and staff networks and also informally through the workplace social media platform and executive question and answer roadshows. Feedback from the NHS staff survey resulted in key actions, including tackling bullying and harassment from patients towards staff and support for colleagues who have a protected characteristic.

JOINT ICS OSC – WORK PROGRAMME 2023-24

Meeting Date / Time	*Items to be considered / Officer Responsible*
3 July 2023 **1.30pm**	• Appointment of Chair / Vice Chair • Terms of Reference (to note) • Neonatal work (central NENC ICB) • Integrated Care Strategy Implementation Plan • NEAS CQC Inspection / Independent Review of NEAS
25 September 2023 **1.30pm**	• Strategic Options for Non-Surgical Oncology Services • Role of the Area ICPs • Progress of Digital Strategy Update
20 November 2023 **2.30pm**	• Access to critical paediatric beds in the region and the step - down arrangements • Children's Mental Health Provision – update on current ICS performance and future provision • Health and Care Workforce – Recruitment, Retention and Development
22 January 2024 **1.30pm**	• Dentistry Update – implementation of new NHS contracts and service implications •
18 March 2024 **2.30pm**	• Health inequalities – How the ICB strategy is addressing this / update on position across the North East

Issues to slot in:

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