East of England Ambulance Service NHS Trust

Inspection report

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Ratings

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

Summary of 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.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

The Evidence appendix appears under the Reports tab on our website here: www.cqc.org.uk/provider/RYC/reports.

Background to the trust

East of England Ambulance Service NHS Trust (EEAST) covers the six counties of Bedfordshire, Cambridgeshire, Essex, Hertfordshire, Norfolk and Suffolk.

EEAST provides 24 hour, 365 days a year accident and emergency services to those in need of emergency medical treatment and transport. The trust has ambulance operation centres (AOC), where 999 calls are received, clinical advice is provided and emergency vehicles dispatched if needed. There is also a Hazardous Area Response Team (HART).

The trust also provides transport services for patients needing non-emergency transport to and from hospital, treatment centres and other similar facilities and who cannot travel unaided because of their medical condition or frailty.

The area is made up of:

• Around six million people

• overs over 7,500 square miles

• Has a total of 19 Clinical Commissioning Groups (CCG)

• Seventeen acute NHS trusts are served by EEAST

In 2018/19 the trust:

- Received more than one million emergency calls
- Treated 64,157 people through the Emergency Clinical Advice and Triage Centre

The trust's resources and teams include:

• More than 4,000 staff and more than 1,500 volunteers

• Three ambulance operations centres (AOCs) in Bedford, Chelmsford and Norwich

• 387 front line ambulances

• 178 rapid response vehicles

• 175 non-emergency ambulances (patient transport service and health care referral team (HCRT) vehicles)

• 46 hazardous area response team (HART) / major incident / resilience vehicles

• More than 130 sites

Summary of findings

Total income in 2018/19 was more than £281 million.

(Source: Trust website)

The trust serves an ethnically and geographically diverse population including rural, coastal and urban environments. There are areas of high deprivation in Essex, Bedfordshire and Norfolk.

We previously inspected EEAST under our current methodology and published the report in July 2019 and rated the trust as requires improvement overall.

We returned to inspect the trust in June 2020 response to escalating concerns of risk to patient and staff safety. We utilised a risk based approach and conducted a focused well-led inspection.

During this focused inspection, we spoke with members of the trust board and senior leadership team both face-to-face (where appropriate and observing social-distancing guidelines) and virtually. In order to receive feedback from staff at all levels we conducted an electronic staff survey which was sent to all staff employed by EEAST. We received 1,813 responses, which represented approximately 45% of the trust's overall workforce. The survey consisted of both quantitative and qualitative questions. We visited the trust headquarters on three separate occasions (25 and 26 June and 15 July 2020) to review records and documentation. We reviewed six employee relations case management records, nine safeguarding crib sheets and committee and board meeting minutes.

Overall summary

Our rating of this trust stayed the same since our last inspection.

What this trust does

East of England Ambulance Service NHS Trust (EEAST) provides emergency and urgent care and treatment across the East of England region. It also provides hear and treat and see and treat services.

In some areas the trust provides non urgent patient transport services, typically to and from hospital.

Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we usually ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? For this focused inspection we looked at the well-led key question only.

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

Summary of findings

We conducted this focused inspection of the well-led domain only between 25 June and 15 July 2020 in response to escalating concerns of risk to patient and staff safety. This was related to the perpetuated poor culture within the organisation and ineffective governance. Before this inspection, we received information from a variety of sources, including seven whistle-blowers in relation to culture (including senior leaders) and independent reports, related to safeguarding patients and staff from sexual abuse, inappropriate behaviours and harassment.

What we found

Overall trust

Our rating of the trust remains the same as the previous inspection because:

This was a focused inspection and we did not inspect any core services. We did not inspect all of the key lines of enquiry as our concerns were related to specific risks. This means that the previous ratings for our 2019 inspection remain.

Well-led rating remains as inadequate. The level of enforcement we undertook to ensure people's safety means that the rating for well-led would have been limited to inadequate had we been rating on this occasion.

On the basis of this inspection, the Chief Inspector of Hospitals has recommended that the trust be placed into special measures.

Are services safe?

We did not inspect this key question on this occasion.

Are services effective?

We did not inspect this key question on this occasion.

Are services caring?

We did not inspect this key question on this occasion.

Are services responsive?

We did not inspect this key question on this occasion.

Are services well-led?

The rating for well-led stayed the same. It remains as inadequate because:

We did not rate on this occasion so previous ratings remain.

There had been more significant changes in the executive leadership team since our previous inspection. There was a continued high level of churn at both executive and non-executive director level.

The style of executive leadership did not represent or demonstrate an open and empowering culture. Not all leaders had the skills, knowledge and experience that they needed to deliver high quality sustainable care.

The governance still did not support delivery of high-quality care. The trust did not have effective structures, processes and systems of accountability to support the delivery of good quality, sustainable services. The trust had been in repeated breach of regulation 17 (good governance) of the Health and Social Care Act 2008 since August 2016.

Leaders did not fully demonstrate that they understood the challenges to quality and sustainability that had triggered this focussed inspection. This meant that they did not always identify the actions needed to address them. Senior leaders showed a lack of awareness of some of the fundamental requirements to safeguard patients and staff from abuse.

Summary of findings

Leaders across the trust did not consistently promote a positive culture that supported and valued staff. Significant work was needed to promote an open and transparent environment where people felt that their concerns were listened to and acted upon.

There remained a mixed culture in the organisation and a lack of pace in the extensive organisational development work needed to improve the culture of the organisation. There were continued high levels of bullying, harassment and discrimination and the organisation had failed to take adequate action to reduce this. There was a failure by the executive team to identify and recognise the risk and impact to staff and patient safety from the poor culture throughout the organisation.

The trust did not have the systems and processes in place to take action to address behaviour that was inconsistent with the trust's vision and values**.**

There was not a strong enough emphasis on health and well-being of staff. Feedback we received from staff demonstrated that the trust was still not giving sufficient priority to mental health and well-being. Reports of cases we reviewed demonstrated that the trust had missed opportunities to support staff with mental health illness due to disjointed occupational health provision and poor staff welfare mechanisms.

The style of leadership amongst the executive directors did not represent or demonstrate an open and empowering culture. Some members of the executive leadership team adopted a combative and defensive approach when asked for assurances about the risks identified. When staff raised concerns, they were not always treated with respect.

Although leaders told us that they continued to work hard to be visible and approachable. The feedback we received from staff demonstrated that there was still a significant 'disconnect' between senior leaders and staff in other areas of the organisation.

The culture, policies and procedures in place did not provide adequate support for staff to raise concerns without fear of reprisal.

Fundamental issues with the quality of human resources (HR) function and process remained. There was inadequate oversight of HR function to ensure consistent application of process and appropriate use of sanctions.

Recruitment processes failed to ensure adequate safeguards to protect staff and patients.

Ratings tables

The ratings tables show the ratings overall and for each key question, for each service and service type, and for the whole trust. They also show the current ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

We only inspected trust-level leadership and were unable to give a rating on this occasion. The ratings on our website relate to previous inspections.

Areas for improvement

We found areas for improvement including twelve breaches of legal requirements that the trust must put right.

On the basis of this inspection, the Chief Inspector of Hospitals has recommended that the trust be placed into special measures.

For more information, see the Areas for improvement section of this report.

Summary of findings

Action we have taken

We issued an urgent notice of decision, under Section 31 of the Health and Social Care Act 2008, on the 29 July 2020, to impose conditions on the trust registration as a service provider in respect of the regulated activities: Treatment of disease, disorder or injury and Transport services, triage and medical advice provided remotely. The conditions set out specific actions to enable the improvement of safety within the service.

We undertook further enforcement and issued a warning notice, on the 28 August 2020, under Section 29A of the Health and Social Care Act 2008. This identified specific areas that the trust must improve and set a date for compliance as 28 November 2020.

The trust initiated immediate steps to improve this included setting up an improvement committee involving multiple stakeholders and a review of systems and policies.

For more information on action we have taken, see the sections on Areas for improvement

What happens next

We will check that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

Following our inspection and enforcement action, the trust were due to attend risk summit on 11 September 2020.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, 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 legal requirements. This action related to the whole trust."

- The trust must implement an effective system to identify and assess any potential safeguarding issues and the management of vulnerable children and adults. (Regulation 13)
- The trust must review any policy, which sets out the processes in place to deal with allegations made against staff. This review must ensure that policies incorporate risk assessments that describe the rationale for any decisions taken (including decisions not to suspend staff and any mitigating measures put in place) and sets out overall management of cases. (Regulation 17)
- The trust must implement an effective system to review the frequency of Disclosure and Barring Service (DBS) renewals of staff within the organisation to include those who have changed job roles or have been transferred from other services. (Regulation 13).
- The trust must implement an effective system to ensure all staff, including those transferred from other services, have full pre-employment checks completed including DBS, including any staff members who have outstanding DBS. (Regulation 19).
- The trust must implement an effective system to ensure the safety and effectiveness of subcontracted private ambulance services and their staff, including monitoring and supervision by the provider. (Regulation 17).

Summary of findings

- The trust must undertake a review of systems in place to protect staff and patients from inappropriate behaviours including sexual harassment and sexual assault. (Regulation 17).
- The trust must incorporate the findings of its review into inappropriate behaviours including sexual harassment and sexual assault into its systems to protect staff and patients. (Regulation 17).
- The trust must implement a system to ensure there are effective processes in place to manage concerns, grievances and disciplinaries. (Regulation 17).
- The trust must ensure there are oversight and governance arrangements in place for all action plans. (Regulation 17).
- The trust must ensure there are oversight and governance arrangements in place in relation to human resources processed for job matching evaluations and job descriptions. (Regulation 17).
- The trust must ensure that there are oversight and governance arrangements in place to ensure that complaints are appropriately investigated and identified as possible serious incidents. (Regulation 16).
- The trust must make significant improvements to address long-standing concerns with bullying and harassment within the organisation. (Regulation 17).

Ratings tables

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 Jul 2019	Requires improvement Jul 2019	Outstanding Jul 2019	Good Jul 2019	Inadequate Jul 2019	Requires improvement Jul 2019

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.

Ratings for ambulance services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	Requires improvement Jul 2019	Requires improvement Jul 2019	Outstanding Jul 2019	Good Jul 2019	Good Jul 2019	Requires improvement Jul 2019
Patient transport services	Requires improvement Jul 2019	Requires improvement Jul 2019	Good Jul 2019	Good Jul 2019	Requires improvement Jul 2019	Requires improvement Jul 2019
Emergency operations centre (EOC)	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Resilience	Good Jul 2019	Good Jul 2019	Good Jul 2019	Good Jul 2019	Outstanding Jul 2019	Good Jul 2019
Overall	Requires improvement Jul 2019	Requires improvement Jul 2019	Outstanding Jul 2019	Requires improvement Jul 2019	Requires improvement Jul 2019	Requires improvement Jul 2018

Overall ratings 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.

This section is primarily information for the provider

Enforcement actions

We took enforcement action because the quality of healthcare required significant improvement.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Section 31 HSCA Urgent procedure for suspension, variation etc.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Section 29A HSCA Warning notice: quality of health care

Our inspection team

Mark Heath , Head of Hospital Inspections (Interim) led this inspection. An executive reviewer and two specialist advisors supported our inspection of well-led for the trust overall.

The team included three further inspectors.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ.