PATIENTS' FORUM

FOR THE LONDON AMBULANCE SERVICE

CQC CONSULTATION ON INSPECTION OF DENTAL, INDEPTENT ACUTE HEALTHCARE AND AMBULANCE SERVICES

Answers to questions regarding Ambulance Services

Consultation questions

1. We have identified the core services that we will check during our inspections of ambulance services (see appendix A). These questions are for both NHS and independent ambulance services:

• Do you agree that these are the right core services to look at?

Answer: ***Yes***

• Do you understand what we mean by these core services? If not, what is unclear?

Answer: ***Yes.***

Issues to consider:

We believe weighting core services equally is in line with our commitment to promote equality in the services we regulate and to uphold Equality Act legislation. Everyone who receives care and treatment should expect to receive the same good quality care, irrespective of the type of service that they are using.

An exception might be where an ambulance service provides a core service to a smaller population than another core service; for example where an ambulance service provides patient transport services to 10% of the population they provide emergency and urgent services to. In this situation the inspection team would use their professional judgement to determine what weight to give the core service when aggregating ratings.

• Do you agree that, in general, core services should be weighted equally with the above exception?

Answer: ***Patient transport services, whether NHS or independent, ought to be weighted slightly differently from /lighter than the others because they are less likely (not entirely) to be used for 999 calls and are, therefore, of a different nature.***

Consultation questions

2. These questions are for both NHS and independent ambulance services:
• Do you feel confident that the key lines of enquiry and the list of prompts will help our inspector's judge how safe, effective, caring, responsive and well-led NHS and independent ambulance services are?
• Is there anything missing?

Answers: ***First question – for a substantial number of the prompts and questions, the answer is yes.***

However, regarding the E5, there is no mention of call centres, which contribute hugely to whether or not the arrival of an ambulance and the care provided are effective. The outcomes must include handover times (often outside an ambulance service's power) and ought to include to what extent dementia is catered for – a very important part of NHS care wherever in the system dementia is found. E5 in particular is well outside an ambulance service's control. CMC is extremely slow getting fully operational. Some of the E prompts need to be revisited with ambulance services in mind.

C2 needs to take dementia on board and the specific training required to be able to communicate effectively with such patients. The final two questions in C3 need to be revisited with ambulance services in mind.

R 1-3 need to be revisited with ambulance services in mind. R4 is imperative for ambulance services. Will those ambulance services who claim that none of their complaints was upheld when asked by the Information Service be questioned specifically about this?

Regarding the W questions, will the CQC differentiate between activities informing the public about how the ambulance service operates and going to schools etc, and those that actually invite and involve patients and public when systems, processes or policies are being devised and whose views are actually used and outcomes fed back?

Second question – what is missing is any reference to information gathered from patient groups. This is particularly important in the pre-inspection phase as such information could help inspectors include or focus upon elements which may not be gathered from elsewhere.

Consultation questions

3. These questions are for both NHS and independent ambulance services:

• Do you agree that the characteristics of 'outstanding' (in appendix C) are what you would expect to see in an outstanding NHS and independent ambulance service?

SAFE

Answer: ***On the whole there appears little logic in the escalation of the rigour of criteria from Inadequate to Outstanding. It is usual to set out, e.g., what is Outstanding in terms of the quality, rigour and robustness of the evidence needed and for those same criteria to be 'diluted' gradually until it is perfectly clear that the quality expected in Requires Improvement is generally missing. Is it the case that in order to be Outstanding, the characteristics of Good are needed PLUS the characteristics of Outstanding?***

Usually when measuring quality of service, much the same characteristics – which are the essential ones – ought to appear in each of the four judgement profiles with

the differences in degree of quality, rigour and robustness graduated downwards until Inadequate is reached.

It is appropriate, though, for one element of Inadequate relating to any of the full criteria being capable of earning Inadequate.

Avoidable harm can result from missing attendance targets. There ought to be something about ambulances meeting its targets – not just for emergency calls but for the C categories also. This harm can also result from insufficient number of paramedics. This ought to be included here as well as under Good (see below). There ought to be something about evidence of how complaints have led to secure improvements and/or monitoring closely to ensure no aspect of safety is overlooked. This would be allied to whistle-blowing also.

EFFECTIVE

Outstanding – ***there is a danger that merely measuring a service as being better than similar other services may not mean much more than a bit better than average (where other services are around average). Therefore, it seems a little odd that an excellent outcome – which clearly surpasses good ones – is not the banner judgement for Outstanding.***

Good: People have good outcomes because they receive effective care and treatment that meets their needs.

Presumably, the outcomes here include being seen within the target times. This ought to be mentioned explicitly.

CARE

The use of the term 'truly' is hard to measure. This could come to haunt the CQC. Might it be better to use terms such as 'There is substantial evidence to demonstrate …… etc 'Similarly, care should fully meet people's expectations rather than exceed them, since this denotes lower expectations (Outstanding). No doubt 'planning care with patients' is absolutely a requirement in other settings, but in an emergency when patients might be unconscious, far from home, or worse, this would need to be revisited to contextualise care in terms of paramedics in emergency situations.

RESPONSIVE – These judgements need to be revisited to embrace ambulance service and staff, and meeting call-out targets. Nothing of the targets is mentioned, or the use of First Responders, bike riders rather than ambulances, the call centre's responses and much else. Inspectors who have not been paramedics will have difficulty applying the criteria as set out under RESPONSIVE specifically to ambulance services.

WELL LED – there is no mention of timeliness in the overarching judgement strapline, whereas time is always of the essence regarding the need for an ambulance or paramedic. The use of 'improve' on its own in the Outstanding criteria would be better shown as 'continuously improve' – otherwise it suggests less than optimal service to begin with, which is not outstanding. In the event it is mentioned only as the final criterion. Although not mentioned, it seems appropriate to mention that all the aspects appearing in Good ought to be required in Outstanding, in addition to the criteria mentioned in Outstanding.

With no wish to be pedantic, ought this to be leadership AND MANAGEMENT. So often it is people and process management, for example, that are found wanting in large organisations. Concentrating on governance (though not much) and SMTs (leaders) might overlook either good or poor middle and senior management performance.

When referring to 'low levels of satisfaction' (Inadequate) what are the national averages? Is CQC going to set its own high, medium and low level to use as markers? How high does satisfaction have to be for Outstanding?
Finally, where NHS ambulance services commission independent services for some of their work, mention ought to be made of the effectiveness of quality management of those independent services.

• Do you agree that the characteristics of 'good' (in appendices B and C) are what you would expect to see in a good NHS and independent ambulance service?

Answer: SAFE - ***Staffing levels are mentioned here but not in Outstanding. See also above***.

• Do you agree that the characteristics of 'requires improvement' (in appendix C) are what you would expect to see in an NHS and independent ambulance service that requires improvement?

Answer: ***As above***

• Do you agree that the characteristics of 'inadequate' (in appendix C) are what you would expect to see in an NHS and independent ambulance service that was inadequate?

Answer: ***The requirements for Good and Outstanding could be built upwards from Inadequate as well as downwards as set out above.***

• Do you agree that rating all ambulances will achieve the purposes described in the Nuffield report?

Answer: ***Little specific included about ambulance performance, but this kind of inspection ought to allow the public to see (a) the existing quality of ambulance published and (c) ensure that continuous improvement is achieved. However, as Nuffield Report stated, the spending/costs involved in achieving significant improvement may yet prove to be a big stumbling block. It is to be hoped that good practice will include examples of smarter working.***

Consultation question

4. Do you think observing care in or from an ambulance is an appropriate way to gather evidence to inform the inspection?

Answer: ***Definitely yes. Otherwise, too much evidence would be oral or written (which can be prepared earlier) and there would be no means of observing what actually happens during emergency care.***

Consultation question

5. Do you think that 30 days is an appropriate period of time to complete an unannounced visit of an NHS ambulance service?
Answer: ***It probably is, based on the explanation provided. In reality, this might need to be flexible and evidence gathered on how realistic this is after some unannounced inspections of varying sizes have taken place.***

Consultation questions

These questions are specific to NHS ambulance services:

6. Do you agree that we should report on and rate core services at trust level?

Answer: ***While reporting at Trust level would give the starting point of a report, it would be important for patients, the public, stakeholders and commissioners et al (including the Trust itself) to know within that overall judgement which components/areas are better than others.***

7. Due to the large geographical areas covered by NHS ambulance services, do you think we should rate core services at area level within an NHS ambulance service? If so, how would we identify the areas, and what criteria could we use?

Answer: ***Ambulance services have records/maps of the station areas under their remits and should provide these readily in time for inspections. While an overall service report could be written, inspection of the various areas must be undertaken and any differences in quality included specifically in the report, with easy identification of which areas perform well and which do not (where applicable).***

This question is specific to independent ambulance services:

8. If we rated independent ambulance services, what would be useful, a rating at location level or at core service level?

Answer: ***The answer has to be both. The judgements being made ought to be contextualised – reporting on the core service at specific locations, especially where independent services are part of a large almost national concern.***

Consultation question

9. Do you think we should rate independent providers at corporate level? If so, how should we do this?

Answer: ***There seems to be no logic in rating at corporate level unless the corporate services are inspected in every location and in every region/part of the country in which it operates.***

Consultation questions

10. These questions are specific to independent ambulance services:

• Do you think we should introduce special measures for independent ambulances?

Answer: If this means placing independent ambulance services into special measures for under-performance, it would be illogical not to do so.

• What do you think this should involve?

Answer: ***There is no overt reason for using different criteria from those for NHS ambulance services. If, however, it means that a different set of criteria ought to be used, the CQC might be interested in the LAS Patients' Forum document attached, which has been circulated to some hospitals, for example, and which have been well received***

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11. As part of this consultation we have published a Regulatory impact assessment and an Equality and human rights duties impact analysis. We would also like your comments on these.

Regulatory Impact Assessment - comments:
We do not feel this fits ambulance services very well. Ambulance services deal both with adults and children, most frequently with urgent medical problems, but also including patient transport. The quality and effectiveness of the service most often depends on how a patient is dealt with in a very short period, e.g. transporting to hospital, referral, or treatment and advice on the spot.

Equality and Human Rights Duties Impact Analysis – comments:
Again the existing document does not cover the different nature of ambulance services, which have to respond to acute medical need in most cases, have typically short term contact with patients, in intimate situations, with little time if any to get to know patients, cultures, languages, background, etc. The contents of the existing document needs to be adapted to these different circumstances, which are not adequately reflected in the current guidance. The human rights and equality duties need to be more specifically focused on emergency service, often in crisis situations with short term contact – and what can be expected in these circumstances. We believe for many reasons this is an important area to develop, particularly but not exclusively within the LAS as by 2020 it is estimated that half of the population of London will be of minority ethnic heritage.

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