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Our reference: INS-212690215621

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07 April 2022

CQC Reference Number: INS2-12690215621

Dear Marcus

Re: CQC inspection of East of England Ambulance Service NHS Trust

Following your feedback meeting with Fiona Collier (Inspection Manager) and Quentin Colley-Bontoft (Inspector) on 06 April 2022. I thought it would be helpful to give you written feedback as highlighted at the inspection and given to you and your colleagues, Emma De-Carteret and Kate Hall (Improvement Director) at the feedback meeting.

This letter does not replace the draft report and evidence log we will send to you, but simply confirms what we fed-back on 06 April 2022 and provides you with a basis to start considering what action is needed.

We would encourage you to discuss the findings of our inspection at the public session of your next board meeting. If your next board meeting takes place prior to receiving a final or draft inspection report and evidence log, this correspondence should be used to inform discussions with the board. When scheduling a discussion of this letter, or the draft report, please inform your CQC Regional Communications Manager, who is copied into this letter.

An overview of our feedback

The feedback given to you in relation to Emergency and Urgent Care was:

- All staff we spoke with were open, honest and welcoming of the inspection team.

- Staff were incredibly passionate about doing their best for patients but were frustrated that they were unable to do their job to the best of their ability.
- We heard many staff speak positively about the support they got from their local operations managers (LOMs) but felt there was a real disconnect between those working operationally and the senior leadership team.
- We recognised the positive contribution the make ready teams had on ensuring vehicles were cleaned and restocked between jobs and saw this was very well established at the Peterborough Ambulance Station.

Areas for Improvement:

- We found that staff were tired and raised concerns around staff retention and the fact they were not receiving mandatory training, one to ones and appraisals.
- Staff raised concerns around the fiat vehicles in relation to their personal safety and that some staff were not able to drive them.
- We were concerned that given the pressures; some crews were three manned because some staff had been waiting a long time for their blue light training. Equally some apprentices had not been able to progress to being qualified because they were waiting an excessive amount of time for their portfolios to be marked.
- At the Holdings Lane Ambulance Station there was some concerns around the storage of medication. This included controlled drugs. Medicines were stored in a locked room with a keypad entrance. Controlled drugs were stored in locked boxes accessible with a key kept in a keypad locked key store. Accessing this box meant that staff had access to all controlled drugs.
- We found that room temperatures were not being monitored where medications were being stored.
- At the Cambridgeshire Ambulance Station we found that cleaning chemicals were being stored in the sluice area in a room that was not locked. In addition, the room and equipment within the room was visibly dirty.
- At the Peterborough Ambulance station, we found cleaning chemicals were stored in a room that was not locked.
- At the Peterborough Ambulance Station, we found the medical gases storage area where the medical gases were stored to be extremely dirty and full of debris, including the plastic caps from the cylinders, paper cups, dirt and leaves.
- Within the Essex area not all staff were consistently wearing Personal Protective Equipment when conveying and caring for patients.

The feedback given to you in relation to the Ambulance Control Room was:

- The rapid release process demonstrated effective working with other providers to support positive patient outcomes.
- We recognised the positive steps that Emergency Call Handler Module (ECHM) were moving to permanent roles by June 22 as this at present is a risk.
- We observed that staff attitudes and their responses to patients was positive and respectful of their needs.

- Staff routinely used special notes to promote positive patient outcomes.

Areas for Improvement:

- The management of the call stack and consistency in the application of Emergency Standard Operating Procedure 3 (ESOP3) remains a concern in terms of risks to patients.
- There was a lack of assurance processes in relation to dispatch and audit / breach analysis in relation to the call stack and risks to patients.
- Staff described a worsening not improving culture, and that acceptance seemed to be the norm as they saw a lack of impact given the time since concerns were raised by the CQC.
- Staff raised concerns around the lack of training, appraisals, one to one support, career progression and competency checks. Staff we spoke with told us they had not received training, professional updates or appraisals within the last twelve months.
- We were concerned about the risks associated with staffing levels being below the planned numbers. Managers we spoke with told us this was affected by high levels of sickness, the current vacancy rates and staff retention. We were not assured that staffing levels met the demands within the service and this may impact on patient safety when managing the high volume of calls within the service.
- Emergency Call Handler Module Staff were not trained to the same level as permanent staff. This raised a risk as they were unable to undertake full patient assessments in line with the Advanced Medical Priority Dispatch System (AMPDS) and needed to call for assistance from other AMPDS qualified call handlers, who were then taken away from answering the front line calls, which may increase call waiting times and double up on resources.
- The environment within the main call centre at Chelmsford was visibly dirty. The carpet was thread bare in certain areas, desks were tatty, damaged and some of the COVID screens were visibly dirty.
- Infection Prevention and Control processes were not always followed. For example, we saw staff moving between workstations at the Chelmsford call centre without masks. At the Bedford call centre the inspection team was temperature checked, asked to see COVID status, follow the one-way system in place and sign in. This was not replicated at the Chelmsford call centre.
- Within the Chelmsford call centre we also noted the lighting was dim, and staff told us the lighting system made them feel like they were working in darkness and there were low levels of natural light entering the building. Staff coats were hung on the rear of chairs and cables laid across the floor without a conduit. The environment was cluttered, and uncoordinated. This posed a health and safety risk for staff working in the environment.

A draft inspection report will be sent to you once we have completed our due processes and you will have the opportunity to check the factual accuracy of the report. I am also copying this letter to Catherine Morgan at NHS England and NHS Improvement.

Could I take this opportunity to thank you once again for the arrangements that you made to help organise the inspection, and for the cooperation that we experienced from you and your staff.

If you have any questions about this letter, please contact me through our National Customer Service Centre using the details below:

Telephone: 03000 616161

Write to: CQC
Citygate
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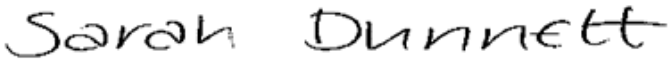
NE1 4PA

If you do get in touch, please make sure you quote or have the reference number (above) to hand. It may cause delay if you are not able to give it to us.

Yours sincerely



Sarah Dunnett

Interim Head of Hospitals Inspection

c.c. Nicola Scrivings (Trust Chair)
Catherine Morgan (NHS England and Improvement)
Johnathan Davies (CQC regional communications manager)