DEFINING 'GOOD' IN HEALTHCARE

SUMMARY REPORT OF FINDINGS: AMBULANCE SERVICES

1. INTRODUCTION, BACKGROUND TO THE RESEARCH AND OBJECTIVES

In April 2013, CQC published its new strategy *'Raising Standards, Putting People First'*. In this document, CQC stated its intention to redevelop its inspection methodology and the information that is provided to the public following an inspection. This change focuses not only on how services are inspected, but also the five key questions which inspectors will ask about services: Are they safe? Are they effective? Are they caring? Are they well led? Are they responsive to people's needs?

CQC has been working to develop new fundamental standards that focus on these five questions. As part of this work, CQC seeks to define the criteria that will be used to assign a rating to a service provider – in other words, understanding the features of a service that is considered 'inadequate', a service that 'requires improvement', is 'good' and 'outstanding'.

For this new inspection model to be credible with the public, it is essential that these criteria reflect the public's expectations. There is a particular focus on understanding what the public expects 'good' and 'outstanding' services to look like, across all care settings, and at all service levels.

Qualitative research was commissioned to provide a clear understanding of what the public and service users think 'good' and 'outstanding' look like when using ambulance services. In addition, the research explores what information requirements the public have in relation to inspection reports about ambulance services. The business objective was:

To inform the criteria that are developed for rating services and to inform the development of a new style of inspection reports for ambulance services.

2. AMBULANCE SERVICES SUMMARY

2.1 Method and sample

We conducted **4 x pair depth interviews with patients and their carers/supporters**. These included a mix of male and female patients and a mix of ages (including children and older people) and socio economic backgrounds.

	ABC1	**C2DE**
Male	Pair depth 1	Pair depth 3
Female	Pair depth 2	Pair depth 4

In addition, the sample contained:

- Users of both routine and emergency services
- A mix of ethnic minority groups
- A mix of urban and rural locations

The fieldwork was conducted in w/c 5th and w/c 12th January 2015.

2.2 Care standards experienced

Unsurprisingly, response times were a significant factor in determining whether respondents felt that the service had delivered the care they required. Firstly, call handling staff were expected to identify the urgency of the problem and set an arrival time. Secondly, ambulance staff were expected to meet the proposed arrival time and arrive fully prepared:

"That's the number one priority – how long these people are going to be." (Ambulance, emergency service user, male)

There were infrequent accounts (and stories heard through friends) of ambulances arriving late in emergency situations. Late arrivals were judged to 'require improvement'. However, there were no further criticisms of emergency ambulance services reported. For routine services, the public were fairly tolerant of difficulties with traffic and delays.

Patient handling and advice over the phone was lacking on one emergency occasion when a patient had been waiting for an ambulance. She was informed that there were no ambulances available. An ambulance arrived later in the day, but the patient had not been informed that it would be dispatched. This experience, in their opinion, was close to being 'inadequate'.

2.3 Spontaneous definitions of 'outstanding', 'good', 'requires improvement' and 'inadequate' care

In emergency situations, patients expected 'outstanding' care, as demonstrated by the timeliness, expert patient handling and professionalism of ambulance personnel.

Elements of care that were expected to be 'outstanding' were: ambulance staff etiquette, efficiency and their clinical abilities. When expectations were *set* by call handling staff (e.g. by stating a time of arrival) and subsequently *met* by ambulance staff (e.g. by arriving on time), patients felt very confident and reassured.

Once the ambulance had arrived, there was an expectation for ambulance staff to *"say the right things"* and reassure the patient. Overall ambulance staff, in emergency situations, needed to appear completely in control and able to establish a supportive relationship with the patient in order to be rated 'outstanding':

> *"I think the way they are to you is very important, especially if you're panicking or if something's happened…"* (Ambulance, emergency service user, male)

'Outstanding' ambulance care was expected to deliver:

- **Immediate understanding of the urgency of the situation**
- **High speed arrival and service**
- **Clear, professional communication** – e.g. call handlers communicating the estimated time of arrival and, once arrived, ambulance personnel communicating what patients can expect in hospital
- **A dignified and respectful service**
- **Reassurance and comfort for service users** and those accompanying them
- **Personalised care** – attending to individual needs and having the necessary equipment to provide it
- **A response to immediate clinical needs** (or fully resolving issues) before arrival at hospital
- **A suitable environment** e.g. new vehicles, beds and equipment
- **A smooth transition into hospital** without delays or complications

Ambulances for non-emergency services were perceived to provide a transport service. Arriving on time was a basic priority, which was generally met. There was also an expectation that staff would be polite and helpful. Meeting these two expectations was sufficient to achieve a 'good' rating.

Care that 'requires improvement' was typically associated with late arrivals, or miscommunication about arrival times. Experience of late arrivals was limited to non-emergency cases and these occasions were rare. If late, respondents expected to be informed and reassured that they would still be seen for their appointment.

Advice given over the phone was perceived to be a crucial way of diagnosing and reassuring patients. Advice given by telephone was also considered a way of using waiting time effectively (for example by asking a patient to lie in the right position, or take specific precautions):

"The person on a phone needs to be as good as an ambulance person – they need to give you proper medical advice – it must be hard to diagnose something over the phone."
(Ambulance, emergency service user, female)

The patient who was told that there were no ambulances available, and was not told that one had been dispatched, subsequently questioned the qualifications required to handle 999 calls. It was generally expected that call handling staff should receive the same kind of training for managing patients as ambulance personnel.

Care that 'requires improvement' included:

- **Late arrival** without communicating this message to patients
- **Poor patient handling** over the phone, and in person
- **Poor communication and administration in general** when keeping patients informed about emergency/non-emergency services, including delays
- **Insufficient space and comfort** (non-emergency users explained that sometimes patients had 'to squeeze in together')

2.4 Definitions of 'good' care within the five domains

2.4.1 Safe

'Safe' care primarily related to ambulances arriving on time in emergency situations. Equally, it was expected that ambulances would provide a suitable environment for staff to work in and avoid accidents or infection. There was also an expectation that ambulance services would provide staff with sufficient training to be able to manage a wide variety of health situations. Ambulance staff were perceived to be "unique" in that they were perceived to need to act fast and 'in the moment' without the support staff and facilities available in a hospital environment. Therefore, respondents felt that ambulance services should provide the optimum environment to accommodate their needs.

A well-equipped, clean environment was seen as a basic necessity. Respondents also felt that ambulances should be subject to universal health and safety measures to keep

everyone safe e.g. suitable steps, seatbelts and ample space for manoeuvre. Safe care was also felt to encompass driver competence to drive at high speeds and under pressure.

An ongoing assessment of practice was also expected to evaluate 'what works' across the wide-ranging incidents that an ambulance team encounter:

"It's quite a self-explanatory job isn't it? To make you safe, as well as you can be, and get you to hospital as quick as they can do. I don't see what else they have to do… They've got to get you there, make you safe, make sure you're not in any more danger, improve your health before you get there and get you there as quick as possible so you can be seen by a doctor." (Carer of ambulance emergency service user, male)

2.4.2 Effective

'Effective' care was perceived to involve ambulance personnel doing what can be done to 'fix' emergency situations i.e. arriving on time, attending to clinical needs inside the ambulance and ensuring an efficient transition into hospital care:

"It was effective. They came out and dealt with him… they did what they had to do to get (him) to the hospital straight away and get him out and in (to the hospital)." (Carer of ambulance emergency service user, female)

Respondents felt that any clinical needs should be addressed until a hospital was reached. This was a basic expectation. Effective care was also perceived to involve well communicated handovers. Some patients had overheard reports of ambulance care being "brilliant", but then patients had later arrived at hospital without a clear transition into hospital care (e.g. waiting around to be seen).

Organising resources effectively was another element of 'effective' ambulance care. Respondents felt that a 'well thought out' ambulance service would ensure good response times by positioning ambulance headquarters' appropriately and training drivers to avoid

hold ups. This expectation touched on elements of the ‘well led’ domain (i.e. allocating resources to meet demand so that services are delivered effectively).

‘Effective’ elements of the descriptions of ‘good’ in the Appendix to the Provider Handbook were not disputed and were reassuring for those with experience of emergency care. Non-emergency patients were less interested in the detail and were more practical about their expectations i.e. ‘get me there comfortably and on time’.

2.4.3 Caring

Good care within the ‘caring’ domain was largely related to respect, comfort and communication. Essentially, respondents expected ambulance personnel to treat service users with dignity and to respect their needs at all times. This also involved providing comfort for patients, including assistance with getting in and out of vehicles for non-emergency situations.

Overall, patients felt that a ‘caring’ ambulance service was vital to managing people in distress. They also felt that a caring approach helped avoid unwanted stress in non-emergency situations, for example, if the driver arrives slightly late but calls ahead and is apologetic, it was perceived to be a less problematic situation:

“All of these things [patient handling, respect, communication] come down to the training; they need to have the right training in place.” (Ambulance, non-emergency service user, male)

‘Good’ in the ‘caring’ domain also involved clear communication. This was an expectation of care throughout the patient pathway: from the initial emergency call, whilst being treated inside the vehicle and during the handover to hospital services.

The ‘caring’ elements of the descriptions of ‘good’ in the Appendix to the Provider Handbook were felt to cover the necessary standards for emergency situations, but appeared somewhat ‘excessive’ for non-emergency situations. However, non-emergency

respondents still welcomed all of the elements. They were conscious that emergency situations might arise for patients using non-emergency ambulance services.

2.4.4 Responsiveness

'Responsiveness' was associated with the call out process and subsequent response times. The overall expectations for 'responsiveness' were:

- **Swift diagnosis** from call handling staff, without any delays , errors or misinterpretation
- **Fast (and standardised) response times** for emergency services and timeliness for non-emergency services
- **Ambulance staff** knowing exactly how to act, treat and respond to patients when arriving at the scene

Responsive elements of the descriptions of 'good' in the Appendix to the Provider Handbook were perceived to be comprehensive. Complaints procedures were accepted, but not spontaneously identified.

2.4.5 Well led

The well-led domain was a challenging domain for the general public to conceptualise in the context of ambulance services. Their first thought was that 'well led' should be about training. It was suggested that compulsory training should ensure that ambulance staff have the clinical expertise to increase patients' chances of survival.

As well as clinical knowledge, respondents also expected that training would establish good standards of patient handling (e.g. staff positivity, support and friendliness). Essentially, respondents felt that the 'well-led' domain should establish a culture that embedded all the elements of the 'caring' domain within day-to-day practice:

"I just feel that they need to have a warm presence about them… Just to calm you down."
(Ambulance, emergency service user, female)

Respondents expected the 'well led' domain to ensure that providers created a well organised system for providing the on time and efficient delivery of services. This was expected to involve a 'top down' evaluation of service coverage and resource allocation. Those with more experience of management felt that this type of evaluation would maximise efficiency and deliver fair response times across different postcode areas.

Overall, the 'well-led' elements of the descriptions of 'good' in the Appendix to the Provider Handbook were difficult for respondents to engage with. However, leadership was recognised as being extremely important when delivering ambulance care in emergency situations. The management of non-emergency services was largely unknown, and was often assumed to be completely outsourced.

2.5 Information requirements

Overall, the descriptions of 'good' care were accepted as a basis for inspections. It was unlikely that respondents would investigate emergency care services beyond an interest in response times. For transport in non-emergency situations, general information (such as availability, contact information and assurances) would be of interest.

The information required by ambulance service users focussed on the 'practicalities' of the service and, to an extent, reassurance regarding 'staff training':

- What are the average response times for emergency calls?
- Am I kept on hold for a long time when I ring?
- How qualified are the staff? Do they know how to treat and look after me in the ambulance?
- Will they make sure that I'm comfortable?